MOLINA HEALTHCARE INC
Form 10-K
February 26, 2015
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K
(Mark One)

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

FOR THE FISCAL YEAR ENDED DECEMBER 31, 2014
or

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

Commission File Number 1-31719

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

Delaware	13-4204626
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
200 Oceangate, Suite 100, Long Beach, California 90802	
(Address of principal executive offices)	
(562) 435-3666	
(Registrant's telephone number, including area code)	

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

Title of Class	Name of Each Exchange on Which Registered
Common Stock, $0.001 Par Value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ý Yes ¨ No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
¨ Yes ý No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ý Yes ¨ No
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

ý Yes ¨ No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ý

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

Large accelerated filer	ý	Accelerated filer	¨
Non-accelerated filer	¨ (Do not check if a smaller reporting company)	Smaller reporting company	¨

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

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2014, the last business day of our most recently completed second fiscal quarter, was approximately $1,338.4 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2014).

As of February 20, 2015, approximately 49,873,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for the 2015 Annual Meeting of Stockholders to be held on May 6, 2015, are incorporated by reference into Part III of this Form 10-K.

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This Annual Report on Form 10-K ("Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the headings "Business," and "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly from the results discussed in the forward-looking statements. Factors that might cause such differences include, but are not limited to, those discussed in Part I, Item 1A of this Form 10-K under the heading "Risk Factors." Each of the terms "Company," "Molina Healthcare," "we," "our," and "us," as used herein refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.

PART I

Item 1: Business

OVERVIEW

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program.

As of December 31, 2014, our health plans served over 2.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Dr. C. David Molina founded our company in 1980 as a provider organization serving the Medicaid population in Southern California. Today, we remain a provider-focused company led by his son, Dr. J. Mario Molina.

Significant Accomplishments in 2014

Our mission is to provide quality health care to those receiving government assistance. Our goal is to achieve this mission while improving our financial strength. Our significant operational, financial and strategic accomplishments supporting this goal during 2014 included:

- Expanding existing markets. Our Health Plans segment enrollment has grown approximately 36% since December 31, 2013, primarily a result of:
  - Our 2014 growth initiatives associated with the Affordable Care Act (ACA). Since the inception of these programs in January 2014 through the end of fiscal 2014, we have added approximately 385,000 Medicaid expansion members, 18,000 integrated Medicare-Medicaid Plan (MMP) members, and 15,000 Marketplace members;
  - The inception and growth of operations at our newer health plans in South Carolina and Illinois, adding over 200,000 members in the aggregate in fiscal 2014; and
  - Acquisition of two Medicaid contracts in Florida, which added approximately 73,000 new members in fiscal 2014.
- Entering new strategic markets. In 2014, we were awarded a managed care contract in the Commonwealth of Puerto Rico that is expected to enroll its first members April 1, 2015. Total enrollment is expected to be approximately 350,000 new members, with anticipated annualized revenue of $750 million.
- Funding future growth. Debt financing transactions generated net cash of approximately $123 million; such transactions both extended the maturity date and lowered the rate of our convertible senior notes previously due in 2014.

Our Structure

We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment. We derive our revenues primarily from health insurance premiums and service revenues. Refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies," and Note 21, "Segment Information," for revenue information by state health plan, and segment revenue, profit and total asset information, respectively.

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The Health Plans segment consists of operational health plans in 11 states and our direct delivery business. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate health plans. Our Health Plans segment operates in a highly regulated environment, with stringent minimum capitalization requirements that limit the ability of our health plan subsidiaries to pay dividends to us.

Our Molina Medicaid Solutions segment provides design, development, implementation (DDI), and business process outsourcing (BPO) solutions to state governments for their Medicaid management information systems (MMIS). MMIS is a core tool used to support the administration of state Medicaid and other health care entitlement programs. Molina Medicaid Solutions currently holds MMIS contracts with the states of Idaho, Louisiana, Maine, New Jersey, and West Virginia; the U.S. Virgin Islands; and a contract to provide pharmacy rebate administration services for the Florida Medicaid program. We added the Molina Medicaid Solutions segment to our business in 2010 to expand our product offerings to include support of state Medicaid agency administrative needs, reduce the variability in our earnings resulting from fluctuations in medical care costs, improve our operating profit margin percentages, and improve our cash flow by adding a business for which there are no restrictions on dividend payments.

Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly. Additionally, our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

Health Care Reform

The ACA has made broad-based changes to the U.S. health care system that have significantly affected the U.S. economy and our business. We expect the ACA to continue to significantly impact our business operations and financial results, including our medical care ratios.

Key components of the legislation will continue to be phased in over the next several years, with the most significant changes having occurred at the start of 2014, including the implementation of the Medicaid expansion (in electing states) and Marketplace programs, Medicare and Marketplace minimum medical loss ratios (MLRs), and new industry-wide fees, assessments, and taxes. We have dedicated material resources and have incurred material expenses in implementing and complying with the ACA, and we will continue to do so. As a result of the novelty and extremely broad scale of all of the programmatic changes effected by the ACA, many of the business and market impacts of the ACA will not be known for several years. Further, given the inherent difficulty of foreseeing how individuals will respond to the choices afforded to them by the ACA, we cannot predict the full effect the ACA will have on us.

Our Strategic Growth Initiatives

Our mission is to provide quality health care to those receiving government assistance. This mission drives our strategic growth and growth-related initiatives as follows:

Enter New Programs Within Existing Markets

- Medicaid Expansion. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. At December 31, 2014, our membership included approximately 385,000 Medicaid expansion members, or 15% of total membership.
- Health Insurance Marketplace. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At December 31, 2014, we had approximately 15,000 Marketplace members.
- Medicare-Medicaid Plans. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and

Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014, and we expect to begin offering MMP coverage in South Carolina and Texas in the first quarter of 2015, and in Michigan in the second quarter of 2015.

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- Direct Delivery. Growth and aging of the U.S. population foreshadows an increasing shortage of physicians over the next 15 years. Health care reform is expected to worsen this shortage. We believe the shortage will be felt most acutely among already under-served populations, such as the financially vulnerable families and individuals we serve. While we have no plans to become an organization that fully integrates primary care delivery with our health plans, by leveraging our direct delivery capability on a selective basis we can improve access for our plan members in areas that are most under-served by primary care providers. We operate primary care clinics in the states of California, Florida, New Mexico, Utah, Virginia and Washington. In addition, we perform certain medical and administrative management services for a hospital in Long Beach, California, including the assumption of financial benefit and risk for a number of acute care beds at the hospital. We believe that this arrangement improves hospital access for our members in the Long Beach, California area, and enhances our overall direct delivery strategy. We may incur losses while we seek to modify various business operations and patient behaviors under the management services agreement.

Enter New Strategic Markets

We plan to continue to enter new markets through both acquisitions and by building our own start-up operations. We intend to focus our expansion in markets with competitive provider communities, supportive regulatory environments, significant size, and, where practicable, mandated Medicaid managed care enrollment. As described above, in December 2014 we entered into a Medicaid contract with the Puerto Rico Health Insurance Administration. The operational start date for the program is expected to be April 1, 2015.

Deliver Administrative Value to Medicaid Agencies

As Medicaid expenditures increase, we believe that an increasing number of states' and other Medicaid agencies will demand comprehensive solutions that improve both quality and cost-effectiveness. We intend to use our MMIS solution to provide state Medicaid agencies with a flexible and robust solution to their administrative needs. We believe that our MMIS platform, together with our extensive experience in health care management and health plan operations, enables us to offer state and other Medicaid agencies a comprehensive suite of Medicaid-related solutions that meets their needs for quality and for the cost-effective operation of their Medicaid programs.

Leverage Operational Efficiencies

We intend to leverage the operational efficiencies created by our centralized administrative infrastructure and flexible information systems to earn higher margins on future revenues. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and enter new markets at lower incremental cost. For example, our general and administrative expenses as a percentage of revenue (the general and administrative expense ratio) declined to 7.9% for the year ended December 31, 2014, compared with 10.1% for the year ended December 31, 2013.

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OUR INDUSTRY

Medicaid

Medicaid was established in 1965 under the U.S. Social Security Act to provide health care and long-term care services and support to low-income Americans. Although jointly funded by federal and state governments, Medicaid is a state-operated and state-implemented program. Subject to federal laws and regulations, states have significant flexibility to structure their own programs in terms of eligibility, benefits, delivery of services, and provider payments. As a result, there are 56 separate Medicaid programs—one for each U.S. state, each U.S. territory, and the District of Columbia.

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all states is currently about 57%, and ranges from a federally established FMAP floor of 50% to as high as 74%.

The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program (TANF), which covers primarily low-income mothers and children. In states that have elected to participate, Medicaid expansion provides eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Another common state-administered Medicaid program is for aged, blind or disabled (ABD) Medicaid beneficiaries, which covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients, and typically use more services because of their critical health issues. Additionally, the Children's Health Insurance Program (CHIP) is a joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs. As of December 31, 2014, approximately 70% of our members were TANF beneficiaries, 15% were Medicaid expansion beneficiaries, 12% were ABD beneficiaries, 2% were Medicare beneficiaries, and 1% were integrated MMP and Marketplace beneficiaries combined. For the year ended December 31, 2014, approximately 54% of our premium revenue was from TANF and Medicaid expansion membership combined; 36% was from ABD membership, 7% was from Medicare membership, 2% was from MMP integrated membership, and 1% was from Marketplace membership.

Every state Medicaid program must balance many potentially competing demands, including the need for quality care, adequate provider access, and cost-effectiveness. To improve quality and provide more uniform and cost-effective care, many states have implemented Medicaid managed care programs. These programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives capitation payments from the state. The health plan, in turn, arranges for the provision of health care services by contracting with a network of medical providers. The health plan implements care management and care coordination programs that seek to improve both care access and care quality, while controlling costs more effectively.

While many states have embraced Medicaid managed care programs, others continue to operate traditional fee-for-service programs to serve all or part of their Medicaid populations. Under fee-for-service Medicaid programs, health care services are made available to beneficiaries as they seek that care, without the benefit of a coordinated effort to maintain and improve their health. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher costs and more unfavorable outcomes. Additionally, providers paid on a fee-for-service basis are compensated based upon services they perform, rather than health outcomes, and therefore lack incentives to coordinate preventive care, monitor utilization, and control costs.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services (CMS). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition.

Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

Medicaid Management Information Systems

Because Medicaid is a state-administered program, every state must have mechanisms, policies, and procedures in place to perform a large number of crucial functions, including the determination of eligibility and the reimbursement of medical providers for services provided. This requirement exists regardless of whether a state has adopted a fee-for-service or a

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managed care delivery model. MMIS are used by states to support these administrative activities. Although a small number of states build and operate their own MMIS, a far more typical practice is for states to sub-contract the design, development, implementation, and operation of their MMIS to private parties. Through our Molina Medicaid Solutions segment, we actively participate in this market.

Competition

The Medicaid managed care industry is fragmented, and the competitive landscape is subject to ongoing changes as a result of health care reform, business consolidations and new strategic alliances. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, quality of provider network, quality of service, and reputation. Our primary competitors in the Medicaid managed care industry include Centene Corporation, WellCare Health Plans, Inc., UnitedHealth Group Incorporated, Anthem, Inc., and Aetna Inc. Competition can vary considerably from state to state. Below is a general description of our principal competitors for state contracts, members, and providers:

- Multi-Product Managed Care Organizations - National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- Medicaid HMOs - National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.
- Prepaid Health Plans - Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.
- Primary Care Case Management Programs - Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as to provide limited oversight of other services.

We will continue to face varying levels of competition. Health care reform proposals may cause organizations to enter or exit the market for government sponsored health programs. However, the licensing requirements and bidding and contracting procedures in some states may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan’s provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Molina Medicaid Solutions competes with large MMIS vendors, such as HP Enterprise Services (formerly known as EDS), ACS (owned by Xerox Corporation), Computer Services Corporation, and CNSI.

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BUSINESS OPERATIONS

Our Strengths

From a strategic perspective, we believe our two business segments allow us to participate in an expanding sector of the economy and continue our mission to provide quality health services to financially vulnerable families and individuals covered by government programs. Our approach to our business is based on the following strengths:

Comprehensive Medicaid Services. We offer a complete suite of Medicaid services, ranging from quality care, disease management, cost management, and direct delivery of health care services, to state-level MMIS administration through our Molina Medicaid Solutions segment. We have the ability to draw upon our experience and expertise in each of these areas to enhance the quality of the services we offer in the others. We also believe that we may have opportunities to market to state Medicaid agencies various cost containment and quality practices used by our health plans, such as care management and care coordination, for incorporation into their own fee-for-service Medicaid programs.

Flexible Service Delivery Systems. Our health plan care delivery systems are diverse and readily adaptable to different markets and changing conditions. We arrange health care services with a variety of providers, including independent physicians and medical groups, hospitals, ancillary providers, and our own clinics. Our systems support multiple types of contract models. Our provider networks are well-suited, based on medical specialty, member proximity, and cultural sensitivity, to provide services to our members. We believe that our Molina Medicaid Solutions platform, which is based on commercial off-the-shelf technology, has the flexibility to meet a wide variety of state Medicaid administrative needs in a timely and cost-effective manner.

Proven Expansion and Acquisition Capability. We have successfully replicated the business model of our Health Plans segment through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The initial acquisitions of our New Mexico, South Carolina and Wisconsin health plans have demonstrated our ability to expand into new states. The establishment of our health plans in Florida, Illinois, Ohio, Texas and Utah reflects our ability to replicate our business model on a start-up basis in new states, while significant contract acquisitions in California, Michigan, New Mexico and Washington have demonstrated our ability to expand our operations within states in which we were already operating.

Administrative Efficiency. Operationally, our two business segments share a common systems platform, which allows for economies of scale and common experience in meeting the needs of state Medicaid programs. We have centralized and standardized various functions and practices to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform and standardization of medical management programs, pharmacy benefits management contracts, and health education programs. In addition, we have designed our administrative and operational infrastructure to be scalable for cost-effective expansion into new and existing markets.

Recognition for Quality of Care. The National Committee for Quality Assurance (NCQA) has accredited nine of our 11 Medicaid managed care plans. We believe that these objective measures of the quality of the services that we provide will become increasingly important to state Medicaid agencies.

Experience and Expertise. Since the founding of our company in 1980 to serve the Medicaid population in southern California through a small network of primary care clinics, we have increased our membership to 2.6 million members as of December 31, 2014, expanded our Health Plans segment to 11 states, and added our Molina Medicaid Solutions segment. Our experience over more than 30 years has allowed us to develop strong relationships with the constituents we serve, establish significant expertise as a government contractor, and develop sophisticated disease management, care coordination and health education programs that address the particular health care needs of our members. We also benefit from a thorough understanding of the cultural and linguistic needs of Medicaid populations.

Pricing

Medicaid. Under our Medicaid contracts, state government agencies pay our health plans fixed PMPM rates that vary by state, line of business and demographics; and we arrange, pay for and manage health care services provided to Medicaid beneficiaries. Therefore, our health plans are at risk for the medical costs associated with their members' health care. The rates we receive are subject to change by each state and, in some instances, provide for adjustments for health risk factors. CMS requires these rates to be actuarially sound. Payments to us under each of our Medicaid

contracts are subject to the annual appropriation process in the applicable state.

Medicare. Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment.

Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to

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federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

Marketplace. For our Marketplace plans, we develop premium rates during early spring of any given year to take effect on January 1st of the following year. We develop our premium rates based on our estimates of projected member utilization, medical unit costs, and administrative costs, with the intent of realizing a target pretax percentage profit margin. In setting premium rates for our Marketplace plans, we also take into account the competitive environment on a region–by–region basis. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proved to be an effective method for coordinating medical care for our members. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use predictive modeling that supports a proactive case and health management approach both for us and our affiliated physicians.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs such as the following:

- Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. "motherhood matters!^{sm}" is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. "breathe with ease!" is a multi-disciplinary disease management program that provides health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and 15. "Healthy Living with Diabetes" is a diabetes disease management program. "Heart Healthy Living" is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.
- Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with information to guide them through various episodes of care. This information, which is available in several languages, is designed to educate members on the use of primary care physicians, emergency rooms, and nurse call centers.
- Pharmacy Management Programs. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members, to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

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Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. Our network of providers includes primary care physicians, specialists and hospitals. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or independent practice associations (IPAs). Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups (DRGs) capitation, and case rates.

Direct Delivery. The clinics we operate are located in neighborhoods where our members live, and provide us a first-hand opportunity to understand the special needs of our members. The clinics we operate, and the clinics and hospital services we manage, assist us in developing and implementing community education, disease management, and other programs. Direct clinic management experience also enables us to better understand the needs of our contracted providers.

Reinsurance

Our health plans currently have reinsurance agreements with an unaffiliated insurer to cover certain claims. We enter into these contracts to reduce the risk of catastrophic losses which in turn reduce our capital and surplus requirements. We frequently evaluate reinsurance opportunities and review our reinsurance and risk management strategies on a regular basis.

Management Information Systems

All of our health plan information technology systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. Our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- Provider Self Services - Providers have the ability to access information regarding their members and claims. Key functionalities include "Check Member Eligibility," "View Claim," and "View/Submit Authorizations."
- Member Self Services - Members can access information regarding their personal data, and can perform the following key functionalities: "View Benefits," "Request New ID Card," "Print Temporary ID Card," and "Request Change of Address/PCP."
- File Exchange Services - Various trading partners, such as service partners, providers, vendors, management companies, and individual IPAs, are able to exchange data files (such as those that may be required by federal health care privacy regulations, or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as

preparation of the Healthcare Effectiveness Data and Information Set (HEDIS), and accreditation by the NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers.

Claims Processing. All of our health plans operate on a single managed care platform for claims processing (the QNXT system).

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Centralized Management Services. We provide certain centralized medical and administrative services to our health plans pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems, and human resources services. Fees for such services are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the health plan's ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General of the U.S. Department of Health and Human Services (HHS). Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event.

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CONTRACTING AND REGULATORY COMPLIANCE

Government Contracts

Medicaid. In all the states in which we operate health plans, we enter into a contract with the state's Medicaid agency to offer managed care benefits to Medicaid-eligible individuals. Some states award contracts to any applicant demonstrating that it meets the state's requirements, while other states engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population; for example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services;
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, to demonstrate our ability to coordinate all of the sources from which our members may receive care;
- We must be able to meet the needs of the disabled and others with special needs;
- Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf; and
- Our member handbook, newsletters, and other communications must be written at the prescribed reading level, and must be available in languages other than English.

To operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. We are regulated by the state agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. For example, we must demonstrate that:

- Our provider network is adequate;
- Our quality and utilization management processes comply with state requirements;
- We have adequate procedures in place for responding to member and provider complaints and grievances;
- We can meet requirements for the timely processing of provider claims;
- We can collect and analyze the information needed to manage our quality improvement activities;
- We have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs;
- We have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion; and
- We have the financial resources needed to protect the state, our providers, and our members against the insolvency of one of our health plans.

