Table of Contents

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

FORM 8-K

Current Report
Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

Date of Report (Date of earliest event reported): September 11, 2007

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	1-31719	13-4204626
(State of incorporation)	(Commission File Number)	(I.R.S. Employer Identification Number)

One Golden Shore Drive, Long Beach, California 90802
(Address of principal executive offices)

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

Check the appropriate box below if the Form 8-K filing is intended to simultaneously satisfy the filing obligation of the registrant under any of the following provisions:

o Written communications pursuant to Rule 425 under the Securities Act (17 CFR 230.425)

o Soliciting material pursuant to Rule 14a-12 under the Exchange Act (17 CFR 240.14a-12)

o Pre-commencement communications pursuant to Rule 14d-2(b) under the Exchange Act (17 CFR 240.14d-2(b))

o Pre-commencement communications pursuant to Rule 13e-4(c) under the Exchange Act (17 CFR 240.13e-4(c))

TABLE OF CONTENTS

Table of Contents

Item 7.01. Regulation FD Disclosure

On September 11, 2007, Molina Healthcare, Inc. issued a press release announcing that it is revising its guidance for fiscal year 2007. The full text of the Company's press release is attached as Exhibit 99.1 to this report. The information contained in the websites cited in the press release is not part of this report.

In addition, on September 12, 2007, at the presentation given at the Company's Investor Day Conference in New York City, the Company displayed and webcast certain slides. A copy of the Company's complete slide presentation is included as Exhibit 99.2 to this report.

The information in this Form 8-K and Exhibits 99.1 and 99.2 attached hereto shall not be deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934 or otherwise subject to the liabilities of that section, nor shall it be deemed incorporated by reference in any filing under the Securities Act of 1933 or the Securities Exchange Act of 1934, except as expressly set forth by specific reference in such a filing.

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits:

Exhibit No.	Description
99.1	Press release of Molina Healthcare, Inc. issued September 11, 2007.
99.2	Slide presentation given at the Company's Investor Day Conference on September 12, 2007.

Table of Contents

SIGNATURE

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

MOLINA HEALTHCARE, INC.

Date: September 12, 2007

By: */s/ Mark L. Andrews*
Mark L. Andrews
Chief Legal Officer, General Counsel, and Corporate Secretary

Table of Contents

EXHIBIT INDEX

Exhibit No.	Description
99.1	Press release of Molina Healthcare, Inc. issued September 11, 2007.
99.2	Slide presentation given at the Company's Investor Day Conference on September 12, 2007.

EXHIBIT 99.1

News Release

Contact:
Juan José Orellana
Investor Relations
Molina Healthcare, Inc.
562-435-3666, ext. 111143

MOLINA HEALTHCARE RAISES EPS GUIDANCE
FOR FISCAL YEAR 2007

LONG BEACH, California (September 11, 2007) — Molina Healthcare, Inc. (NYSE: MOH) today announced that it is revising its guidance for fiscal year 2007. The Company now expects earnings per diluted share for the year ending December 31, 2007, to be in the range of $1.85 to $1.95. The Company had previously issued an EPS guidance range for fiscal year 2007 of $1.75 to $1.90 per share.

For its 2007 fiscal year, the Company's revised guidance is as follows:

Earnings per diluted share of approximately	$1.85 to $1.95
Net income of approximately	$52.9 to $55.8 million
Premium revenue of approximately	$2.4 billion
Medical care costs as a percentage of premium revenue of approximately	84.9%
Core G&A (administrative expenses excluding premium taxes) as a percentage of total revenue of approximately	7.9%
Administrative expenses (including premium taxes) as a percentage of total revenue of approximately	11.2%

The revised guidance assumes an effective tax rate of 38.2% and weighted average diluted shares outstanding of 28.6 million.

Molina Healthcare's management will discuss the revised guidance during its Investor Day conference being held on Wednesday, September 12, 2007, from 8:30 a.m. to 12:30 p.m. Eastern Time. A live web simulcast of the conference can be accessed on Molina Healthcare's website at www.molinahealthcare.com, or at www.earnings.com. An online replay of the webcast will be available beginning approximately one hour following its conclusion.

-MORE-

About Molina Healthcare
Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of healthcare services to persons eligible for Medicaid and other government-sponsored programs for low-income families and individuals. Molina Healthcare, Inc. currently operates health plans in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington. More information about Molina Healthcare, Inc. can be obtained at www.molinahealthcare.com.

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: *This press release contains "forward-looking statements" identified by words such as "expects" "assumes," "anticipates," "estimates," and similar words and expressions. In addition, any statements that explicitly or impliedly refer to earnings guidance, expectations, projections, or their underlying assumptions, or other characterizations of future events or circumstances, are forward-looking statements. All of our forward-looking statements are based on current expectations and assumptions that are subject to numerous known and unknown risks, uncertainties, and other factors that could cause our actual results to differ materially. Such factors include, without limitation, risks related to: the achievement of a decrease in the medical care ratio of our start-up health plans in Ohio and Texas; the achievement of projected savings from a decrease in the overall medical care ratio of all of our health plans; an increase in enrollment in our Ohio and California health plans and in our dual eligible population consistent with our expectations; our ability to reduce administrative costs in the event enrollment or revenue is lower than expected for the remainder of the year; increased administrative costs in support of the Company's efforts to expand Medicare membership; risks related to our minimal experience with Ohio, Texas, and dual eligible members and attendant claims estimation difficulties; our ability to accurately estimate incurred but not reported medical costs across all health plans; the securing of premium rate increases, particularly in the states of California and Michigan; the effect of the DRG rate rebasing in Washington being greater than expected; the payment of savings sharing income by the state of Utah to our Utah health plan consistent with our expectations; the successful renewal and continuation of the government contracts of all of our health plans; the availability of adequate financing to fund and/or capitalize our acquisitions and start-up activities, and applicable interest rates that are consistent with our expectations; the successful and cost-effective integration of our acquisitions, including Mercy CarePlus; membership eligibility processes and methodologies; unexpected changes in member utilization patterns, healthcare practices, or healthcare technologies; high dollar claims related to catastrophic illness; changes in federal or state laws or regulations or in their interpretation; failure to maintain effective and efficient information systems and claims processing technology; funding decreases in the Medicaid, SCHIP, or Medicare programs or the failure to timely renew the SCHIP program; the favorable resolution of pending litigation or arbitration; competition; epidemics such as the avian flu; and other risks and uncertainties as detailed in our reports and filings with the Securities and Exchange Commission and available on its website at www.sec.gov. All forward-looking statements in this release represent our judgment as of September 11, 2007. We disclaim any obligation to update any forward-looking statement to conform the statement to actual results or changes in our expectations.*

-END-

EXHIBIT 99.2

Molina Healthcare, Inc.
September 12th, 2007
New York, NY

Investor Day 2007B

Juan José Orellana
VP, Investor Relations

MOLINA HEALTHCARE

Cautionary Statement

"Safe Harbor" Statement under the Private Securities Litigation Reform Act of 1995: This presentation contains numerous "forward-looking statements" identified by words such as "goal," "will," "aspiration," "expects," and similar words and expressions. In addition, any statements that refer to earnings guidance or projections, or their underlying assumptions, are also forward-looking statements. All of our forward-looking statements are subject to numerous risks, uncertainties, and other factors that could cause our actual results to differ materially. Anyone viewing or listening to this presentation is urged to read the risk factors and cautionary statements found in Molina Healthcare's most recent Form