Our state contracts determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. The contracts also detail the requirements for operating in the Medicaid sector, including provisions relating to: eligibility; enrollment and dis-enrollment processes; covered benefits; eligible providers; subcontractors; record-keeping and record retention; periodic financial and informational reporting; quality assurance; marketing; financial standards; timeliness of claims payments; health education, wellness and prevention programs; safeguarding of member information; fraud and abuse detection and reporting; grievance procedures; and organization and administrative systems. A health plan's compliance with these requirements is subject to monitoring by state regulators. A health plan is subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan.

The contractual relationship with the state is generally for a period of three to four years and is renewable on an annual or biennial basis at the discretion of the state. In general, either the state Medicaid agency or the health plan may terminate the state contract with or without cause upon 30 days to nine months' prior written notice.

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Most of these contracts contain renewal options that are exercisable by the state. Our health plan subsidiaries have generally been successful in obtaining the renewal of their contracts in each state prior to the actual expiration of their contracts. Our state contracts are generally at greatest risk of loss when a state issues a new request for proposals (RFP), subject to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. For instance, in early 2012 our Missouri health plan was notified that it was not awarded a new contract under that state's RFP, and therefore its contract expired in that year.

Medicare. Under annually renewable contracts with CMS, our state health plans offer Medicare Advantage special needs plans which include a mandatory Part D prescription drug benefit. Molina Medicare Options Plus, our trade name for these plans, serves beneficiaries who are dually eligible for both Medicare and Medicaid, such as low-income seniors and people with disabilities. We believe offering these Medicare plans is consistent with our historical mission of serving low-income and medically under-served families and individuals. We employ sales personnel, and engage independent brokers, agents and consultants to enroll new Molina Medicare Options Plus members. None of our health plans operates a Medicare Advantage private fee-for-service plan.

Total enrollment in our Medicare Advantage plans as of December 31, 2014 was approximately 49,000 members. For the year ended December 31, 2014, Medicare premium revenues in the aggregate represented approximately 7% of our total premium revenues.

Federal regulations place prohibitions and limitations on certain sales and marketing activities of Medicare Advantage plans. Among other things, Medicare Advantage plans are not permitted to make unsolicited outbound calls to potential members or engage in other forms of unsolicited contact, establish appointments without documented consent from potential members, or conduct sales events in certain provider-based settings. Additionally, there are certain restrictions on agent and broker compensation.

Molina Medicaid Solutions. We continually monitor the status of various states' legacy MMIS capabilities and contracts to determine whether Molina Medicaid Solutions' value proposition and core strengths will address a state's MMIS goals. Once an RFP with a Medicaid agency is won, our Molina Medicaid Solutions contracts may extend over a number of years, particularly in circumstances where we deliver extensive and complex DDI services, such as the initial design, development and implementation of a complete MMIS. For example, the initial terms of our most recently implemented Molina Medicaid Solutions contracts (in Idaho and Maine) were each seven years in total, consisting of two years allocated for the delivery of DDI services, followed by five years for the performance of BPO services. The terms of our other Molina Medicaid Solutions contracts - which primarily involve the delivery of BPO services with only minimal DDI activity (consisting of system enhancements) - are shorter in duration than our Idaho and Maine contracts.

The federal government typically reimburses the states for 90% of the costs incurred in the design, development, and implementation of an MMIS and for 75% of the costs incurred in operating a certified MMIS. Federal certification increases the share of the claims processing costs the federal government will pay for monthly operations. With an uncertified system, the federal government contributes approximately 50% of claims processing costs, with the state paying the other half. With a certified system, the federal government pays 75% of costs, reducing the state's share.

Regulatory Compliance

Our health plans are highly regulated by both state and federal government agencies. Regulation of managed care products and health care services varies from jurisdiction to jurisdiction, and changes in applicable laws and rules occur frequently. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Such agencies have become increasingly active in recent years in their review and scrutiny of health insurers and managed care organizations, including those operating in the Medicaid and Medicare programs.

Health Insurer Fee (HIF). One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231 million.

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For further discussion of the risks and uncertainties relating to this excise tax, refer to Part II, Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, under the subheading "Liquidity and Capital Resources—Financial Condition."

States' Risk-Based Capital Requirements. Our health plans are required to file quarterly and annual reports of their operating results with the appropriate state regulatory agencies. These reports are accessible for public viewing. Each health plan undergoes periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. The minimum statutory net worth requirements differ by state, and are generally based on statutory minimum risk-based capital (RBC) requirements. The RBC requirements are based on guidelines established by the National Association of Insurance Commissioners (NAIC) and are administered by the states. All of our state health plans are subject to RBC requirements, except California and Florida. Any acquisition of another plan's members or its state contracts must also be approved by the state, and our ability to invest in certain financial securities may be prescribed by statute. For further information regarding RBC requirements, refer to Part II, Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies."

In addition, we are also regulated by each state's department of health services or the equivalent agency charged with oversight of Medicaid and CHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

HIPAA. In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). All health plans are subject to HIPAA, including ours. HIPAA generally requires health plans to:

- Establish the capability to receive and transmit electronically certain administrative health care transactions, like claims payments, in a standardized format;
- Afford privacy to patient health information; and
- Protect the privacy of patient health information through physical and electronic security measures.

Health care reform created additional tools for fraud prevention, including increased oversight of providers and suppliers participating or enrolling in Medicaid, CHIP, and Medicare. Those enhancements included mandatory licensure for all providers, and site visits, fingerprinting, and criminal background checks for higher risk providers.

The Health Information Technology for Economic and Clinical Health Act (HITECH Act), a part of the American Recovery and Reinvestment Act of 2009, or ARRA, modified certain provisions of HIPAA by, among other things, extending the privacy and security provisions to business associates, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions, and increasing penalties for violations. As required by ARRA, the Secretary of HHS has promulgated regulations implementing various provisions of the HITECH Act. The Final Omnibus Rule promulgated by HHS in January 2013, included the Final Breach Notification Rule as well as provisions that apply the HIPAA regulatory scheme to business associates. We anticipate that HHS will promulgate additional rules under the HITECH Act to implement provisions of the statute which were not addressed in the Final Omnibus Rule. The various requirements of the HITECH Act and the Final Omnibus Rule have different compliance dates, and in some cases, the applicable compliance date may depend on the publication of additional rules or guidance by HHS. With respect to those requirements whose compliance dates have passed, we believe that we are in compliance with such provisions. With respect to additional requirements that may be issued in the future by HHS, it is our intention to implement any such new requirements on or before the applicable compliance dates.

Fraud and Abuse Laws. Our operations are subject to various state and federal health care laws commonly referred to as "fraud and abuse" laws. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. These fraud and abuse laws include the federal False Claims Act which prohibits the knowing filing of a false claim or the knowing use of false statements to obtain payment from the federal government. Many states have false claim act statutes that closely resemble the federal False Claims Act. If an entity is determined to have violated the federal False Claims Act, it must pay three times the actual damages sustained by the government, plus mandatory

civil penalties up to fifty thousand dollars for each separate false claim. Suits filed under the Federal False Claims Act, known as "qui tam" actions, can be brought by any individual on behalf of the government and such individuals (known as "relators" or, more commonly, as "whistleblowers") may share in any amounts paid by the entity to the government in fines or settlement. Qui tam actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines or be excluded from the Medicaid, Medicare or other state or Federal health care programs as a result of an investigation arising out of such action. In addition, the Deficit Reduction Act of 2005 (DRA) encourages states to enact state-versions of the federal False Claims Act that establish liability to the state for false and fraudulent Medicaid claims and that provide for, among other things, claims to be filed by qui tam relators.

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Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public sector programs are complex and subject to change. Violations of certain fraud and abuse laws applicable to us could result in civil monetary penalties, criminal fines and imprisonment, and/or exclusion from participation in Medicaid, Medicare, other federal health care programs and federally funded state health programs.

Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Although we believe that our compliance efforts are adequate, we will continue to devote significant resources to support our compliance efforts.

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OTHER INFORMATION

Intellectual Property

We have registered and maintain various service marks, trademarks and trade names that we use in our businesses, including marks and names incorporating the "Molina" or "Molina Healthcare" phrase, and from time to time we apply for additional registrations of such marks. We utilize these and other marks and names in connection with the marketing and identification of products and services. We believe such marks and names are valuable and material to our marketing efforts.

Employees

As of December 31, 2014, we had approximately 10,500 employees. Our employee base is multicultural and reflects the diverse membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Available Information

We are organized as a C corporation under Delaware law. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

You can access our website at www.molinahealthcare.com to learn more about our Company. From that site, you can download and print copies of our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, along with amendments to those reports. You can also download our Corporate Governance Guidelines, Board of Directors committee charters, and Code of Business Conduct and Ethics. We make periodic reports and amendments available, free of charge, as soon as reasonably practicable after we file or furnish these reports to the SEC. We will also provide a copy of any of our corporate governance policies published on our website free of charge, upon request. To request a copy of any of these documents, please submit your request to: Molina Healthcare, Inc., 200 Oceangate, Suite 100, Long Beach, California 90802, Attn: Investor Relations. Information on or linked to our website is neither part of nor incorporated by reference into this Annual Report on Form 10-K or any other SEC filings.

Executive Officers of the Registrant

The following sets forth certain information regarding our executive officers, including the business experience of each executive officer during the past five years:

Name	Age	Position
J. Mario Molina, M.D.	56	President and Chief Executive Officer
John C. Molina, J.D.	50	Chief Financial Officer
Terry P. Bayer	64	Chief Operating Officer
Joseph W. White	56	Chief Accounting Officer
Jeff D. Barlow	52	Chief Legal Officer and Corporate Secretary

Dr. Molina has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board of Directors since 1996. Dr. Molina is the brother of John C. Molina.

Mr. Molina has served as Chief Financial Officer since 1995. He also has served as a member of the Board of Directors since 1994. Mr. Molina is the brother of Dr. J. Mario Molina.

Ms. Bayer has served as Chief Operating Officer since 2005.

Mr. White has served as Chief Accounting Officer since 2007.

Mr. Barlow has served as Chief Legal Officer and Corporate Secretary since 2010. From 2004 to 2010, Mr. Barlow served as Vice President, Assistant Secretary, and Assistant General Counsel of Molina Healthcare.

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Item 1A: Risk Factors

RISK FACTORS

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995

This Annual Report on Form 10-K and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). Other than statements of historical fact, all statements that we include in this report and in the documents we incorporate by reference may be deemed to be forward-looking statements for purposes of the Securities Act and the Exchange Act. Such forward-looking statements may be identified by words such as "anticipates," "believes," "could," "estimates," "expects," "guidance," "intends," "may," "outlook," "plans," "projects," "seeks," "will," or similar words or expressions.

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as the other information we include or incorporate by reference in this report and the information in the other reports we file with the U.S. Securities Exchange Commission, or SEC. Such risk factors should be considered not only with regard to the information contained in this annual report, but also with regard to the information and statements in the other periodic or current reports we file with the SEC, as well as our press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. No assurance can be given that we will actually achieve the results contemplated or disclosed in our forward-looking statements. Such statements may turn out to be wrong due to the inherent uncertainties associated with future events. Accordingly, you should not place undue reliance on our forward-looking statements, which reflect management’s analyses, judgments, beliefs, or expectations only as of the date they are made.

If any of the events described in the following risk factors actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties not currently known to us or that we currently deem immaterial may also affect our business and operations. As such, you should not consider this list to be a complete statement of all potential risks or uncertainties. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results, and do not undertake to address how any of these factors may have caused results to differ from discussions or information contained in previous filings or communications.

Risks Related to Our Health Plans Segment

Numerous risks associated with the Affordable Care Act and its implementation could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, President Obama signed both the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act (collectively, the Affordable Care Act, or ACA). The ACA enacts comprehensive changes to the United States health care system, elements of which will be phased in at various stages over the next several years. However, the most significant changes effected by the ACA were implemented as of January 1, 2014. There are a multitude of risks associated with the scope of change in the health care system represented by the ACA, including, but not limited to, the following:

- Risks associated with the health care federal excise tax. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums. However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. The state of California has not formally committed to reimburse us for either the HIF itself, or the related tax effects. The states of Michigan and Utah have reimbursed us

for the HIF, but have not formally committed to reimbursement for the related tax effect. The total amount of HIF revenue for which agreements were not secured (and revenue was not recognized) amounted to approximately $20 million for fiscal 2014. We expect to collect and recognize this revenue related to 2014 in 2015. We further expect to recognize revenue in 2015 sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2015. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231

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million. The failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows or results of operations.

- Risks associated with the duals expansion. Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014, and we expect to begin offering MMP coverage in South Carolina and Texas in the first quarter of 2015, and in Michigan in the second quarter of 2015.

  There are numerous risks associated with the initial implementation of a new program, with a health plan's expansion into a new service area, and with the provision of medical services to a new population which has not previously been in managed care. One such risk is the development of actuarially sound rates. Because there is limited historical information on which to develop rates, certain assumptions are required to be made which may subsequently prove to have been inaccurate. Rates of utilization could be significantly higher than had been projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, because of our lack of actuarial experience for that program, region, or population, our reserve levels may be set at an inadequate level. For instance, these problems arose at our Texas health plan in the second quarter of 2012, leading to extremely elevated medical care costs and substantial losses at the health plan. All of these risks are present in the implementation of the duals demonstration programs. In the event these risks materialize at one or more of our health plans, the negative results of the health plan or plans could adversely affect our business, financial condition, cash flows, or results of operations.

- Risks associated with Medicaid expansion. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. At December 31, 2014, our membership included approximately 385,000 Medicaid expansion members, or 15% of total membership. The new enrollees in our health plans represent a population that is different from the population of Medicaid enrollees we have historically managed. All of the risk factors described above with regard to the duals demonstration programs apply equally to Medicaid expansion.

- Risks associated with health insurance marketplaces. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in all of the states in which we operate, except Illinois and South Carolina. At December 31, 2014, we had approximately 15,000 Marketplace members, and that enrollment is expected to grow appreciably in 2015, particularly at our Florida health plan. All of the risk factors described above with regard to the duals demonstration programs apply equally to our participation in the insurance marketplaces.

- Risks associated with the King v. Burwell case. There is a case currently pending before the United States Supreme Court to be argued on March 4, 2015, challenging whether the IRS may permissibly promulgate regulations to extend tax-credit subsidies to coverage purchased through exchanges established by the federal government under Section 1321 of the ACA. In the event the Supreme Court rules against Health and Human Services Secretary Burwell, no federal subsidies would be allowed to be paid to those individuals purchasing health insurance through the federally

facilitated exchanges, of which there are currently 36. This would undermine the functioning of those exchanges, and cause major disruption under the entire ACA throughout the nation.

- Risk associated with implementing regulations. There are many parts of the ACA that require further guidance in the form of regulations. Due to the breadth and complexity of the ACA, the lack of implementing regulations and interpretive guidance, and the phased nature of the ACA's implementation, the overall impact of the ACA on our business and on the health industry in general over the coming years is difficult to predict and not yet fully known, and implementing regulations could contain provisions that have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio, continuing operations, for the year ended December 31, 2014 of 89.5% had been one percentage point higher, or 90.5%, our net income from continuing operations for the year ended December 31, 2014 would have been approximately $0.12 per diluted share rather than our actual income from continuing operations of $1.30 per diluted share, a decrease of approximately 91%.

Factors that may affect our medical care costs include the level of utilization of health care services, unexpected patterns in the annual flu season, increases in hospital costs, an increased incidence or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in health care regulations and practices, epidemics, new medical technologies, and other various external factors. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could reduce our revenues and profit margins.

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. Due to high unemployment levels, Medicaid enrollment levels and Medicaid costs remain elevated at the same time that state budgets are suffering from significant fiscal strain. Because Medicaid is one of the largest expenditures in every state budget, and one of the fastest-growing, it is a prime target for cost-containment efforts. The states in which we operate our health plans regularly face significant budgetary pressures. These budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

We are unable to determine how any future Congressional spending cuts will affect Medicare and Medicaid reimbursement. There likely will continue to be legislative and regulatory proposals at the federal and state levels directed at containing or lowering the cost of health care that, if adopted, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such "incurred but not paid" (IBNP) medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to duals, Medicaid expansion members, or

aged, blind or disabled Medicaid members, is impacted by the more limited experience we have had with those populations.

The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served.

If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our

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results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

An increased incidence of flu in one or more of the states in which we operate a health plan could significantly increase utilization rates and medical costs.

Our results can be significantly impacted by a severe flu season in the states in which we operated our health plans. We seek to set our IBNP reserves appropriately to account for seasonal spikes in the incidence of the flu. However, if the actual utilization rates of our members are higher than we had anticipated, our results in the relevant periods could be materially and adversely affected.

If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed, our premium revenues could be materially reduced and our operating results could be negatively impacted.

Our government contracts may be subject to periodic competitive bidding. In such process, our health plans may face competition as other plans, many with greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. In the event the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states, and our premium revenues could be materially reduced as a result. Alternatively, even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected.

In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also subject to cancellation by the state in the event of the unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. Further, most of our contracts are terminable without cause.

Our government contracts generally run for periods of three to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. Although our health plans have generally been successful in obtaining the renewal and/or extension of their state contracts, there can be no guarantee that any of our state government contracts will be renewed or extended, as shown by the loss of our Missouri contract in 2012 in connection with an unsuccessful RFP bid. During 2015, our Michigan Medicaid contract will be subject to a new RFP. We expect the Michigan RFP to be released on May 1, 2015, and for the new contract to become effective on October 1, 2015. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, including our Michigan contract, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, cash flows, or results of operations could be adversely affected.

If we sustain a cyberattack or suffer privacy or data security breaches that disrupt our operations or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences.

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data in our operations, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. We may be subject to breaches of the information technology systems we use. Experienced computer programmers and hackers may be able to penetrate our layered security controls and misappropriate or compromise sensitive personal information or proprietary or confidential information, create system disruptions, or cause shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit any security vulnerabilities. Because the techniques used to circumvent security systems can be highly sophisticated and change frequently, often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world, we may be unable to proactively address these techniques or to implement adequate preventive measures. Our facilities may also be vulnerable to security incidents or security attacks; acts of vandalism or theft; misplaced or lost data; human errors; acts of malicious insiders, or other similar events that could negatively affect our systems and our and our members' data. The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident

could be significant. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us, damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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The exorbitant cost of specialty drugs and new generic drugs could have a material adverse effect on the level of our medical costs and our results of operations.

In 2014, Gilead's pricing of the hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy received major attention as a health care policy and public policy matter. Because of the relatively high incidence of hepatitis C throughout the nation, particularly in the Medicaid population, the pricing of specialty drugs for the treatment of hepatitis C represents a major public health and public financing problem. In the case of Sovaldi, because of its advent on the health care market in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates, thus threatening to undermine the actuarial soundness of those rates. New high priced specialty drugs and generic drugs are expected to enter the health care market in 2015. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. We will seek to work with state Medicaid agencies to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals. In the event we are required to bear the high costs of new specialty drugs or generic drugs without an appropriate rate adjustment or other reimbursement mechanism, or if new regulations or mandates affect our pharmaceutical costs, our business, financial condition, cash flows, or results of operations could be adversely affected.

States may not adequately compensate us for the value of drug rebates that were previously earned by us but that are now collectible by the states.

ACA includes certain provisions that change the way drug rebates are handled for drug claims filled by Medicaid managed care plans. Retroactive to March 23, 2010, state Medicaid programs are now required to collect federal rebates on all Medicaid-covered outpatient drugs dispensed or administered to Medicaid managed care enrollees (excluding certain drugs that are already discounted), and pharmaceutical manufacturers are required to pay specified rebates directly to the state Medicaid programs for those claims. This has impacted the level of rebates received by managed care plans from the manufacturers for Medicaid managed care enrollees. Many manufacturers have renegotiated or discontinued their rebate contracts with Medicaid managed care plans and pharmacy benefits managers to offset these new rebates paid directly to state Medicaid programs. As a result, the drug rebate amounts paid to managed care plans like ours continue to remain at levels that are much lower than prior to ACA implementation. There are provisions in the ACA that require rates paid to Medicaid managed care plans to be actuarially sound in regard to drug rebates. Although we will be pursuing rate increases with state agencies to make us whole for the rebate amounts lost, there can be no assurances that the premium increases we may receive, if any, will be adequate to offset the amount of the lost rebates. If such premium increases prove to be inadequate, our business, financial condition, cash flows, or results of operations could be adversely affected.

We derive our premium revenues from a relatively small number of state health plans.

We currently derive our premium revenues from 11 state health plans, with our Puerto Rico health plan expected to commence operations in April 2015. If we are unable to continue to operate in any of those 11 states, or if our current operations in any portion of the states we are in are significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on an abrupt loss of membership, significant rate reductions, a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic, an unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate, or a significant change in the nature of our existing operations, could adversely affect our business, financial condition, cash flows, or results of operations.

There are performance risks and other risks associated with certain provisions in the state Medicaid contracts of several of our health plans.

The state contracts of our California, Illinois, New Mexico, Ohio, Texas, Washington, and Wisconsin health plans contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues in those states. In the event we are unsuccessful in achieving the stated performance measure, the health plan will be unable to recognize the revenue associated with that measure. Any failure of our

health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations. In addition, the state contracts of our California, Florida, Illinois, Michigan, New Mexico, Ohio, Texas, and Washington health plans contain provisions pertaining to medical cost floors and corridors, administrative cost and profit ceilings, and profit-sharing arrangements. Our Medicare and Marketplace business is also subject to medical cost floor requirements enacted by the Federal government. These provisions are subject to interpretation and application by our health plans. In the event the applicable state government agency disagrees with our health plan's interpretation or application of the sometimes complicated contract provisions at issue, the health plan could be required to adjust the amount of its obligations under these provisions and/or make a payment or payments to the state. Any interpretation or application of these provisions at

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variance with our health plan's interpretation or inconsistent with our revenue recognition accounting treatment could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Failure to attain profitability in any new start-up operations, including in our new Puerto Rico health plan, could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable health plan in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the health plan. Rapid growth in an existing state will also result in increased net worth requirements. In such circumstances, we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. All of these risks will pertain to our new start-up Puerto Rico health plan, which is expected to commence operations in April 2015. The expenses associated with starting up a health plan in a new state or commonwealth, or expanding a health plan in an existing state could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations.

Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide health care services as established by the state governments. We use a large portion of our revenues to pay the costs of health care services delivered to our members. If premiums do not increase when expenses related to medical services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, or could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect our business, financial condition, cash flows, or results of operations.

Furthermore, a state undergoing a budget crisis may significantly delay the premiums paid to one of our health plans. Any significant delay in the monthly payment of premiums to any of our health plans could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Reductions in Medicare payments could reduce our earnings potential for our Medicare Advantage plans and our duals demonstration programs.

The Sequestration Transparency Act of 2012 included a 2% reduction of payments from CMS to our Medicare Advantage plans beginning April 1, 2013. Medicare Advantage plans will continue to be affected until Congress lifts the sequestration mandated under the Sequestration Transparency Act of 2012. The impact of sequestration cuts on our Medicare Advantage revenues is partially mitigated by reductions in provider reimbursements paid to those providers with rates indexed to the Medicare fee-for-service reimbursement rates. Such reduction in our Medicare payments may have an adverse effect on our earnings potential for our Medicare Advantage plans and our duals demonstration programs. In addition, reductions to provider reimbursement rates associated with sequestration may adversely impact our relations with the impacted providers.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of other health plans and the assignment and assumption of Medicaid contract rights of other health plans have accounted for a significant amount of our growth over the last several years. Although we cannot predict

with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets—particularly operators of large commercial health plans—have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us, or at all, or obtain the necessary financing for these acquisitions. For these reasons, among others, we cannot provide assurance that we will be able to complete favorable acquisitions, especially in light of the volatility in the capital markets over the past several years, or that we will not complete acquisitions that turn out to be unfavorable. Further, to the extent we complete an acquisition, we

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may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- new provider networks which may operate on terms different from our existing networks,
- additional members who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record-keeping systems,
- internal controls and accounting policies, including those which require the exercise of judgment and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters, and
- new regulatory schemes, relationships, practices, and compliance requirements.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions of health plans. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. Furthermore, we may be required to renegotiate contracts with the network providers of the acquired business. We may be unable to obtain the necessary governmental approvals, comply with these regulatory requirements or renegotiate the necessary provider contracts in a timely manner, if at all.

In addition, we may be unable to successfully identify, consummate, and integrate future acquisitions, including integrating the acquired businesses on our information technology platform, or to implement our operations strategy in order to operate acquired businesses profitably. Furthermore, we may incur significant transaction expenses in connection with a potential acquisition which may or may not be consummated. These expenses could impact our selling, general and administrative expense ratio.

For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

We face periodic routine and non-routine reviews, audits, and investigations by government agencies, and these reviews and audits could have adverse findings, which could negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits, and investigations. Violation of the laws, regulations, or contract provisions governing our operations, or changes in interpretations of those laws and regulations, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, the exclusion from participation in government sponsored health programs, or the revision and recoupment of past payments made based on audit findings. If we are unable to correct any noted deficiencies, or become subject to material fines or other sanctions, we could suffer a substantial reduction in profitability, and could also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations.

Premium payments to our health plan segment are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers.

We are subject to extensive fraud and abuse laws which may give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including the federal False Claims Act, which permit agencies and enforcement authorities to institute suit against us for violations and, in some cases, to seek treble damages, penalties, and assessments. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information

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we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Qui tam actions under federal and state law can be brought by any individual on behalf of the government. Qui tam actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We are currently defending two qui tam actions where both the federal and state governments declined to intervene: (i) USA and State of Florida ex rel Charles Wilhelm v. Molina Healthcare and Molina Healthcare of Florida; and (ii) USA ex rel Anita Silingo v. Mobile Medical Examination Service, Molina Healthcare of California, et al. We believe we have meritorious defenses to both matters, and intend to defend both matters vigorously. In the event we are subject to liability under these or other qui tam actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

Our business could be adversely impacted by adoption of the new ICD-10 standardized coding set for diagnoses.

The U.S. Department of Health and Human Services, or HHS, has released rules pursuant to the Health Insurance Portability and Accountability Act, or HIPAA, which mandate the use of standard formats in electronic health care transactions. HHS also has published rules requiring the use of standardized code sets and unique identifiers for providers. These new standardized code sets, known as ICD-10, will require substantial investments from health care organizations, including us. CMS has now scheduled implementation of ICD-10 by October 1, 2015. Use of the ICD-10 code sets will require significant administrative changes and may result in errors and otherwise negatively impact our service levels. In addition, we may experience complications related to supporting customers that are not fully compliant with the revised requirements as of the applicable compliance date. Furthermore, if physicians fail to provide appropriate codes for services provided as a result of the new coding set, we may not be reimbursed, or adequately reimbursed, for such services.

If we are unable to deliver quality care, maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to ensure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and/or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. We cannot be sure that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre-established understanding between the provider and our health plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our health plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our business, financial condition, results of operations, and cash flows.

The insolvency of a delegated provider could obligate us to pay its referral claims, which could have an adverse effect on our business, cash flows, or results of operations.

Circumstances may arise where providers to whom we have delegated risk, due to insolvency or other circumstances, are unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so or we have already paid claims to a delegated provider and payments cannot be recouped when the delegated provider becomes insolvent. To reduce the risk that delegated providers are unable to pay referral claims,

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we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability. In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These funds are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. However, there can be no assurances that these precautionary steps will fully protect us against the insolvency of a delegated provider. Liabilities incurred or losses suffered as a result of provider insolvency could have an adverse effect on our business, financial condition, cash flows, or results of operations.

Regulatory actions and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes and intensified regulatory scrutiny and regulatory burdens.

Several of our health care competitors have recently been involved in governmental investigations and regulatory actions which have resulted in significant volatility in the price of their stock. In addition, there has been negative publicity and proposed programmatic changes regarding Medicare Advantage private fee-for-service plans, a part of the Medicare Advantage program in which we do not participate. These actions and the resulting negative publicity could become associated with or imputed to us, regardless of our actual regulatory compliance or programmatic participation. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for changes in the programs in which we do not participate, intensified scrutiny by regulators, additional regulatory requirements and burdens, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five-year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state’s application for renewal, our business would suffer as a result of a likely decrease in membership.

If state regulators do not approve payments of dividends and distributions by our subsidiaries, it may negatively affect our business strategy.

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days’ advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. For the years ended December 31, 2013 and 2012, we received dividends from our health plan subsidiaries amounting to $24.4 million and $101.8 million, respectively. We did not receive any dividends from our health plan subsidiaries during the year ended December 31, 2014. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2014, 2013 and 2012,

without approval of the regulatory authorities, were approximately $96 million, $54 million, and $24 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our convertible senior notes or any credit facility.

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Risks Related to the Operation of Our Molina Medicaid Solutions Segment

We may be unable to retain or renew the state government contracts of the Molina Medicaid Solutions segment on terms consistent with our expectations or at all.

Molina Medicaid Solutions currently has management contracts in only six states. If we are unable to continue to operate in any of those six states, or if our current operations in any of those six states are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

If the responsive bids to RFPs of Molina Medicaid Solutions are not successful, our revenues could be materially reduced and our operating results could be negatively impacted.

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. For instance, in 2012, the government contract of Molina Medicaid Solutions in Louisiana was subject to competitive bidding, and we were unsuccessful in being awarded a new contract. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. In the event our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

Because of the complexity and duration of the services and systems required to be delivered under the government contracts of Molina Medicaid Solutions, there are substantial risks associated with full performance under the contracts.

The state contracts of Molina Medicaid Solutions typically require significant investment in the early stages that is expected to be recovered through billings over the life of the contracts. These contracts involve the construction of new computer systems and communications networks and the development and deployment of complex technologies. Substantial performance risk exists under each contract. Some or all elements of service delivery under these contracts are dependent upon successful completion of the design, development, construction, and implementation phases. Any increased or unexpected costs or delays in connection with the performance of these contracts, including delays caused by factors outside our control, could make these contracts less profitable or unprofitable, which could have an adverse effect on our business, financial condition, cash flows, or results of operations.

If we fail to comply with our state government contracts or government contracting regulations, our business could be adversely affected.

Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance. Any failure to comply with the specific provisions in our customer contracts or any violation of government contracting regulations could result in the imposition of various civil and criminal penalties, which may include termination of the contracts, forfeiture of profits, suspension of payments, imposition of fines, and suspension from future government contracting. Further, any negative publicity related to our state government contracts or any proceedings surrounding them may damage our business by affecting our ability to compete for new contracts. The termination of a state government contract, our suspension from government work, or any negative impact on our ability to compete for new contracts, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

System security risks and systems integration issues that disrupt our internal operations or information technology services provided to customers could adversely affect our financial results and damage our reputation.

Computer programmers and hackers may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause shutdowns. Computer programmers and hackers also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our products or otherwise exploit any security vulnerabilities of our products. In addition,

sophisticated hardware and operating system software and applications that we produce or procure from third parties may contain defects in design or manufacture, including "bugs" and other problems that could unexpectedly interfere with the operation of the system. The costs to us to eliminate or alleviate security problems, bugs, viruses, worms, malicious software programs and security vulnerabilities could be significant, and the efforts to address these problems could result in interruptions, delays, cessation of service, and loss of existing or potential government customers.

Molina Medicaid Solutions routinely processes, stores, and transmits large amounts of data for our clients, including sensitive and personally identifiable information. Breaches of our security measures could expose us, our customers, or the individuals affected to a risk of loss or misuse of this information, resulting in litigation and potential liability for us and damage to our

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brand and reputation. Accordingly, we could lose existing or potential government customers for outsourcing services or other information technology solutions or incur significant expenses in connection with our customers' system failures or any actual or perceived security vulnerabilities in our products. In addition, the cost and operational consequences of implementing further data protection measures could be significant.

Portions of our information technology infrastructure also may experience interruptions, delays, or cessations of service or produce errors in connection with systems integration or migration work that takes place from time to time. We may not be successful in implementing new systems and transitioning data, which could cause business disruptions and be more expensive, time consuming, disruptive, and resource-intensive. Such disruptions could adversely impact our ability to fulfill orders and interrupt other processes. Delayed sales, lower margins, or lost government customers resulting from these disruptions could adversely affect our financial results, reputation, and stock price.

In the course of providing services to customers, Molina Medicaid Solutions may inadvertently infringe on the intellectual property rights of others and be exposed to claims for damages.

The solutions we provide to our state government customers may inadvertently infringe on the intellectual property rights of third parties resulting in claims for damages against us. The expense and time of defending against these claims may have a material and adverse impact on our profitability. Additionally, the publicity we may receive as a result of infringing intellectual property rights may damage our reputation and adversely impact our ability to develop new MMIS business or retain existing MMIS business.

Inherent in the government contracting process are various risks which may materially and adversely affect our business and profitability.

We are subject to the risks inherent in the government contracting process. These risks include government audits of billable contract costs and reimbursable expenses and compliance with government reporting requirements. In the event we are found to be out of compliance with government contracting requirements, our reputation may be adversely impacted and our relationship with the government agencies we work with may be damaged, resulting in a material and adverse effect on our profitability.

Our performance on contracts, including those on which we have partnered with third parties, may be adversely affected if we or the third parties fail to deliver on commitments.

In some instances, our contracts require that we partner with other parties, including software and hardware vendors, to provide the complex solutions required by our state government customers. Our ability to deliver the solutions and provide the services required by our customers is dependent on our and our partners' ability to meet our customers' delivery schedules. If we or our partners fail to deliver services or products on time, our ability to complete the contract may be adversely affected, which may have a material and adverse impact on our revenues and profitability.

Risks Related to our General Business Operations

Ineffective management of our growth may negatively affect our business, financial condition, or results of operations.

We expect to continue to grow our membership and to expand into other markets through acquisitions and other opportunities. Continued rapid growth could place a significant strain on our management and on our other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our business, financial condition, cash flows, or results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government

contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or

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different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management systems could disrupt our operations.

Our business is dependent on effective and secure information systems that assist us in, among other things, processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations, ability to pay claims, and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, upgrade or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography, or other events or developments could result in compromises or breaches of our security systems and member data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our members, providers, or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability, and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if security breaches are not prevented.

Because our corporate headquarters are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters is located in Long Beach, California. In addition, the claims of our health plans are also processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the disaster recovery plan will be successful or that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major Southern California earthquake.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. We maintain medical malpractice insurance for our clinics in an amount which we believe to be reasonable in light of our experience to date. However, given the

significant amount of some medical malpractice awards and settlements, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our business, financial condition, cash flows, or results of operations.

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We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we establish reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows, and could prompt us to change our operating procedures.

We are subject to competition which negatively impacts our ability to increase penetration in the markets we serve.

We operate in a highly competitive environment and in an industry that is subject to ongoing changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC, or other regulatory authorities which would require additional financial and management resources.

Changes in accounting may affect our results of operations.

U.S. generally accepted accounting principles (GAAP) and related implementation guidelines and interpretations can be highly complex and involve subjective judgments. Changes in these rules or their interpretation, or the adoption of new pronouncements could significantly affect our stated results of operations.

The value of our investments is influenced by varying economic and market conditions, and a decrease in value could have an adverse effect on our results of operations, liquidity, and financial condition.

Our investments consist solely of investment-grade debt securities. The unrestricted portion of this portfolio is designated as available-for-sale. Our non-current restricted investments are designated as held-to-maturity. Available-for-sale investments are carried at fair value, and the unrealized gains or losses are included in accumulated other comprehensive income or loss as a separate component of stockholders' equity, unless the decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such securities until their full cost can be recovered. For our available-for-sale investments and held-to-maturity investments, if a decline in value is deemed to be other-than-temporary and we do not have the intent and ability to hold such security until its full cost can be recovered, the security is deemed to be other-than-temporarily impaired and it is written down to fair value and the loss is recorded as an expense.

In accordance with applicable accounting standards, we review our investment securities to determine if declines in fair value below cost are other-than-temporary. This review is subjective and requires a high degree of judgment. We

conduct this review on a quarterly basis, using both quantitative and qualitative factors, to determine whether a decline in value is other-than-temporary. Such factors considered include the length of time and the extent to which market value has been less than cost, the financial condition and near term prospects of the issuer, recommendations of investment advisors, and forecasts of economic, market or industry trends. This review process also entails an evaluation of our ability and intent to hold individual securities until they mature or full cost can be recovered.

The current economic environment and recent volatility of the securities markets increase the difficulty of assessing investment impairment and the same influences tend to increase the risk of potential impairment of these assets. Over time, the economic and market environment may provide additional insight regarding the fair value of certain securities, which could change our

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judgment regarding impairment. This could result in realized losses relating to other-than-temporary declines to be recorded as an expense. Given the current market conditions and the significant judgments involved, there is continuing risk that declines in fair value may occur and material other-than-temporary impairments may result in realized losses in future periods which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to income taxes in the United States. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in U.S. tax laws and regulations, and changes in our interpretations of tax laws, including pending tax law changes, such as the health care federal excise tax discussed above. In addition, we are subject to the routine examination of our income tax returns by the Internal Revenue Service and other local and state tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. Adverse outcomes from tax examinations could have a material adverse effect on our provision for income taxes, estimated income tax liabilities, or results of operations.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our executive officers. The loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. It is critical that we recruit, manage, enable, and retain talent to successfully execute our strategic objections which requires aligned policies, a positive work environment, and a robust succession and talent development process. Further, particularly in light of the changing healthcare environment, we must focus on building employee capabilities to help ensure that we can meet upcoming challenges and opportunities. If we are unsuccessful in recruiting, retaining, managing, and enabling such personnel and are unable to meet upcoming challenges and opportunities, our operations could be negatively impacted.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with independent third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures under applicable business associate agreements or other applicable outsourcing agreements. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could

result in substantial costs or other operational or financial problems that could adversely impact our business, financial condition, cash flows, or results of operations.

An impairment charge with respect to our recorded goodwill, or our finite-lived intangible assets, could have a material impact on our financial results.

As of December 31, 2014, the balance of goodwill was $272.0 million, and the balance of intangible assets, net, was $89.3 million. Intangible assets are amortized generally on a straight-line basis over their estimated useful lives. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit

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below its carrying amount. Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable.

The determination of the value of goodwill, and intangible assets, net, requires us to make estimates and assumptions about estimated asset lives, future business trends, and growth. Such evaluation is significantly impacted by estimates and assumptions of future revenues, costs and expenses, and other factors. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net, such revision could result in a non-cash impairment charge that could have a material impact on our financial results.

We are subject to the risks of owning and leasing real property.

We are a tenant under numerous leases in multiple states, including a 25-year lease of an approximately 460,000 square foot office building housing our principal executive offices in Long Beach, California. We also own a 186,000 square-foot office building in Troy, Michigan, a 26,700 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot community clinic in Pomona, California. Accordingly, we are subject to all of the risks generally associated with leasing and owning real estate, which include, but are not limited to: the possibility of environmental contamination, the costs associated with fixing any environmental problems and the risk of damages resulting from such contamination; adverse changes in the value of the property due to interest rate changes, changes in the neighborhood in which the property is located, or other factors; ongoing maintenance expenses and costs of improvements; the possible need for structural improvements in order to comply with changes in zoning, seismic, disability act, or other requirements; inability to renew or enter into leases for space not utilized by us on commercially acceptable terms or at all; and possible disputes with neighboring owners or other individuals and entities.

Risks Related to Our Common Stock

Delaware law and our charter documents may impede or discourage a takeover, which could cause the market price of our common stock to decline.

We are a Delaware corporation, and the anti-takeover provisions of Delaware law impose various impediments to the ability of a third party to acquire control of us, even if a change in control would be beneficial to our existing stockholders. In addition, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock and certain provisions of Delaware law and our certificate of incorporation and bylaws could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock and the value of our convertible senior notes.

Members of the Molina family own a significant amount of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Members of the Molina family, either directly or as trustees or beneficiaries of Molina family trusts, in the aggregate owned or were entitled to receive upon certain events approximately 32% of our capital stock as of December 31, 2014. Our president and chief executive officer, as well as our chief financial officer, are members of the Molina family, and they are also on our board of directors. Because of the amount of their shareholdings, Molina family members, if they were to act as a group with the trustees of their family trusts, have the ability to significantly influence all matters submitted to stockholders for approval, including the election of directors, amendments to our charter, and any merger, consolidation, or sale of our company. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of share ownership in the Molina family could delay or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of the Molina family may be different from those of our company or our other stockholders, and they may vote their common stock in a manner that is contrary to the vote of our other stockholders.

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Future sales of our common stock or equity-linked securities in the public market could adversely affect the trading price of our common stock and our ability to raise funds in new stock offerings.

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150,000,000 shares of common stock and 20,000,000 shares of preferred stock. As of December 31, 2014, approximately 49,727,000 shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

It may be difficult for a third party to acquire us, which could inhibit stockholders from realizing a premium on their stock price.

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us. In addition, any change in control of our state health plans would require the approval of the applicable insurance regulator in each state in which we operate.

Our certificate of incorporation and bylaws also contain provisions that could have the effect of delaying, deferring, or preventing a change in control of our company that stockholders may consider favorable or beneficial. These provisions could discourage proxy contests and make it more difficult for our stockholders to elect directors and take other corporate actions. These provisions could also limit the price that investors might be willing to pay in the future for shares of our common stock. These provisions include:

- a staggered board of directors, so that it would take three successive annual meetings to replace all directors,
- prohibition of stockholder action by written consent, and
- advance notice requirements for the submission by stockholders of nominations for election to the board of directors and for proposing matters that can be acted upon by stockholders at a meeting.

In addition, changes of control are often subject to state regulatory notification, and in some cases, prior approval.

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Item 1B: Unresolved Staff Comments

None.

Item 2: Properties

As of December 31, 2014, the Health Plans segment leases a total of 70 facilities and the Molina Medicaid Solutions segment leases a total of 12 facilities. We own a 186,000 square-foot office building in Troy, Michigan, a 26,700 square-foot data center in Albuquerque, New Mexico, and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operations growth prospects to determine if additional space is required, and where it would be best located.

Item 3: Legal Proceedings

The health care and business process outsourcing industries are subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues.

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain matters for which we deem the loss to be both probable and estimable. Although we believe that our estimates of such losses are reasonable, these estimates could change as a result of further developments of these matters. The outcome of legal actions is inherently uncertain and such pending matters for which accruals have not been established have not progressed sufficiently through discovery and/or development of important factual information and legal issues to enable us to estimate a range of possible loss, if any. While it is not possible to accurately predict or determine the eventual outcomes of these items, an adverse determination in one or more of these pending matters could have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

State of Louisiana v. Molina Medicaid Solutions et al. On June 26, 2014, the state of Louisiana filed a Petition for Damages against Molina Medicaid Solutions, Molina Healthcare, Inc., Unisys Corporation, and Paramax Systems Corporation, a subsidiary of Unisys, in the Parish of Baton Rouge, 19th Judicial District, versus number 631612. The Petition alleges that between 1989 and 2012, the defendants utilized an incorrect reimbursement formula for the payment of pharmaceutical claims. The petitioner seeks actual damages to be proved at trial, plus interest. We believe we have several meritorious defenses to the claims of the state, and any liability for the alleged claims is not currently probable or reasonably estimable.

USA and State of Florida ex rel. Charles Wilhelm v Molina Healthcare of Florida et al. On July 24, 2014, Molina Healthcare, Inc. and Molina Healthcare of Florida, Inc. were served with a Complaint filed under seal on December 5, 2012 in District Court for the Southern District of Florida by relator, Charles C. Wilhelm, M.D., Case No. 12-24298. The Complaint alleges that, in late 2008 and early 2009, in connection with the acquisition of Florida NetPass by which Molina Healthcare entered into the state of Florida, the defendants failed to adequately staff the plan and provide other services, resulting in a disproportionate number of sicker beneficiaries of Florida NetPass moving back into the Florida fee-for-service Medicaid program. This alleged conduct purportedly resulted in a violation of the federal False Claims Act. The relator seeks treble damages in the alleged amount of $62.3 million, plus interest and penalties. Both the United States of America and the state of Florida have declined to intervene. We believe we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

United States of America, ex rel., Anita Silingo v. Mobile Medical Examination Services, Inc., et al. On or around October 14, 2014, Molina Healthcare of California, Molina Healthcare of California Partner Plan, Inc., Mobile Medical Examination Services, Inc. (MedXM), and other health plan defendants were served with a Complaint previously filed under seal in the Central District Court of California by relator, Anita Silingo, Case No. SACV13-1348-FMO(SHx). The Complaint alleges that MedXM improperly modified medical records and otherwise took inappropriate steps to increase members' risk adjustment scores, and that the defendants, including Molina

Healthcare of California and Molina Healthcare of California Partner Plan, Inc., purportedly turned a “blind eye” to these unlawful practices. The relator seeks treble damages in the amount of $3 billion, plus interest and penalties. The Department of Justice has declined to intervene. We believe that we have several meritorious defenses to the claims of the relator, and any liability for the alleged claims is not currently probable or reasonably estimable.

Item 4: Mine Safety Disclosures

None.

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PART II

Item 5: Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Our common stock is listed on the New York Stock Exchange under the trading symbol "MOH." As of February 20, 2015, there were approximately 120 holders of record of our common stock. The high and low intra-day sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2014		
First Quarter	$39.21	$32.41
Second Quarter	$46.17	$32.86
Third Quarter	$48.03	$39.23
Fourth Quarter	$54.57	$40.79
2013		
First Quarter	$33.85	$25.70
Second Quarter	$38.74	$30.26
Third Quarter	$40.90	$33.31
Fourth Quarter	$37.39	$31.10

Dividends

To date we have not paid cash dividends on our common stock. We currently intend to retain any future earnings to fund our projected business growth. However, we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future.

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Any future determination to pay dividends will be at the discretion of our Board and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see Item 7 of this Form 10-K, Management's Discussion and Analysis of Financial Condition and Results of Operations, in "Liquidity and Capital Resources," under the subheading "Regulatory Capital and Dividend Restrictions."

Unregistered Issuances of Equity Securities

None.

Stock Repurchase Programs

Securities Repurchases and Repurchase Programs. Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This newly authorized repurchase program extends through December 31, 2015.

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Purchases of common stock made by or on behalf of the Company during the quarter ended December 31, 2014, including shares withheld by the Company to satisfy our employees' income tax obligations, are set forth below:

	Total Number of Shares Purchased (1)	Average Price Paid per Share (1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs (2)	Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs (2)
October 1 — October 31	1,052	$41.66	—	$47,338,505
November 1 — November 30	1,781	$48.64	—	$47,338,505
December 1 — December 31	1,523	$49.96	—	$47,338,505
	4,356	$47.42	—	

(1) During the quarter we withheld 4,356 shares of common stock under our 2002 Equity Incentive Plan and 2011 Equity Incentive Plan to settle our employees' income tax obligations.

(2) Effective as of September 30, 2013, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. This repurchase program expired December 31, 2014.

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STOCK PERFORMANCE GRAPH

The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10-K pursuant to Item 201(e) of Regulation S-K and shall not be deemed to be "soliciting materials" or to be "filed" with the SEC (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2009 to December 31, 2014. The comparison assumes $100 was invested on December 31, 2009, in the Company’s common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.

The old peer group index, used in last year's Annual Report on Form 10-K and also set forth below, consists of Centene Corporation (CNC), Community Health Systems, Inc. (CYH), Coventry Health Care, Inc. (CVH), Health Management Associates, Inc. (HMA), Health Net, Inc. (HNT), Laboratory Corporation of America Holdings (LH), Lifepoint Hospitals, Inc. (LPNT), Magellan Health Services, Inc. (MGLN), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), and WellCare Health Plans, Inc. (WCG).

The new peer group index consists of Brookdale Senior Living, Inc. (BKD), Catamaran Corporation (CTRX), Centene Corporation (CNC), Community Health Systems, Inc. (CYH), DaVita HealthCare Partners, Inc. (DVA), Health Net, Inc. (HNT), Kindred Healthcare, Inc. (KND), Laboratory Corporation of America Holdings (LH), Life Point Hospitals, Inc. (LPNT), Magellan Health, Inc. (MGLN), Omnicare, Inc. (OCR), Quest Diagnostics, Inc. (DGX), Select Medical Holdings Corporation (SEM), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

	December 31,					
Name	2009	2010	2011	2012	2013	2014
Molina Healthcare, Inc.	$100.00	$121.78	$146.46	$177.48	$227.92	$351.09
S&P 500	100.00	115.06	117.49	136.30	180.44	205.14
Old Peer Group	100.00	112.08	135.26	142.21	177.30	236.56
New Peer Group	100.00	111.51	124.46	147.53	178.64	225.58

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Item 6. Selected Financial Data

SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption "Operating Statistics, Continuing Operations") for the five years ended December 31, 2014 from our audited consolidated financial statements. You should read the data in conjunction with our consolidated financial statements, related notes and other financial information included herein. All dollar amounts are presented in thousands, except per-share data. The data under the caption "Operating Statistics, Continuing Operations" has not been audited.

	Year Ended December 31,				
	2014	2013	2012	2011	2010 (1)
Statements of Income Data:					
Revenue:					
Premium revenue	$9,022,511	$6,179,170	$5,544,121	$4,211,493	$3,632,142
Service revenue (1)	210,051	204,535	187,710	160,447	89,809
Premium tax revenue	294,388	172,017	158,991	154,589	139,775
Health insurer fee revenue	119,484	—	—	—	—
Investment income	8,093	6,890	5,075	5,446	6,198
Other revenue	12,074	26,322	18,312	8,288	7,140
Total revenue	9,666,601	6,588,934	5,914,209	4,540,263	3,875,064
Operating expenses:					
Medical care costs	8,076,331	5,380,124	4,991,188	3,664,161	3,190,566
Cost of service revenue (1)	156,764	161,494	141,208	143,987	78,647
General and administrative expenses	764,693	665,996	518,615	393,452	326,193
Premium tax expenses	294,388	172,017	158,991	154,589	139,775
Health insurer fee expenses	88,591	—	—	—	—
Depreciation and amortization	92,917	72,743	63,114	48,253	43,246
Total operating expenses	9,473,684	6,452,374	5,873,116	4,404,442	3,778,427
Operating income	192,917	136,560	41,093	135,821	96,637
Other expenses, net:					
Interest expense	56,811	52,071	16,769	15,519	15,509
Other expense, net	802	3,343	945	—	—
Total other expenses, net	57,613	55,414	17,714	15,519	15,509
Income from continuing operations before income taxes	135,304	81,146	23,379	120,302	81,128
Income tax expense	72,726	36,316	10,513	42,914	30,511
Income from continuing operations	62,578	44,830	12,866	77,388	50,617
(Loss) income from discontinued operations, net of tax (benefit) expense (2)	(355)	8,099	(3,076)	(56,570)	4,353
Net income	$62,223	$52,929	$9,790	$20,818	$54,970
Basic net income per share:					
Income from continuing operations	$1.34	$0.98	$0.28	$1.69	$1.23
(Loss) income from discontinued operations	(0.01)	0.18	(0.07)	(1.24)	0.11
Basic net income per share	$1.33	$1.16	$0.21	$0.45	$1.34
Diluted net income per share:					
Income from continuing operations	$1.30	$0.96	$0.27	$1.67	$1.22
(Loss) income from discontinued operations	(0.01)	0.17	(0.06)	(1.22)	0.10

Diluted net income per share	$1.29	$1.13	$0.21	$0.45	$1.32
Weighted average shares outstanding:					
Basic	46,935,000	45,717,000	46,380,000	45,756,000	41,174,000
Diluted	48,340,000	46,862,000	46,999,000	46,425,000	41,631,000
Operating Statistics, Continuing Operations:					
Medical care ratio (3)	89.5%	87.1%	90.0%	87.0%	87.8%
General and administrative expense ratio (4)	7.9%	10.1%	8.8%	8.7%	8.4%
Premium tax ratio (5)	3.2%	2.7%	2.8%	3.5%	3.7%
Members (6)	2,623,000	1,931,000	1,797,000	1,618,000	1,532,000

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	Year Ended December 31,				
	2014	2013	2012	2011	2010
Balance Sheet Data:					
Cash and cash equivalents	$1,539,063	$935,895	$795,770	$493,827	$455,886
Total assets	4,477,215	3,002,937	1,934,822	1,652,146	1,509,214
Long-term debt, including current maturities (7)	905,389	784,862	262,939	218,126	164,014
Total liabilities	3,466,773	2,110,000	1,152,508	897,073	790,157
Stockholders' equity	1,010,442	892,937	782,314	755,073	719,057

(1) Service revenue and cost of service revenue represent revenue and costs generated by our Molina Medicaid Solutions segment. Because we acquired this business on May 1, 2010, results for the year ended December 31, 2010 include eight months of results for this segment.

(2) As previously reported, in February 2012 the Division of Purchasing of the Missouri Office of Administration notified our Missouri health plan that it was not awarded a contract under the Missouri HealthNet Managed Care Request for Proposal; therefore, the Missouri health plan's existing contract with the state expired without renewal on June 30, 2012. In connection with this notification, the Missouri health plan recorded a non-cash impairment charge of $64.6 million in the fourth quarter of 2011. Results relating to the Missouri health plan have been reported as discontinued operations for all periods presented. (Loss) income from discontinued operations is presented net of income tax (benefit) expense of $(203), $(9,912), $(1,238), $922, and $4,011, respectively.

(3) Medical care ratio represents medical care costs as a percentage of premium revenue. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, utilization of medical services, our ability to effectively manage costs, contract changes, and changes in accounting estimates related to incurred but not paid claims. See Item 7 in this Form 10-K, "Management's Discussion and Analysis of Financial Condition and Results of Operations," for further discussion.

(4) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(5) Premium tax ratio represents such expenses as a percentage of premium revenue plus premium tax revenue.

(6) Number of members at end of period.

(7) Includes convertible senior notes, lease financing obligations, and other long-term debt.

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion of our financial condition and results of operations should be read in conjunction with Items 6 and 8 of this Form 10-K, Selected Financial Data, and Financial Statements and Supplementary Data, respectively. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth in Part I, Item 1A of this Form 10-K, Risk Factors.

Overview

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of December 31, 2014, these health plans served over 2.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplace members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we reported the results relating to the Missouri health plan as discontinued operations for all periods presented. The following discussion and analysis, with the exception of cash flow information, is presented in the context of continuing operations unless otherwise noted.

Fiscal Year 2014 Financial Highlights

- Net income from continuing operations increased to $62.6 million in 2014, from $44.8 million in 2013 due to increases in enrollment and revenue, and improved administrative cost efficiency; which offset higher medical costs and higher tax rates.
- Strong enrollment growth across all of our programs combined with an 18% increase in premium revenue per member, generated almost $3 billion, or 46%, more premium revenue in 2014 compared with 2013.
- General and administrative expenses as a percentage of revenue declined to 7.9% in 2014, versus 10.1% in 2013.
- Medical care costs as a percentage of premium revenue increased to 89.5% in 2014, from 87.1% in 2013.
- Debt financing transactions generated net cash of $122.6 million; such transactions both extended the maturity date and lowered the rate of our convertible senior notes previously due in 2014.

Health Care Reform

We believe that the government-sponsored initiatives, including the Affordable Care Act (ACA), will continue to provide us with significant opportunities for membership growth in our existing markets and in new programs in the future as follows:

- Medicaid Expansion. In the states that have elected to participate, the ACA provides for the expansion of the Medicaid program to offer eligibility to nearly all low-income people under age 65 with incomes at or below 138% of the federal poverty line. Medicaid expansion membership phased in beginning January 1, 2014. Since that date, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have begun participating in Medicaid expansion. At December 31, 2014 our membership included approximately 385,000 Medicaid expansion members, or 15% of total membership.
- Marketplace. The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the

Marketplace in all of the states in which we operate, except Illinois and South Carolina. At December 31, 2014, we had approximately 15,000 Marketplace members, and that enrollment is expected to grow appreciably in 2015, particularly at our Florida health plan.

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- Medicare-Medicaid Plans. Policymakers at the federal and state levels are increasingly focused on the design and implementation of programs that improve the coordination of care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to deliver services to the dual eligible in a more financially efficient manner. As a result of these efforts, 15 states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual-eligible individuals. The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). Our MMPs in California, Illinois, and Ohio offered coverage beginning in 2014, and we expect to begin offering MMP coverage in South Carolina and Texas in the first quarter of 2015, and in Michigan in the second quarter of 2015.

Health Insurer Fee. The ACA imposes an annual fee, or excise tax, on health insurers for each calendar year beginning on or after January 1, 2014. A health insurer's liability for the payment of the fee (the health insurer fee, or HIF) is established upon first writing business in 2014 or any subsequent year. In other words, an active health insurer becomes liable for the fee on January 1st of any given year. The amount of the HIF for the insurer is based upon the insurer's share of the industry's net premiums written during the preceding calendar year. The HIF must be paid by the insurer by September 30th of the year in which the insurer becomes liable for the HIF. During the third quarter of 2014 we paid our 2014 HIF assessment, which amounted to $88.6 million. This expense was recognized on a straight-line basis in 2014; and is non-deductible for income tax purposes.

We believe that state Medicaid agencies are required to reimburse us for the HIF imposed on our Medicaid premiums, as well as for the negative financial impact associated with the absence of tax deductibility for the HIF. Although all of our state Medicaid partners have agreed informally to reimbursement of the HIF and the costs of its related tax effects, we have not secured binding commitments to that effect from California, Michigan and Utah. Our 2014 results were adversely affected by our inability to recognize as revenue reimbursement (including reimbursement for tax effects) for the full impact of the HIF from those states. The state of California has not formally committed to reimburse us for either the HIF itself, or the related tax effects. The states of Michigan and Utah have reimbursed us for the HIF, but have not formally committed to reimbursement for the related tax effect. The total amount of HIF revenue for which agreements were not secured (and revenue was not recognized) amounted to approximately $20 million for fiscal 2014. We expect to collect and recognize this revenue related to 2014 in 2015. We further expect to recognize revenue in 2015 sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2015. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231 million.

For further discussion of the risks and uncertainties relating to the HIF, refer to the subheading below, "Liquidity and Capital Resources—Financial Condition."

Market Updates—Health Plans Segment

Florida. During 2014, our Florida health plan acquired two Medicaid contracts, adding approximately 73,000 members.

Puerto Rico. In 2014, we were awarded a managed care contract in the Commonwealth of Puerto Rico that is expected to enroll its first members April 1, 2015. Total enrollment is expected to be approximately 350,000 new members, with anticipated annualized revenue of $750 million.

South Carolina. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

Market Update—Molina Medicaid Solutions Segment

In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid management information system (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana canceled its contract award to CNSI. The state had informed us that we will continue to perform under our current contract until a successor is named. On December 18, 2014, Molina Medicaid Solutions received notice from the state of Louisiana that they have extended our contract through December 31, 2015. We recognized approximately $41 million of service revenue under this contract in 2014.

Composition of Revenue and Membership

Health Plans Segment

Our Health Plans segment derives its revenue, in the form of premiums, chiefly from Medicaid contracts with the states in which our health plans operate; and, to a lesser degree, from Medicare contracts entered into with the Centers for Medicare and Medicaid Services (CMS), a federal government agency.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or

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without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

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

Premium revenue is fixed in advance of the periods covered and, except as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 2 "Significant Accounting Policies," is not generally subject to significant accounting estimates. For the year ended December 31, 2014, we received more than 95% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. Revenue not received on a fixed PMPM basis is recognized as earned.

The amount of the premiums paid to us may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program, on a per-member per-month basis for the year ended December 31, 2014. The "Consolidated" column represents the weighted-average amounts for our total membership by program.

	Ending Membership	PMPM Premiums Low	High	Consolidated
Temporary Assistance for Needy Families (TANF), CHIP (1)	1,831,000	$130.00	$280.00	$180.00
Medicaid Expansion	385,000	340.00	520.00	420.00
Aged, Blind or Disabled (ABD)	325,000	320.00	1,580.00	900.00
Medicare Special Needs Plans (Medicare)	49,000	970.00	1,480.00	1,180.00
Medicare-Medicaid Plan (MMP) – Integrated (2)	18,000	1,510.00	3,240.00	1,970.00
Marketplace	15,000	190.00	560.00	320.00

(1) CHIP stands for Children's Health Insurance Program.

(2) MMP members who receive both Medicaid and Medicare coverage from Molina Healthcare.

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

	As of December 31,		
	2014	2013	2012
Ending Membership by Health Plan:			
California	531,000	368,000	336,000
Florida	164,000	89,000	73,000
Illinois	100,000	4,000	—
Michigan	242,000	213,000	220,000
New Mexico	212,000	168,000	91,000
Ohio	347,000	255,000	244,000
South Carolina (1)	118,000	—	—
Texas	245,000	252,000	282,000
Utah	83,000	86,000	87,000
Washington	497,000	403,000	418,000
Wisconsin	84,000	93,000	46,000
	2,623,000	1,931,000	1,797,000
Ending Membership by Program:			
TANF/CHIP	1,831,000	1,624,000	1,517,000
Medicaid Expansion (2)	385,000	—	—
ABD	325,000	268,000	244,000
Medicare	49,000	39,000	36,000
MMP - Integrated	18,000	—	—
Marketplace (2)	15,000	—	—
	2,623,000	1,931,000	1,797,000

(1) Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

(2) Medicaid expansion membership phased in, and the Marketplace became available for consumers to access coverage, beginning January 1, 2014.

Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed. For further information regarding revenue recognition for the Molina Medicaid Solutions segment, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Composition of Expenses

Health Plans Segment

Operating expenses for the Health Plans segment include expenses related to the provision of medical care services (including long-term services and supports, or LTSS), general and administrative expenses, premium tax and health insurer fee expenses. Our results of operations are impacted by our ability to effectively manage expenses related to medical care services and to accurately estimate medical costs incurred. Expenses related to medical care services are captured in the following categories:

Fee-for-service expenses: Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are

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recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.

- Pharmacy expenses: All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- Capitation expenses: Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- Direct delivery expenses: All costs associated with our direct delivery of medical care are separately identified.
- Other medical expenses: All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2014, 2013, and 2012, medically related administrative costs were $262.6 million, $153.0 million, and $125.2 million, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Estimates" below, and Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for further information on how we estimate such liabilities.

Molina Medicaid Solutions Segment

Cost of service revenue consists primarily of the costs incurred to provide BPO and technology outsourcing services under our MMIS contracts. General and administrative costs consist primarily of indirect administrative costs and business development costs. In some circumstances we may defer recognition of incremental direct costs (such as direct labor, hardware, and software) associated with a contract if revenue recognition is also deferred. Such deferred contract costs are amortized on a straight-line basis over the contract term, consistent with the revenue recognition period.

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Financial Performance Summary, Continuing Operations

The following table and narrative briefly summarize our financial and operating performance from continuing operations for the years ended December 31, 2014, 2013, and 2012. All ratios, with the exception of the medical care ratio and the premium tax ratio, are computed as a percentage of total revenue. The medical care ratio is computed as a percentage of premium revenue, and the premium tax ratio is computed as a percentage of premium revenue plus premium tax revenue, because direct relationships exist between premium revenue earned, and the cost of health care and premium taxes.

	Year Ended December 31,		
	2014	2013	2012
	(Dollar amounts in thousands, except per-share data)		
Net income per diluted share	$1.30	$0.96	$0.27
Adjusted net income per diluted share	$3.43	$3.13	$1.72
Premium revenue	$9,022,511	$6,179,170	$5,544,121
Service revenue	$210,051	$204,535	$187,710
Operating income	$192,917	$136,560	$41,093
Net income	$62,578	$44,830	$12,866
Total ending membership	2,623,000	1,931,000	1,797,000
Premium revenue	93.3 %	93.8 %	93.7 %
Service revenue	2.2	3.1	3.2
Premium tax revenue	3.1	2.6	2.7
Health insurer fee revenue	1.2	—	—
Investment income	0.1	0.1	0.1
Other revenue	0.1	0.4	0.3
Total revenue	100.0 %	100.0 %	100.0 %
Medical care ratio	89.5 %	87.1 %	90.0 %
General and administrative expense ratio	7.9 %	10.1 %	8.8 %
Premium tax ratio	3.2 %	2.7 %	2.8 %
Operating income	2.0 %	2.1 %	0.7 %
Net income	0.6 %	0.7 %	0.2 %
Effective tax rate	53.8 %	44.8 %	45.0 %

Non-GAAP Financial Measures

We use the following non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance and the performance of other companies in the health care industry. These non-GAAP financial measures should be considered as supplements to, and not substitutes for or superior to, GAAP measures (GAAP stands for U.S. generally accepted accounting principles).

The first of these non-GAAP measures is earnings before interest, taxes, depreciation and amortization, or EBITDA. The following table reconciles net income, which we believe to be the most comparable GAAP measure, to EBITDA.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Net income	$62,223	$52,929	$9,790
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	113,715	93,866	78,764

Interest expense	56,811	52,071	16,769
Income tax expense	72,523	26,404	9,275
EBITDA	$305,272	$225,270	$114,598

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The second of these non-GAAP measures is adjusted net income and adjusted net income per diluted share, continuing operations. The following tables reconcile net income and net income per diluted share from continuing operations, which we believe to be the most comparable GAAP measures, to adjusted net income and adjusted net income per diluted share, continuing operations.

	Year Ended December 31,					
	2014		2013		2012	
	(In thousands, except diluted per-share amounts)					
Net income, continuing operations	$62,578	$1.30	$44,830	$0.96	$12,866	$0.27
Adjustments, net of tax:						
Depreciation, and amortization of capitalized software	58,770	1.21	46,018	0.98	35,267	0.75
Amortization of convertible senior notes and lease financing obligations	17,249	0.36	14,377	0.31	3,714	0.08
Share-based compensation	14,288	0.29	24,501	0.52	14,556	0.31
Amortization of intangible assets	12,870	0.27	13,117	0.28	13,592	0.29
Change in fair value of derivatives	(10)	—	3,580	0.08	817	0.02
Adjusted net income per diluted share, continuing operations	$165,745	$3.43	$146,423	$3.13	$80,812	$1.72

Results of Operations, Continuing Operations

Year Ended December 31, 2014 Compared with the Year Ended December 31, 2013

Health Plans Segment

Premium Revenue

A 28% increase in membership and an 18% increase in revenue PMPM in 2014 resulted in an increase in premium revenue of 46%, or over $2.8 billion, when compared with 2013. Medicare premium revenue was approximately $627 million in the year ended December 31, 2014, compared with approximately $526 million in the year ended December 31, 2013.

Enrollment growth was primarily due to Medicaid expansion program membership added as a result of the Affordable Care Act, and membership added at our South Carolina and Illinois health plans. Higher PMPM premium revenue was primarily the result of the inclusion of long-term services and supports (LTSS) benefits in various Medicaid managed care programs in California, Florida, Illinois, New Mexico, and Ohio.

Medical Care Costs

Although medical margin (defined as the excess of premium revenue over medical care costs) increased nearly 20% in 2014 over 2013; our consolidated medical care ratio (defined as medical care costs as a percentage of premium revenue) increased to 89.5% in 2014 from 87.1% in 2013.

The medical care ratio increased substantially in 2014 as a result of three developments:

- Much of our revenue growth has come from participation in Medicaid programs covering LTSS. Percentage profit margins for LTSS benefits are generally lower than percentage profit margins for acute medical benefits.
- Increases to our base premiums in recent years have not kept pace with medical cost trends.
- Lack of coordination in the design of profit caps and medical cost floors in some of our state Medicaid contracts is resulting in counterproductive outcomes. In some instances, givebacks due to profitable performance in one product cannot be offset against losses in other products.

Medical care ratios by program for 2014 were as follows: TANF and CHIP - 89.3%; Medicaid expansion - 79.4%; ABD - 92.3%; Medicare - 95.8%; MMP integrated - 92.1%; and Marketplace - 83.7%.

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The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,							
	2014				2013			
	Amount	PMPM	% of Total		Amount	PMPM	% of Total	
Fee for service	$5,672,483	$202.87	70.2	%	$3,611,529	$160.43	67.1	%
Pharmacy	1,273,329	45.54	15.8		935,204	41.54	17.4	
Capitation	748,388	26.77	9.3		603,938	26.83	11.2	
Direct delivery	96,196	3.44	1.2		48,288	2.14	0.9	
Other	285,935	10.22	3.5		181,165	8.05	3.4	
	$8,076,331	$288.84	100.0	%	$5,380,124	$238.99	100.0	%

Individual Health Plan Analysis

California. The medical care ratio for the California health plan decreased significantly to 83.3% in 2014, from 88.9% in 2013. Additionally, medical margin improved $171.0 million when compared with 2013. This improvement was the result of higher enrollment, primarily due to the addition of approximately 107,000 Medicaid expansion members; and premium increases effective October 1, 2013 (2.5%), and July 1, 2014 (5.5%). During 2014, the California health plan benefited from the recognition of approximately $23 million in premium revenue that related to 2013 as a result of certain programmatic changes implemented by the state of California. In 2013, the California health plan recognized approximately $32 million of premium revenue related to 2012 and earlier years as a result of retroactive rate increases from the state of California. The California health plan served its first MMP members in 2014.

Florida. Due to the re-procurement undertaken by the Florida Agency for Health Care Administration as part of its Managed Medical Assistance program starting in 2014, the Florida health plan transitioned many of its members to other health plans in the second quarter of 2014, and then added approximately 105,000 members in the second half of 2014, both from the addition of new service areas and through acquisitions. Although revenue increased approximately 66% at the Florida health plan for the year ended December 31, 2014, when compared with 2013, profitability fell in 2014. Medical margin declined $14.1 million, and the medical care ratio increased to 95.5% from 87.3% in 2013. The higher medical care costs were the result of 1) the assumption of risk for LTSS benefits for certain members effective December 2013 (as noted above percentage profit margins for LTSS benefits are generally less than those for other benefits); and 2) our inability to recognize revenue related to a rate increase effective September 1, 2014, as a result of those rates not being finalized prior to year end.

Illinois. The medical care ratio for the Illinois health plan decreased to 91.7% in 2014, from 96.9% in 2013. The plan experienced significant growth in 2014; enrollment increased approximately 96,000 members overall, with 78,000 members added in the fourth quarter alone. This growth occurred primarily within the traditional TANF program, and to a lesser degree within the Medicaid expansion program. The Illinois health plan served its first MMP members in 2014.

Michigan. The medical care ratio of the Michigan health plan was consistent year over year, at 84.6% in 2014, compared with 84.4% in 2013.

New Mexico. Premium revenue at the New Mexico health plan increased 141% for 2014 compared with 2013, primarily as a result of the addition of Medicaid behavioral health and LTSS benefits effective January 1, 2014, and the addition of approximately 54,000 Medicaid expansion members during the course of 2014. The medical care ratio of the New Mexico health plan increased to 92.6% in 2014, from 86.1% in 2013. The higher medical care ratio was the result of 1) the assumption of risk for LTSS benefits effective January 1, 2014; and 2) premium rates effective January 1, 2014 that did not keep pace with the increase in medical costs in 2014. The New Mexico health plan received a blended rate increase of approximately 3% effective January 1, 2015. For the portion of New Mexico health plan’s membership that is eligible for LTSS benefits, the rate increase effective January 1, 2015 was 8%.

Ohio. The medical care ratio of the Ohio health plan increased to 86.0% in 2014, from 84.2% in 2013, primarily due to the increase in Medicaid expansion enrollment (which is incurring a medical care ratio slightly in excess of the plan's traditional experience), and the initiation of the Ohio MMP.

South Carolina. Our South Carolina health plan commenced operations effective January 1, 2014 and finished the year with a medical care ratio of 84.7%.

Texas. Financial performance at the Texas health plan declined in 2014, when compared with 2013. The medical care ratio of the Texas health plan increased to 90.8% in 2014, from 86.4% in 2013. Our inability to recognize a portion of the Texas health

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plan's quality revenue reduced income before taxes by approximately $26 million, or $0.33 per diluted share, for the year ended December 31, 2014. Approximately $20 million of this amount is related to measures for which we lack sufficient information to calculate our compliance. Should such information become available in the future, we may be able to recognize all or a portion of such revenue. Removing quality revenue and profit-sharing adjustments would have resulted in a medical care ratio at the Texas health plan of approximately 88% in 2014 and 86% in 2013.

Utah. The medical care ratio of the Utah health plan increased to 92.2% in 2014, from 83.4% in 2013, due to deteriorating margins for both Medicaid and Medicare products.

Washington. Financial performance at the Washington health plan declined in 2014, when compared with 2013. The medical care ratio of the Washington health plan increased to 93.4% in 2014, compared with 88.0% in 2013, primarily due to the high cost of medical services relative to revenue for members served under the state's program for ABD members; and to the $11.2 million net settlement with the Washington Health Care Authority, as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20, "Commitments and Contingencies." The Washington health plan added approximately 102,000 Medicaid expansion members in 2014. The Washington health plan received a blended rate increase of approximately 3% effective January 1, 2015. For the Washington health plan’s ABD membership, the rate increase effective January 1, 2015 was 11%.

Wisconsin. The medical care ratio of the Wisconsin health plan increased to 86.8% in 2014, compared with 79.7% in 2013.

Operating Data

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

	Year Ended December 31, 2014						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	5,630	$1,523,084	$270.51	$1,268,937	$225.37	83.3 %	$254,147
Florida	1,104	439,107	397.79	419,422	379.95	95.5	19,685
Illinois	307	153,271	498.48	140,480	456.88	91.7	12,791
Michigan	2,802	780,896	278.68	660,790	235.81	84.6	120,106
New Mexico	2,471	1,075,330	435.17	995,626	402.92	92.6	79,704
Ohio	3,650	1,552,949	425.47	1,335,436	365.87	86.0	217,513
South Carolina	1,463	381,317	260.72	323,061	220.89	84.7	58,256
Texas	2,980	1,318,192	442.32	1,197,465	401.81	90.8	120,727
Utah	996	309,411	310.64	285,303	286.43	92.2	24,108
Washington	5,522	1,304,605	236.27	1,218,886	220.75	93.4	85,719
Wisconsin	1,036	156,229	150.87	135,557	130.91	86.8	20,672
Other (3)	—	28,120	—	95,368	—	—	(67,248)
	27,961	$9,022,511	$322.68	$8,076,331	$288.84	89.5 %	$946,180

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	Year Ended December 31, 2013						
	Member Months (1)	Premium Revenue		Medical Care Costs		MCR (2)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,233	$749,755	$177.10	$666,592	$157.46	88.9 %	$83,163
Florida	973	264,998	272.23	231,261	237.57	87.3	33,737
Illinois	7	8,121	1,201.34	7,869	1,164.10	96.9	252
Michigan	2,581	676,000	261.91	570,644	221.09	84.4	105,356
New Mexico	1,492	446,758	299.36	384,466	257.62	86.1	62,292
Ohio	3,007	1,098,795	365.44	924,675	307.53	84.2	174,120
South Carolina	—	—	—	—	—	—	—
Texas	3,178	1,291,001	406.27	1,114,852	350.84	86.4	176,149
Utah	1,040	310,895	299.05	259,397	249.51	83.4	51,498
Washington	4,941	1,168,405	236.47	1,028,210	208.10	88.0	140,195
Wisconsin	1,060	143,465	135.40	114,340	107.91	79.7	29,125
Other [3]	—	20,977	—	77,818	—	—	(56,841)
	22,512	$6,179,170	$274.48	$5,380,124	$238.99	87.1 %	$799,046

(1) A member month is defined as the aggregate of each month's ending membership for the period presented.

(2) "MCR" represents medical costs as a percentage of premium revenue.

(3) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2014	2013
	(In thousands)	
Service revenue before amortization	$212,965	$207,449
Amortization recorded as reduction of service revenue	(2,914)	(2,914)
Service revenue	210,051	204,535
Cost of service revenue	156,764	161,494
General and administrative costs	7,105	5,285
Amortization of customer relationship intangibles	3,355	5,127
Operating income	$42,827	$32,629

Operating income for our Molina Medicaid Solutions segment improved $10.2 million for the year ended December 31, 2014, compared with 2013. This improvement was primarily the result of increased revenues due to higher Medicaid transaction volumes and lower cost of services overall, as existing contract operations gained efficiencies.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses decreased to 7.9% of revenue in 2014, from 10.1% in 2013. The significant decline in the ratio of general and administrative expenses relative to total revenue was primarily the result of improved leverage of fixed administrative expenses over higher total revenue.

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Premium Tax Expense

Premium tax expense was 3.2% in 2014, compared with 2.7% in 2013. In June 2014, the state of Michigan instituted a 6% use tax on medical premiums. That state has agreed to fund this tax through rate increases; as a result, we recorded approximately $30 million in additional premium revenue in 2014, as well as corresponding premium tax expense.

Health Insurer Fee Revenue and Expenses

Refer to "Liquidity and Capital Resources—Financial Condition" below for a comprehensive discussion of the HIF.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,					
	2014			2013		
	Amount	% of Total Revenue		Amount	% of Total Revenue	
	(Dollar amounts in thousands)					
Depreciation, and amortization of capitalized software, continuing operations	$75,402	0.8	%	$54,837	0.8	%
Amortization of intangible assets, continuing operations	17,515	0.2		17,906	0.3	
Depreciation and amortization, continuing operations	92,917	1.0		72,743	1.1	
Depreciation and amortization, discontinued operations	—	—		2	—	
Amortization recorded as reduction of service revenue	2,914	—		2,914	—	
Amortization of capitalized software recorded as cost of service revenue	38,573	0.4		18,207	0.3	
Depreciation and amortization reported in statement of cash flows	$134,404	1.4	%	$93,866	1.4	%

Interest Expense

Interest expense increased to $56.8 million for the year ended December 31, 2014, compared with $52.1 million for the year ended December 31, 2013. The increase was due primarily to our 3.75% Notes exchange transaction and related issuance of 1.625% Notes in the third quarter of 2014, and lease financing transactions executed in 2013. For further details regarding these transactions, please refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Long-Term Debt."

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $27.4 million and $22.8 million for the years ended December 31, 2014 and 2013, respectively.

Other Expenses, Net

Other expenses, net decreased to $0.8 million for the year ended December 31, 2014, from $3.3 million for the year ended December 31, 2013. Other expenses, net include primarily gains or losses associated with changes in the fair value of our derivative financial instruments. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to the change in fair value of warrants issued in connection with the 1.125% Notes, with no comparable activity in 2014.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 53.8% for the year ended December 31, 2014, compared with 44.8% for the year ended December 31, 2013. The increase is primarily due to the nondeductible health insurer fee in 2014 that did not exist in 2013.

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Results of Operations, Continuing Operations

Year Ended December 31, 2013 Compared with the Year Ended December 31, 2012

Premium Revenue

Premium revenue in 2013 increased 11% over 2012, due to a 6% increase in member months, and a 5% increase in revenue PMPM. Medicare premium revenue was $526 million for the year ended December 31, 2013, compared with $468 million for the year ended December 31, 2012.

Medical Care Costs

The following table provides the details of consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31, 2013				2012			
	Amount	PMPM	% of Total		Amount	PMPM	% of Total	
Fee for service	$3,611,529	$160.43	67.1	%	$3,423,751	$161.67	68.6	%
Pharmacy	935,204	41.54	17.4		835,830	39.47	16.7	
Capitation	603,938	26.83	11.2		552,136	26.07	11.1	
Direct delivery	48,288	2.14	0.9		33,920	1.60	0.7	
Other	181,165	8.05	3.4		145,551	6.87	2.9	
	$5,380,124	$238.99	100.0	%	$4,991,188	$235.68	100.0	%

Excluding our Illinois health plan, which was not operational until 2013, eight of our nine health plans reported higher medical margins in 2013 than in 2012. The consolidated medical margin increased by approximately 45% year over year. Our consolidated medical care ratio decreased to 87.1% for the year ended December 31, 2013, compared with 90.0% for the year ended December 31, 2012.

Individual Health Plan Analysis

California. Financial performance improved at the California health plan in 2013, when compared with 2012, primarily due to the receipt of premium rate increases for both TANF and ABD membership; and lower inpatient facility costs for the TANF membership. Approximately $32 million of premium revenue received and recognized in 2013 related to 2012 and earlier years. The medical care ratio at the California health plan decreased to 88.9% in 2013 from 91.1% in 2012.

Florida. The medical care ratio of the Florida health plan increased to 87.3% in 2013, from 85.3% in 2012, due to higher fee-for-service costs that more than offset lower pharmacy costs.

Illinois. The medical care ratio for the Illinois health plan was 96.9% in 2013. The Illinois health plan served its first member effective September 2013.

Michigan. Financial performance improved at the Michigan health plan in 2013, when compared with 2012. The medical care ratio of the Michigan health plan decreased to 84.4% in 2013, from 88.3% in 2012, primarily due to lower fee-for-service and pharmacy costs for both the ABD and the TANF membership.

New Mexico. Financial performance improved at the New Mexico health plan in 2013, when compared with 2012. The medical care ratio of the New Mexico health plan decreased to 86.1% in 2013, from 87.0% in 2012, primarily as a result of higher Medicaid premium rates PMPM effective January 1, 2013, and stable medical costs PMPM. The New Mexico health plan added approximately 80,000 new members in 2013, as a result of its acquisition of Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program effective August 1, 2013.

Ohio. Financial performance improved at the Ohio health plan in 2013, when compared with 2012. The medical care ratio of the Ohio health plan decreased to 84.2% in 2013, from 88.6% in 2012, primarily due to lower fee-for-service and pharmacy costs for both the ABD and the TANF membership. Financial performance deteriorated in the second half of 2013 due to both premium decreases, and increases to fee schedules effective July 1, 2013, that combined to reduce medical margin approximately 3% for the second half of 2013. We also experienced an additional 1.5% decrease in premium rates in Ohio effective July 1, 2013, due to a re-basing of revenue risk adjusters.

Texas. Financial performance improved at the Texas health plan in 2013, when compared with 2012. The medical care ratio of the Texas health plan decreased to 86.4% in 2013, from 93.7% in 2012, primarily due to rate increases

received on September 1, 2013 and 2012, respectively.

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Utah. Financial performance deteriorated at the Utah health plan in 2013, when compared with 2012. Reductions to the medical portion of the Medicaid premium, and the addition of the pharmacy benefit to our Medicaid premium, both effective January 1, 2013, more than offset stable medical costs. The medical care ratio of the Utah health plan increased to 83.4% in 2013, from 82.3% in 2012.

Washington. The medical care ratio of the Washington health plan increased to 88.0% in 2013, compared with 86.8% in 2012, due to the addition of ABD members effective July 1, 2012 and lower TANF premium rates. The higher premium revenue PMPM associated with the ABD membership, however, offset the increased medical care ratio, so that medical margin increased to $140.2 million in 2013, from $129.0 million in 2012.

Wisconsin. Financial performance improved at the Wisconsin health plan in 2013, when compared with 2012. The medical care ratio of the Wisconsin health plan decreased to 79.7% in 2013, compared with 96.2% in 2012, due to both higher revenue PMPM and lower fee-for-service physician, specialty and outpatient costs PMPM. Additionally, the health plan gained approximately 50,000 members in the first half of 2013 due to another health plan's exit from the market.

Health Plans Segment Operating Data

The following table summarizes member months, premium revenue, medical care costs, medical care ratio, and medical margin by health plan for the periods indicated (PMPM amounts are in whole dollars; member months and other dollar amounts are in thousands):

	Year Ended December 31, 2013						
	Member Months (2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,233	$749,755	$177.10	$666,592	$157.46	88.9 %	$83,163
Florida	973	264,998	272.23	231,261	237.57	87.3	33,737
Illinois	7	8,121	1,201.34	7,869	1,164.10	96.9	252
Michigan	2,581	676,000	261.91	570,644	221.09	84.4	105,356
New Mexico	1,492	446,758	299.36	384,466	257.62	86.1	62,292
Ohio	3,007	1,098,795	365.44	924,675	307.53	84.2	174,120
Texas	3,178	1,291,001	406.27	1,114,852	350.84	86.4	176,149
Utah	1,040	310,895	299.05	259,397	249.51	83.4	51,498
Washington	4,941	1,168,405	236.47	1,028,210	208.10	88.0	140,195
Wisconsin	1,060	143,465	135.40	114,340	107.91	79.7	29,125
Other[4]	—	20,977	—	77,818	—	—	(56,841)
	22,512	$6,179,170	$274.48	$5,380,124	$238.99	87.1 %	$799,046
	Year Ended December 31, 2012						
	Member Months (2)	Premium Revenue (1)		Medical Care Costs (1)		MCR (3)	Medical Margin
		Total	PMPM	Total	PMPM		
California	4,177	$665,600	$159.36	$606,494	$145.20	91.1 %	$59,106
Florida	850	228,832	269.36	195,226	229.80	85.3	33,606
Illinois	—	—	—	—	—	—	—
Michigan	2,639	646,551	244.97	570,636	216.20	88.3	75,915
New Mexico	1,069	321,853	301.08	280,108	262.03	87.0	41,745
Ohio	3,065	1,095,137	357.36	970,504	316.69	88.6	124,633
Texas	3,245	1,233,621	380.18	1,155,433	356.08	93.7	78,188
Utah	1,026	298,392	290.78	245,671	239.41	82.3	52,721
Washington	4,600	974,712	211.91	845,733	183.87	86.8	128,979
Wisconsin	508	70,678	139.25	67,968	133.91	96.2	2,710
Other[4]	—	8,745	—	53,415	—	—	(44,670)
	21,179	$5,544,121	$261.79	$4,991,188	$235.68	90.0 %	$552,933

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(1) Premium revenue for our former Missouri health plan was $0.2 million and $114.4 million for the years ended December 31, 2013 and 2012, respectively. Medical care costs for the plan were $1.5 million and $105.6 million for the years ended December 31, 2013 and 2012, respectively. These amounts are excluded from the tables above because the results of this health plan are classified as discontinued operations.

(2) A member month is defined as the aggregate of each month's ending membership for the period presented.

(3) "MCR" represents medical costs as a percentage of premium revenue.

(4) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

Molina Medicaid Solutions Segment

Performance of the Molina Medicaid Solutions segment was as follows:

	Year Ended December 31,	
	2013	2012
	(In thousands)	
Service revenue before amortization	$207,449	$189,281
Amortization recorded as reduction of service revenue	(2,914)	(1,571)
Service revenue	204,535	187,710
Cost of service revenue	161,494	141,208
General and administrative costs	5,285	17,648
Amortization of customer relationship intangibles	5,127	5,127
Operating income	$32,629	$23,727

Operating income for our Molina Medicaid Solutions segment increased $8.9 million for the year ended December 31, 2013, compared with 2012. The increase in operating income was primarily the result of additional sales in existing markets, and the favorable resolution of certain contingencies related to the Maine contract.

Consolidated Expenses

General and Administrative Expenses

General and administrative expenses increased to 10.1% of revenue in 2013, from 8.8% in 2012, primarily due to higher costs incurred as we prepared for significant membership growth anticipated in 2014. Increased administrative expenses related to anticipated membership growth represented approximately 2% of premium revenue, or $135 million during 2013.

Premium Tax Expense

Premium tax expense was consistent year over year.

Depreciation and Amortization

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of service revenue, or as cost of service revenue.

	Year Ended December 31,				
	2013		2012		
	Amount	% of Total Revenue	Amount	% of Total Revenue	
	(Dollar amounts in thousands)				
Depreciation, and amortization of capitalized software, continuing operations	$54,837	0.8 %	$42,938	0.7 %	
Amortization of intangible assets, continuing operations	17,906	0.3	20,176	0.3	
Depreciation and amortization, continuing operations	72,743	1.1	63,114	1.0	
Depreciation and amortization, discontinued operations	2	—	590	—	
Amortization recorded as reduction of service revenue	2,914	—	1,571	—	
Amortization of capitalized software recorded as cost of service revenue	18,207	0.3	13,489	0.2	

	$93,866	1.4	%	$78,764	1.2	%

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Interest Expense

Interest expense was $52.1 million for the year ended December 31, 2013, compared with $16.8 million for the year ended December 31, 2012. Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $22.8 million and $5.9 million for the years ended December 31, 2013 and 2012, respectively. The increase in interest expense for the year ended December 31, 2013, was primarily due to our issuance of $550.0 million aggregate principal amount 1.125% cash convertible senior notes due 2020 (the 1.125% Notes) in the first quarter of 2013. Interest expense in 2013 also included the immediate recognition of approximately $6 million in debt issuance costs associated with this transaction. The remaining fees associated with that issuance, amounting to approximately $12 million, are being amortized over the life of the 1.125% Notes. For the year ended December 31, 2013, interest expense also includes amounts relating to lease financing transactions executed in the second quarter of 2013.

Other Expenses, Net

Other expenses, net increased to $3.3 million for the year ended December 31, 2013, from $0.9 million for the year ended December 31, 2012. Other expenses, net include primarily gains or losses associated with changes in the fair value of our derivative financial instruments. In the second quarter of 2013 we recorded a one-time non-cash charge of $3.9 million related to the change in fair value of warrants issued in connection with the 1.125% Notes. We settled the interest rate swap in the second quarter of 2013, which resulted in a gain of $0.4 million, partially offsetting the $3.9 million charge described above. Other expenses, net was $0.9 million for the year ended December 31, 2012, primarily due to the change in fair value of the interest rate swap.

Income Taxes

The provision for income taxes in continuing operations is recorded at an effective rate of 44.8% for the year ended December 31, 2013, compared with 45.0% for the year ended December 31, 2012.

Liquidity and Capital Resources

Introduction

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

Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments. As of December 31, 2014, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities. All of our investments are classified as current assets, except for our restricted investments, and our investments in auction rate securities, which are classified as non-current assets. Our restricted investments are invested principally in certificates of deposit and U.S. treasury securities.

Investment income increased to $8.1 million for the year ended December 31, 2014, compared with $6.9 million for the year ended December 31, 2013, primarily due to the increase in invested assets. Our annualized portfolio yields for the years ended December 31, 2014 and 2013 were 0.4% and for 2012 was 0.5%.

Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold our restricted investments until maturity. Declines in interest rates over time will

reduce our investment income.

Cash in excess of the capital needs of our regulated health plans is generally paid to our non-regulated parent company in the form of dividends, when and as permitted by applicable regulations, for general corporate use. We did not receive any dividends from our health plan subsidiaries during the year ended December 31, 2014, because significant growth across all of our health plans necessitated that the plans retain their capital for operations. See further discussion in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, Note 20, "Commitments and Contingencies," under the subheading

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"Regulatory Capital and Dividend Restrictions," and Note 23, "Condensed Financial Information of Registrant," under "Note C - Dividends and Capital Contributions."

Liquidity

A condensed schedule of cash flows to facilitate our discussion of liquidity follows:

	Year Ended December 31,		
	2014	2013	Change
	(In thousands)		
Net cash provided by operating activities	$1,060,257	$190,083	$870,174
Net cash used in investing activities	(535,729)	(543,311)	7,582
Net cash provided by financing activities	78,640	493,353	(414,713)
Net increase in cash and cash equivalents	$603,168	$140,125	$463,043

	Year Ended December 31,		
	2013	2012	Change
	(In thousands)		
Net cash provided by operating activities	$190,083	$347,784	$(157,701)
Net cash used in investing activities	(543,311)	(93,584)	(449,727)
Net cash provided by financing activities	493,353	47,743	445,610
Net increase in cash and cash equivalents	$140,125	$301,943	$(161,818)

Operating Activities. Cash provided by operating activities was $1,060.3 million in 2014 compared with $190.1 million in 2013, an increase of $870.2 million. This increase was due primarily to the following:

- $441.8 million increase in amounts due to government agencies, due to a significant increase in amounts accrued for medical cost floor contract provisions primarily associated with our Medicaid expansion membership; and
- $355.5 million increase in medical claims and benefits payable due to significant membership growth in 2014.

In 2013, cash provided by operating activities was $190.1 million compared with $347.8 million for 2012, a decrease of $157.7 million. In 2013, deferred revenue was a use of cash from operations amounting to $19.6 million, compared with a source of cash amounting to $90.9 million in 2012. This was primarily due to an advance premium payment received by our Washington health plan in December 2012, with no comparable advance premium receipts in December 2013.

Investing Activities. Cash used in investing activities decreased to $535.7 million in 2014, compared with $543.3 million in 2013. This $7.6 million decline in cash used was primarily due to lower purchases of investments, net of sales and maturities, compared with 2013. As described below, there was greater investment activity in 2013 associated with significant debt financing transactions.

In 2013, cash used in investing activities was $543.3 million compared with $93.6 million in 2012. This $449.7 million increase was primarily due to greater purchases of investments in 2013, as a result of the cash generated in financing activities, described below. In addition to increased purchases of investments, we paid $61.5 million in connection with business combinations in 2013, with no comparable activity in 2012.

Financing Activities. Cash provided by financing activities was $78.6 million in 2014 compared with $493.4 million in 2013, a decrease of $414.7 million. Cash provided by financing activities in 2014 included primarily $122.6 million net proceeds from our fiscal 2014 offering of 1.625% Notes, partially offset by $50.3 million paid in the settlement of contingent consideration liabilities associated with our 2013 business combinations. Cash provided by financing activities in 2014 was significantly outpaced by debt financing activities in 2013, as described below.

In 2013, cash provided by financing activities was $493.4 million compared with $47.7 million in 2012, an increase of $445.6 million. The increase in cash provided by financing activities was primarily due to 2013 activity including $538.0 million in proceeds received from our offering of 1.125% Notes, $158.7 million received from sale-leaseback transactions, and $75.1 million from the sale of warrants, partially offset by $149.3 million paid for the purchased call option relating to 1.125% Notes, $52.7 million paid for repurchases of our common stock, $47.5 million used to repay our term loan, and $40.0 million used to repay our credit facility. Our credit facility was terminated in early 2013 when the balance was repaid.

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Financial Condition

On a consolidated basis, at December 31, 2014, our working capital was $1,070.6 million compared with $745.7 million at December 31, 2013. At December 31, 2014, our cash and investments amounted to $2,665.9 million, compared with $1,712.9 million of cash and investments at December 31, 2013.

Health Insurer Fee. One notable provision of the ACA is an excise tax or annual fee that applies to most health plans, including commercial health plans and Medicaid managed care plans like Molina Healthcare. While characterized as a "fee" in the text of the ACA, the intent of Congress was to impose a broad-based health insurance industry excise tax, with the understanding that the tax could be passed on to consumers, most likely through higher commercial insurance premiums.

However, because Medicaid is a government funded program, Medicaid health plans have no alternative but to look to their respective state partners for payment to offset the impact of this tax. Additionally, when states reimburse us for the amount of the HIF, that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. We expect our 2015 HIF assessment related to our Medicaid business to be approximately $143 million, with an expected tax effect from the reimbursement of the assessment of approximately $88 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $231 million.

Our 2014 HIF assessment amounted to $88.6 million, which was paid in September 2014. As indicated in the table below, it was necessary for the states to pay us an incremental amount of approximately $131 million during 2014 to account for the HIF and the absence of its deductibility.

The state of California has not formally committed to reimburse us for either the HIF itself, or the related tax effects. The states of Michigan and Utah have reimbursed us for the HIF, but have not formally committed to reimbursement for the related tax effect. The total amount of HIF revenue for which agreements were not secured (and revenue was not recognized) amounted to approximately $20 million for fiscal 2014. We expect to collect and recognize this revenue related to 2014 in 2015. We further expect to recognize revenue in 2015 sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2015.

We continue to work with our state partners to obtain reimbursement for the full economic impact of the excise tax. The failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows or results of operations.

The following table provides the details of our HIF revenue reimbursement by health plan to date in 2014 (in thousands):

	HIF Reimbursement Recognized					Required HIF
	Three Months Ended				Year Ended	Reimbursement
	March 31, 2014	June 30, 2014	Sept. 30, 2014	Dec. 31, 2014	Dec. 31, 2014	through Dec. 31, 2014
	Gross (1)					
California	$—	$—	$—	$—	$—	$11,616
Florida	1,416	1,473	1,487	1,459	5,835	5,835
Illinois	40	42	40	40	162	162
Michigan	—	—	8,011	2,663	10,674	17,471
New Mexico	—	—	—	11,322	11,322	11,322
Ohio	7,791	8,117	6,912	7,606	30,426	30,426
Texas	—	—	—	18,518	18,518	18,518
Utah	—	—	3,000	1,049	4,049	5,332
Washington	6,229	6,489	6,217	6,311	25,246	25,246
Wisconsin	1,080	1,126	1,372	1,193	4,771	4,771
Medicaid	16,556	17,247	27,039	50,161	111,003	130,699
Medicare	2,892	3,199	3,068	3,053	12,212	12,212
	$19,448	$20,446	$30,107	$53,214	$123,215	$142,911

Recognized in:

Health insurer fee revenue	$18,696	$19,662	$29,427	$51,699	$119,484
Premium tax revenue	752	784	680	1,515	3,731
	$19,448	$20,446	$30,107	$53,214	$123,215

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(1) Amounts in the table include the full economic impact of the excise tax including premium tax and the income tax effect.

Regulatory Capital and Dividend Restrictions

For a comprehensive discussion of our regulatory capital requirements and dividend restrictions, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20 "Commitments and Contingencies."

Future Sources and Uses of Liquidity

For a comprehensive discussion of our debt instruments, including our convertible senior notes transactions in 2014 and 2013, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12 "Long-Term Debt."

For a discussion of our shelf registration statement, and our securities repurchase programs through December 31, 2014, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 15, "Stockholders' Equity."

Effective as of February 25, 2015, our board of directors authorized the repurchase of up to $50 million in aggregate of our common stock. Stock repurchases under this program may be made through open-market and/or privately negotiated transactions at times and in such amounts as management deems appropriate. The timing and actual number of shares repurchased will depend on a variety of factors including price, corporate and regulatory requirements and market conditions. This newly authorized repurchase program extends through December 31, 2015.

Critical Accounting Estimates

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

- Health Plans segment medical claims and benefits payable (see discussion below).
- Health Plans segment contractual provisions that may adjust or limit revenue or profit. For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- Health Plans segment quality incentives. For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."
- Molina Medicaid Solutions segment revenue and cost recognition. For a comprehensive discussion of this topic, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies."

Medical Claims and Benefits Payable — Health Plans Segment

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

	December 31, 2014	2013	2012
	(In thousands)		
Fee-for-service claims incurred but not paid (IBNP)	$870,429	$424,173	$377,614
Pharmacy payable	71,412	45,037	38,992
Capitation payable	28,150	20,267	49,066
Other (1)	230,531	180,310	28,858
	$1,200,522	$669,787	$494,530

(1) "Other" medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. As of December 31, 2014 and 2013, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $119.3 million and $151.3 million, respectively.

The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. Such determination of our liability requires the application of a significant degree of judgment by our management.

As a result, the determination of our liability for claims and medical benefits payable is subject to an inherent degree of uncertainty. Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated

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liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the table above, our estimated IBNP liability represented $870.4 million of our total medical claims and benefits payable of $1,200.5 million as of December 31, 2014. Excluding amounts that we anticipate paying on behalf of certain capitated providers in Ohio (which we will subsequently withhold from those providers' monthly capitation payments), our IBNP liability at December 31, 2014, was $861.8 million.

The factors we consider when estimating our IBNP include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims deviation, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2014 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2014, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	$ 223,129
(4)%	148,753
(2)%	74,376
2%	(74,376)
4%	(148,753)
6%	(223,129)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2014 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in thousands.

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(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	$ (135,631)
(4)%	(90,421)
(2)%	(45,210)
2%	45,210
4%	90,421
6%	135,631

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 48.3 million diluted shares outstanding for the year ended December 31, 2014. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2014, net income for the year ended December 31, 2014 would increase or decrease by approximately $23 million, or $0.48 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2014, net income for the year ended December 31, 2014 would increase or decrease by approximately $14 million, or $0.29 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $117 million, or $2.42 per diluted share, and $71 million, or $1.47 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are overestimated, trended PMPM costs tend to be underestimated. Both circumstances will create an overstatement of net income. Likewise, when completion factors are underestimated, trended PMPM costs tend to be overestimated, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $23 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNP reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, once again using actuarial techniques, to account for adverse deviation in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims deviation. The provision for adverse claims deviation is a component of our overall determination of the adequacy of our IBNP. It is intended to capture the potential inadequacy of our IBNP estimate as a result of our inability to adequately assess the impact of factors such as changes in the speed of claims receipt and payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind or disabled (ABD), changes to state-controlled fee schedules upon which a large proportion of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNP after considering the base actuarial model reserves and the provision for adverse claims deviation.

We also include in our IBNP liability an estimate of the administrative costs of settling all claims incurred through the reporting date.

The development of IBNP is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly.

On a monthly basis, we review and update our estimated IBNP and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past been required to increase significantly our claims reserves for periods previously reported, and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially

decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended

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PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 11, "Medical Claims and Benefits Payable," for additional information regarding the specific factors used to determine our changes in estimates of IBNP for all periods presented in the accompanying consolidated financial statements.

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

	Year ended December 31,		
	2014	2013	2012
	(Dollars in thousands, except per-member amounts)		
Balances at beginning of period	$669,787	$494,530	$402,476
Components of medical care costs related to:			
Current period	8,122,885	5,434,443	5,136,055
Prior periods	(45,979)	(52,779)	(39,295)
Total medical care costs	8,076,906	5,381,664	5,096,760
Change in non-risk provider payables	(31,973)	111,267	(7,004)
Payments for medical care costs related to:			
Current period	7,064,427	4,932,195	4,689,395
Prior periods	449,771	385,479	308,307
Total paid	7,514,198	5,317,674	4,997,702
Balances at end of period	$1,200,522	$669,787	$494,530
Benefit from prior periods as a percentage of:			
Balance at beginning of period	6.9%	10.7%	9.8%
Premium revenue	0.5%	0.9%	0.7%
Medical care costs	0.6%	1.0%	0.8%
Claims Data:			
Days in claims payable, fee for service	49	43	40
Number of members at end of period	2,623,000	1,931,000	1,797,000
Number of claims in inventory at end of period	307,700	145,800	122,700
Billed charges of claims in inventory at end of period	$718,500	$276,500	$255,200
Claims in inventory per member at end of period	0.12	0.08	0.07
Billed charges of claims in inventory per member end of period	$273.92	$143.19	$142.01
Number of claims received during the period	27,597,000	21,317,500	20,842,400
Billed charges of claims received during the period	$30,315,600	$21,414,600	$19,429,300

Commitments and Contingencies

We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 20 ,"Commitments and Contingencies."

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Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2014.[1] Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	Total	2015	2016-2017	2018-2019	2020 and Beyond
Medical claims and benefits payable	$1,200,522	$1,200,522	$—	$—	$ —
Principal amount of convertible senior notes (2)	851,551	—	—	—	851,551
Amounts due government agencies	527,193	527,193	—	—	—
Lease financing obligations	380,956	11,397	23,830	25,282	320,447
Interest on long-term debt	176,405	11,088	22,176	22,175	120,966
Operating leases	122,035	29,142	44,591	33,073	15,229
Lease financing obligations - related party	102,394	5,346	11,243	12,021	73,784
Purchase commitments	26,029	14,232	11,797	—	—
	$3,387,085	$1,798,920	$113,637	$92,551	$ 1,381,977

(1) As of December 31, 2014, we have recorded approximately $2.6 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 14, "Income Taxes."

(2) Represents the principal amounts due on our 1.125% Cash Convertible Senior Notes due 2020, and our 1.625% Convertible Senior Notes due 2044 (1.625% Notes). The 1.625% Notes have a contractual maturity date in 2044; however, on specified dates beginning in 2018 holders of the 1.625% Notes may require us to repurchase some or all of the 1.625% Notes, as described in Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 12, "Long-Term Debt."

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Quantitative and Qualitative Disclosures About Market Risk

Refer to Item 8 of this Form 10-K, Notes to Consolidated Financial Statements, in Note 2, "Significant Accounting Policies," Note 5, "Fair Value Measurements," and Note 6, "Investments."

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. There can be no assurance, however, that our strategies to mitigate health care cost inflation will be successful. Competitive pressures, new health care and pharmaceutical product introductions, demands from health care providers and customers, applicable regulations, or other factors may affect our ability to control health care costs.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2014 and 2013, and the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2014. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2014 and 2013, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2014, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2014, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 26, 2015 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
February 26, 2015

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MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	December 31, 2014	2013
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$1,539,063	$935,895
Investments	1,019,462	703,052
Receivables	596,456	298,935
Income tax refundable	—	32,742
Deferred income taxes	39,532	26,556
Prepaid expenses and other current assets	50,884	42,484
Total current assets	3,245,397	2,039,664
Property, equipment, and capitalized software, net	340,778	292,083
Deferred contract costs	53,675	45,675
Intangible assets, net	89,273	98,871
Goodwill	271,964	230,738
Restricted investments	102,479	63,093
Derivative asset	329,323	186,351
Other assets	44,326	46,462
	$4,477,215	$3,002,937
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$1,200,522	$669,787
Accounts payable and accrued liabilities	241,654	263,043
Amounts due government agencies	527,193	56,922
Deferred revenue	196,076	122,216
Income taxes payable	8,987	—
Current maturities of long-term debt	341	182,008
Total current liabilities	2,174,773	1,293,976
Convertible senior notes	704,097	416,368
Lease financing obligations	160,710	159,394
Lease financing obligations - related party	40,241	27,092
Deferred income taxes	24,271	580
Derivative liability	329,194	186,239
Other long-term liabilities	33,487	26,351
Total liabilities	3,466,773	2,110,000
Stockholders' equity:		
Common stock, $0.001 par value; 150,000 shares authorized; outstanding: 49,727 shares at December 31, 2014 and 45,871 shares at December 31, 2013	50	46
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	396,059	340,848
Accumulated other comprehensive loss	(1,019)	(1,086)
Retained earnings	615,352	553,129
Total stockholders' equity	1,010,442	892,937

	$4,477,215	$3,002,937

See accompanying notes.

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MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2014	2013	2012
	(In thousands, except per-share data)		
Revenue:			
Premium revenue	$9,022,511	$6,179,170	$5,544,121
Service revenue	210,051	204,535	187,710
Premium tax revenue	294,388	172,017	158,991
Health insurer fee revenue	119,484	—	—
Investment income	8,093	6,890	5,075
Other revenue	12,074	26,322	18,312
Total revenue	9,666,601	6,588,934	5,914,209
Operating expenses:			
Medical care costs	8,076,331	5,380,124	4,991,188
Cost of service revenue	156,764	161,494	141,208
General and administrative expenses	764,693	665,996	518,615
Premium tax expenses	294,388	172,017	158,991
Health insurer fee expenses	88,591	—	—
Depreciation and amortization	92,917	72,743	63,114
Total operating expenses	9,473,684	6,452,374	5,873,116
Operating income	192,917	136,560	41,093
Other expenses, net:			
Interest expense	56,811	52,071	16,769
Other expense, net	802	3,343	945
Total other expenses, net	57,613	55,414	17,714
Income from continuing operations before income tax expense	135,304	81,146	23,379
Income tax expense	72,726	36,316	10,513
Income from continuing operations	62,578	44,830	12,866
(Loss) income from discontinued operations, net of tax (benefit) expense of $(203), $(9,912), and $(1,238), respectively	(355)	8,099	(3,076)
Net income	$62,223	$52,929	$9,790
Basic net income per share:			
Income from continuing operations	$1.34	$0.98	$0.28
(Loss) income from discontinued operations	(0.01)	0.18	(0.07)
Basic net income per share	$1.33	$1.16	$0.21
Diluted net income per share:			
Income from continuing operations	$1.30	$0.96	$0.27
(Loss) income from discontinued operations	(0.01)	0.17	(0.06)
Diluted net income per share	$1.29	$1.13	$0.21
Weighted average shares outstanding:			
Basic	46,935	45,717	46,380
Diluted	48,340	46,862	46,999

See accompanying notes.

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MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Net income	$62,223	$52,929	$9,790
Other comprehensive income (loss):			
Unrealized investment gain (loss)	108	(1,015)	1,529
Effect of income tax expense (benefit)	41	(386)	581
Other comprehensive income (loss), net of tax	67	(629)	948
Comprehensive income	$62,290	$52,300	$10,738

See accompanying notes.

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MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Loss	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
	(In thousands)						
Balance at January 1, 2012	45,815	$46	$266,022	$ (1,405)	$490,410	$—	$755,073
Net income	—	—	—	—	9,790	—	9,790
Other comprehensive income, net	—	—	—	948	—	—	948
Purchase of treasury stock	(111)	—	—	—	—	(3,000)	(3,000)
Share-based compensation	1,058	1	16,361	—	—	—	16,362
Tax benefit from share-based compensation	—	—	3,141	—	—	—	3,141
Balance at December 31, 2012	46,762	47	285,524	(457)	500,200	(3,000)	782,314
Net income	—	—	—	—	52,929	—	52,929
Other comprehensive loss, net	—	—	—	(629)	—	—	(629)
Purchase of treasury stock	(1,710)	(2)	—	—	—	(52,660)	(52,662)
Retirement of treasury stock	—	—	(55,660)	—	—	55,660	—
Issuance of warrants	—	—	78,997	—	—	—	78,997
Share-based compensation	819	1	30,385	—	—	—	30,386
Tax benefit from share-based compensation	—	—	1,602	—	—	—	1,602
Balance at December 31, 2013	45,871	46	340,848	(1,086)	553,129	—	892,937
Net income	—	—	—	—	62,223	—	62,223
Other comprehensive income, net	—	—	—	67	—	—	67
Convertible senior notes transactions, including issuance costs	1,787	2	21,961	—	—	—	21,963
Share-based compensation	2,069	2	30,261	—	—	—	30,263
Tax benefit from share-based compensation	—	—	2,989	—	—	—	2,989
Balance at December 31, 2014	49,727	$50	$396,059	$ (1,019)	$615,352	$—	$1,010,442

See accompanying notes.

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MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Operating activities:			
Net income	$62,223	$52,929	$9,790
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	134,404	93,866	78,764
Deferred income taxes	(2,352)	(31,047)	(9,887)
Share-based compensation	21,727	28,694	20,018
Amortization of convertible senior notes and lease financing obligations	27,379	22,820	5,942
Gain on sale of subsidiary	—	—	(1,747)
Other, net	6,222	17,729	11,224
Changes in operating assets and liabilities:			
Receivables	(297,521)	(149,253)	18,216
Prepaid expenses and other current assets	(19,517)	(23,064)	(8,958)
Medical claims and benefits payable	530,735	175,257	92,054
Accounts payable and accrued liabilities	11,097	32,550	8,078
Amounts due government agencies	470,271	28,446	15,267
Deferred revenue	73,860	(19,582)	90,851
Income taxes	41,729	(39,262)	18,172
Net cash provided by operating activities	1,060,257	190,083	347,784
Investing activities:			
Purchases of investments	(953,355)	(770,083)	(306,437)
Proceeds from sales and maturities of investments	632,800	399,595	298,006
Purchases of equipment	(114,934)	(98,049)	(78,145)
Net cash paid in business combinations	(44,133)	(61,521)	—
Increase in restricted investments	(33,661)	(18,992)	(2,647)
Proceeds from sale of subsidiary, net of cash surrendered	—	—	9,162
Other, net	(22,446)	5,739	(13,523)
Net cash used in investing activities	(535,729)	(543,311)	(93,584)
Financing activities:			
Proceeds from issuance of convertible senior notes, net of financing costs paid	122,625	537,973	—
Proceeds from sale-leaseback transactions	—	158,694	—
Purchase of call option	—	(149,331)	—
Proceeds from issuance of warrants	—	75,074	—
Contingent consideration liabilities settled	(50,349)	—	—
Treasury stock purchases	—	(52,662)	(3,000)
Principal payments on term loan	—	(47,471)	(1,129)
Repayment of amount borrowed under credit facility	—	(40,000)	(20,000)
Proceeds from employee stock plans	14,040	9,402	8,205
Principal payments on convertible senior notes	(10,449)	—	—
Amount borrowed under credit facility	—	—	60,000
Other, net	2,773	1,674	3,667
Net cash provided by financing activities	78,640	493,353	47,743

Net increase in cash and cash equivalents	603,168	140,125	301,943
Cash and cash equivalents at beginning of period	935,895	795,770	493,827
Cash and cash equivalents at end of period	$1,539,063	$935,895	$795,770

See accompanying notes.

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MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS
(continued)

	Year Ended December 31,		
	2014	2013	2012
	(Amounts in thousands)		
	(Unaudited)		
Supplemental cash flow information:			
Cash paid (received) during the period for:			
Income taxes	$30,413	$95,240	$(4,634)
Interest	$29,178	$34,881	$10,099
Schedule of non-cash investing and financing activities:			
3.75% Notes exchanged for 1.625% Notes	$176,551	$—	$—
Retirement of treasury stock	$—	$55,660	$—
Increase in non-cash lease financing obligation - related party	$13,841	$27,211	$—
Common stock used for stock-based compensation	$(8,802)	$(7,711)	$(11,862)
Details of business combinations:			
Fair value of assets acquired	$(52,057)	$(121,801)	$—
Fair value of contingent consideration liabilities incurred	—	59,948	—
Payable to seller	7,924	—	—
Escrow deposit	—	332	—
Net cash paid in business combinations	$(44,133)	$(61,521)	$—
Details of change in fair value of derivatives, net:			
Gain on 1.125% Call Option	$142,972	$37,020	$—
Loss on 1.125% Notes Conversion Option	(142,955)	(36,908)	—
Loss on 1.125% Warrants	—	(3,923)	—
Gain (loss) on interest rate swap	—	433	(1,307)
Change in fair value of derivatives, net	$17	$(3,378)	$(1,307)
Details of sale of subsidiary:			
Decrease in carrying value of assets	$—	$—	$30,942
Decrease in carrying value of liabilities	—	—	(23,527)
Gain on sale	—	—	1,747
Proceeds from sale of subsidiary, net of cash surrendered	$—	$—	$9,162

See accompanying notes.

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MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. provides quality health care to those receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist state agencies in their administration of the Medicaid program. We report our financial performance based on two reportable segments: the Health Plans segment and the Molina Medicaid Solutions segment.

Our Health Plans segment consists of health plans in 11 states, and includes our direct delivery business. As of December 31, 2014, these health plans served over 2.6 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. Additionally, we serve a small number of Health Insurance Marketplace members, many of whom are eligible for government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO). Our direct delivery business consists primarily of the management of a hospital in southern California under a management services agreement, and the operation of primary care clinics in several states in which we operate.

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Our health plan subsidiaries have generally been successful in retaining their contracts, but such contracts are subject to risk of loss when a state issues a new request for proposals (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal.

Our Molina Medicaid Solutions segment provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida.

Market Updates—Health Plans Segment

Florida. During 2014, our Florida health plan acquired two Medicaid contracts, adding approximately 73,000 members. See Note 4, "Business Combinations," for further information.

Puerto Rico. In 2014, we were awarded a managed care contract in the Commonwealth of Puerto Rico that is expected to enroll its first members April 1, 2015.

South Carolina. Our South Carolina health plan began serving members under the state of South Carolina's new full-risk Medicaid managed care program effective January 1, 2014.

Market Update—Molina Medicaid Solutions Segment

In 2011, Molina Medicaid Solutions received notice from the state of Louisiana that the state intended to award the contract for a replacement Medicaid management information system (MMIS) to a different vendor, CNSI. However, in March 2013, the state of Louisiana canceled its contract award to CNSI. The state had informed us that we will continue to perform under our current contract until a successor is named. On December 18, 2014, Molina Medicaid Solutions received notice from the state of Louisiana that they have extended our contract through December 31, 2015. We recognized approximately $41 million of service revenue under this contract in 2014.

Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 19, "Variable Interest Entities," for more information regarding these variable interest entities. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition.

Presentation and Reclassifications

We previously reported that our Medicaid managed care contract with the state of Missouri expired without renewal in 2012, and effective June 2013 the transition obligations associated with that contract terminated. Therefore, beginning in the second quarter of 2013, we reported the results relating to the Missouri health plan as discontinued operations for all periods presented. Additionally, we abandoned our equity interests in the Missouri health plan during the second quarter of 2013, resulting in the

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recognition of a tax benefit of $9.5 million, which is also included in discontinued operations in the consolidated statements of income. The Missouri health plan's premium revenues were insignificant in 2014 and 2013, and amounted to $114.4 million for the year ended December 31, 2012.

We have reclassified certain amounts in the 2013 consolidated balance sheet, and 2013 and 2012 statements of cash flows to conform to the 2014 presentation, including the presentation of amounts due government agencies as a separate line item in the consolidated balance sheets and statements of cash flows.

Use of Estimates

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

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

2. Significant Accounting Policies

Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase.

Investments

Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available-for-sale securities, and held-to-maturity securities. Available-for-sale securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders’ equity as other comprehensive income, net of applicable income taxes. Held-to-maturity securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis.

Our investment policy requires that all of our investments have final maturities of 10 years or less (excluding auction rate and variable rate securities where interest rates may be periodically reset), and that the average maturity be three years or less. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time will reduce our investment income.

In general, our available-for-sale securities are classified as current assets without regard to the securities’ contractual maturity dates because they may be readily liquidated. Our auction rate securities are classified as non-current assets and reported in other assets. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, including auction rate securities, see Note 5, "Fair Value Measurements," Note 6, "Investments," and Note 10, "Restricted Investments."

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Receivables

Receivables are readily determinable and because our creditors are primarily state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 7, "Receivables."

Property, Equipment, and Capitalized Software

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Furniture and equipment are generally depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software developed for internal use is capitalized. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 to 40 years. See Note 8, "Property, Equipment, and Capitalized Software."

As discussed below, the costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period.

Depreciation and Amortization

Depreciation and amortization related to our Health Plans segment is all recorded in "Depreciation and Amortization" in the consolidated statements of income. Depreciation and amortization related to our Molina Medicaid Solutions segment is recorded within three different headings in the consolidated statements of income as follows:

- Amortization of purchased intangibles relating to customer relationships is reported as amortization within the heading "Depreciation and amortization;"
- Amortization of purchased intangibles relating to contract backlog is recorded as a reduction of "Service revenue;" and
- Amortization of capitalized software is recorded within the heading "Cost of service revenue."

The following table presents all depreciation and amortization recorded in our consolidated statements of income, regardless of whether the item appears as depreciation and amortization, a reduction of revenue, or as cost of service revenue.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Depreciation, and amortization of capitalized software, continuing operations	$75,402	$54,837	$42,938
Amortization of intangible assets, continuing operations	17,515	17,906	20,176
Depreciation and amortization, continuing operations	92,917	72,743	63,114
Depreciation and amortization, discontinued operations	—	2	590
Amortization recorded as reduction of service revenue	2,914	2,914	1,571
Amortization of capitalized software recorded as cost of service revenue	38,573	18,207	13,489
Depreciation and amortization reported in the statement of cash flows	$134,404	$93,866	$78,764

Long-Lived Assets, including Intangible Assets

Long-lived assets comprise primarily property, equipment, capitalized software and intangible assets. Finite-lived, separately-identifiable intangible assets are acquired in business combinations and are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at their fair values and are then amortized on a straight-line basis over their expected useful lives, generally between three and 15 years.

Identifiable intangible assets associated with Molina Medicaid Solutions are classified as either contract backlog or customer relationships as follows:

- The contract backlog intangible asset comprises all contractual cash flows anticipated to be received during the remaining contracted period for each specific contract relating to work that was performed prior to acquisition. Because each acquired contract constitutes a single revenue stream, amortization of the contract backlog intangible is

recorded to contra-service revenue so that amortization is matched to any revenues associated with contract performance that occurred prior to the acquisition date. The contract backlog intangible asset is amortized on a

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straight-line basis for each specific contract over periods generally ranging from one to six years. The contract backlog intangible assets will be fully amortized in 2015.

- The customer relationship intangible asset comprises all contractual cash flows that are anticipated to be received during the option periods of each specific contract as well as anticipated renewals of those contracts. The customer relationship intangible is amortized on a straight-line basis for each specific contract over periods generally ranging from four to nine years.

Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators. For example, our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the undiscounted cash flows that are expected to result from the use of the asset or related group of assets. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2014, 2013, and 2012.

Goodwill

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of a reporting unit below its carrying amount.

To determine whether goodwill is impaired, we measure the fair values of our reporting units and compare them to the carrying values of the respective units, including goodwill. If the fair value is less than the carrying value of the reporting unit, then the implied value of goodwill would be calculated and compared to the carrying amount of goodwill to determine whether goodwill is impaired.

We estimate the fair values of our reporting units using discounted cash flows. To determine fair values, we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates.

No impairment charges relating to goodwill were recorded in the years ended December 31, 2014, 2013, and 2012.

Restricted Investments

Restricted investments, which consist of certificates of deposit and U.S. treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to specific purposes as required by each state, or as protection against the insolvency of capitated providers. We have the ability to hold our restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. See Note 10, "Restricted Investments."

Other Assets

Other assets primarily includes deferred financing costs associated with our convertible senior notes and lease financing obligations, and certain investments held in connection with our employee deferred compensation program. The deferred financing costs are being amortized on a straight-line basis over the terms of the convertible senior notes and lease financing obligations.

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Delegated Provider Insolvency

Circumstances may arise where providers to whom we have delegated risk are unable to pay claims they have incurred with third parties in connection with referral services (including hospital inpatient services) provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so. To reduce the risk that delegated providers are unable to pay referral claims, we monitor the operational and financial performance of such providers. We also maintain contingency plans that include transferring members to other providers in response to potential network instability.

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2014 and 2013.

Premium Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the year ended December 31, 2014, we received more than 95% of our premium revenue as a fixed amount per member per month (PMPM), pursuant to our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. Revenue not received on a fixed PMPM basis is recognized as earned. The state Medicaid programs and the federal Medicare program periodically adjust premium rates.

The following table summarizes premium revenue from continuing operations for the periods indicated:

	Year Ended December 31,								
	2014			2013			2012		
	Amount	% of Total		Amount	% of Total		Amount	% of Total	
	(Dollars in thousands)								
California	$1,523,084	16.9	%	$749,755	12.1	%	$665,600	12.0	%
Florida	439,107	4.9		264,998	4.3		228,832	4.1	
Illinois	153,271	1.7		8,121	0.1		—	—	
Michigan	780,896	8.7		676,000	11.0		646,551	11.7	
New Mexico	1,075,330	11.9		446,758	7.2		321,853	5.8	
Ohio	1,552,949	17.2		1,098,795	17.8		1,095,137	19.7	
South Carolina	381,317	4.2		—	—		—	—	
Texas	1,318,192	14.6		1,291,001	20.9		1,233,621	22.2	
Utah	309,411	3.4		310,895	5.0		298,392	5.4	
Washington	1,304,605	14.5		1,168,405	18.9		974,712	17.6	
Wisconsin	156,229	1.7		143,465	2.3		70,678	1.3	
Direct delivery	28,120	0.3		20,977	0.4		8,745	0.2	
	$9,022,511	100.0	%	$6,179,170	100.0	%	$5,544,121	100.0	%

Certain components of premium revenue are subject to accounting estimates and fall into the following categories:

Contractual Provisions That May Adjust or Limit Revenue or Profit

Health Plan Medical Cost Floors (Minimums), Medical Cost Corridors, and Administrative Cost Ceilings (Maximums): A portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $392.4 million and $1.4 million at December 31, 2014, and December 31, 2013, respectively, to amounts due government agencies. Such liability amounts could be subject to

future changes in estimate. The increase is primarily driven by contractual provisions relating to the Medicaid expansion program, which began to phase in during January 2014. Beginning in 2014, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined

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maximum threshold. Separately, in certain states we may be levied with non-monetary sanctions if certain minimum amounts are not spent on defined medical care costs, or if administrative costs exceed certain amounts.

Health Plan Profit Sharing and Profit Ceiling: Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage, in some cases in accordance with a tiered rebate schedule. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. As a result of profits in excess of the amount we are allowed to fully retain, we recorded a liability of $0.5 million and $2.5 million at December 31, 2014 and December 31, 2013, respectively.

Medicare Revenue Risk Adjustment: Based on member encounter data that we submit to the Centers for Medicare and Medicaid Services (CMS), our Medicare premiums are subject to retroactive adjustment for both member risk scores and member pharmacy cost experience for up to two years after the original year of service. This adjustment takes into account the acuity of each member's medical needs relative to what was anticipated when premiums were originally set for that member. In the event that a member requires less acute medical care than was anticipated by the original premium amount, CMS may recover premium from us. In the event that a member requires more acute medical care than was anticipated by the original premium amount, CMS may pay us additional retroactive premium. A similar retroactive reconciliation is undertaken by CMS for our Medicare members' pharmacy utilization. We estimate the amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health care utilization patterns and CMS practices. Based on our knowledge of member health care utilization patterns and expenses we have recorded a net receivable of $7.6 million and $20.8 million for anticipated Medicare risk adjustment premiums at December 31, 2014 and December 31, 2013, respectively.

Quality Incentives

At our California, Illinois, New Mexico, Ohio, Texas, Washington and Wisconsin health plans, revenue ranging from approximately 1% to 4% of certain health plan premiums is earned if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the period presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2014 are not known, we have no reason to believe that the adjustments to prior years noted below are not indicative of the potential future changes in our estimates as of December 31, 2014.

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Maximum available quality incentive premium - current period	$90,327	$63,311	$74,564
Amount of quality incentive premium revenue recognized in current period:			
Earned current period	$40,396	$45,803	$62,489
Earned prior periods	3,950	9,056	2,202
Total	$44,346	$54,859	$64,691
Total premium revenue recognized for state health plans with quality incentive premiums	$7,083,660	$2,980,019	$2,721,289

California Health Plan Rate Settlement Agreement

In the fourth quarter of 2013, our California health plan entered into a settlement agreement with the California Department of Health Care Services (DHCS). The agreement settled rate disputes initiated by our California health plan dating back to 2003 with respect to its participation in Medi-Cal (California's Medicaid program). Under the terms of the agreement, a settlement account (the Account) applicable to the California health plan's managed care contracts has been established.

Effective January 1, 2014, the Account was established with an initial balance of zero, and will be settled after December 31, 2017. DHCS will make an interim partial settlement payment to us if it terminates early, without

replacement, any of our managed care contracts. The Account will be adjusted annually to reflect a calendar year deficit or surplus, which is determined by comparing the California health plan's pre-tax margin and a target margin established in the settlement agreement. Upon expiration of the settlement agreement, if the Account is in a deficit position, then DHCS will pay the amount of the deficit to us, subject to an alternative minimum payment amount. If the Account is in a surplus position, then no amount is owed to either party. The maximum amount that DHCS would pay to us under the terms of the settlement agreement is $40.0 million.

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We estimate and recognize the retrospective adjustments to premium revenue based on our experience to date under the California health plan's managed care contracts. As of December 31, 2014, the California health plan's pre-tax margin exceeded the target margin, resulting in a surplus position. Consequently, a retrospective premium adjustment was not required for the year ended December 31, 2014.

Medical Care Costs

Expenses related to medical care services are captured in the following categories:

- Fee-for-service expenses: Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.
- Pharmacy expenses: All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- Capitation expenses: Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- Direct delivery expenses: All costs associated with our direct delivery of medical care are separately identified.
- Other medical expenses: All medically related administrative costs, certain provider incentive costs, reinsurance costs and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2014, 2013, and 2012, medically related administrative costs were $262.6 million, $153.0 million, and $125.2 million, respectively.

The following table provides the details of our consolidated medical care costs from continuing operations for the periods indicated (dollars in thousands, except PMPM amounts):

	Year Ended December 31,											
	2014				2013				2012			
	Amount	PMPM	% of Total		Amount	PMPM	% of Total		Amount	PMPM	% of Total	
Fee-for-service	$5,672,483	$202.87	70.2	%	$3,611,529	$160.43	67.1	%	$3,423,751	$161.67	68.6	%
Pharmacy	1,273,329	45.54	15.8		935,204	41.54	17.4		835,830	39.47	16.7	
Capitation	748,388	26.77	9.3		603,938	26.83	11.2		552,136	26.07	11.1	
Direct delivery	96,196	3.44	1.2		48,288	2.14	0.9		33,920	1.60	0.7	
Other	285,935	10.22	3.5		181,165	8.05	3.4		145,551	6.87	2.9	
Total	$8,076,331	$288.84	100.0	%	$5,380,124	$238.99	100.0	%	$4,991,188	$235.68	100.0	%

The Missouri health plan's medical care costs, which are not included in the table above, amounted to $0.6 million, $1.5 million, and $105.6 million for the years ended December 31, 2014, 2013, and 2012, respectively.

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, unpaid fee-for-service claims, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our

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balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 11, "Medical Claims and Benefits Payable."

We report reinsurance premiums as medical care costs, while related reinsurance recoveries are reported as deductions from medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

Taxes Based on Premiums

Health Insurer Fee. The federal government under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the Affordable Care Act, or ACA) imposes an annual fee, or excise tax, on health insurers for each calendar year. The health insurer fee (HIF) is based on a company's share of the industry's net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Because we primarily serve individuals in government-sponsored programs, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year.

Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include the premium tax assessment. We have reported these taxes on a gross basis, as premium tax revenue and as premium tax expense in the consolidated statements of income.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was recorded as of December 31, 2014, or 2013.

Service Revenue and Cost of Service Revenue — Molina Medicaid Solutions Segment

The payments received by our Molina Medicaid Solutions segment under its state contracts are based on the performance of multiple services. The first of these is the design, development and implementation (DDI) of a Medicaid management information system (MMIS). An additional service, following completion of DDI, is the operation of the MMIS under a business process outsourcing (BPO) arrangement. When providing BPO services (which include claims payment and eligibility processing) we also provide the state with other services including both hosting and support, and maintenance. Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, we recognize revenue associated with such contracts on a straight-line basis over the contract term during which BPO, hosting, and support and maintenance services are delivered. There may be certain contractual provisions containing contingencies, however that require us to delay recognition of all or part of our service revenue until such contingencies have been removed.

We have evaluated our Molina Medicaid Solutions contracts to determine if such arrangements include a software element. Based on this evaluation, we have concluded that these arrangements do not include a software element, and are therefore multiple-element service arrangements.

Additionally, we evaluate each required deliverable under our multiple-element service arrangements to determine whether it qualifies as a separate unit of accounting. Such evaluation is generally based on whether the deliverable has standalone value to the customer. If the deliverable has standalone value, the arrangement’s consideration that is fixed or determinable is then allocated to each separate unit of accounting based on the relative selling price of each deliverable. In general, the consideration allocated to each unit of accounting is recognized as the related goods or services are delivered, limited to the consideration that is not contingent.

We have concluded that the various service elements in our Molina Medicaid Solutions contracts represent a single unit of accounting due to the fact that DDI, which is the only service performed in advance of the other services (all other services are performed over an identical period), does not have standalone value because our DDI services are not sold separately by any vendor and the customer could not resell our DDI services. Further, we have no objective

and reliable evidence of fair value for any of the individual elements in these contracts, and at no point in the contract will we have objective and reliable evidence of fair value for the undelivered elements in the contracts. We lack objective and reliable evidence of the fair value of the individual elements of our Molina Medicaid Solutions contracts for the following reasons:

- Each contract calls for the provision of its own specific set of services. While all contracts support the system of record for state MMIS, the actual services we provide vary significantly between contracts; and

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- The nature of the MMIS installed varies significantly between our older contracts (proprietary mainframe systems) and our new contracts (commercial off-the-shelf technology solutions).

Because we have determined the services provided under our Molina Medicaid Solutions contracts represent a single unit of accounting, and because we are unable to determine a pattern of performance of services during the contract period, we recognize all revenue (both the DDI and BPO elements) associated with such contracts on a straight-line basis over the period during which BPO, hosting, and support and maintenance services are delivered. Therefore, absent any contingencies as discussed in the following paragraph, or contract extensions, we would recognize all revenue associated with those contracts over the initial contract period. When a contract is extended, we generally consider the extension to be a continuation of the single unit of accounting; therefore, the deferred revenue as of the extension date is recognized prospectively over the new remaining term of the contract. In cases where there is no DDI element associated with our contracts, BPO revenue is recognized on a monthly basis as specified in the applicable contract or contract extension.

Provisions specific to each contract may, however, lead us to modify this general principle. In those circumstances, the right of the state to refuse acceptance of services, as well as the related obligation to compensate us, may require us to delay recognition of all or part of our revenue until that contingency (the right of the state to refuse acceptance) has been removed. In those circumstances, we defer recognition of any contingent revenue (whether DDI, BPO services, hosting, and support and maintenance services) until the contingency has been removed. These types of contingency features are present in our Maine and Idaho contracts, for example. In those states, we deferred recognition of revenue until the contingencies were removed.

Costs associated with our Molina Medicaid Solutions contracts include software related costs and other costs. With respect to software related costs, we apply the guidance for internal-use software and capitalize external direct costs of materials and services consumed in developing or obtaining the software, and payroll and payroll-related costs associated with employees who are directly associated with and who devote time to the computer software project. With respect to all other direct costs, such costs are expensed as incurred, unless corresponding revenue is being deferred. If revenue is being deferred, direct costs relating to delivered service elements are deferred as well and are recognized on a straight-line basis over the period of revenue recognition, in a manner consistent with our recognition of revenue that has been deferred. Such direct costs can include:

- Transaction processing costs;
- Employee costs incurred in performing transaction services;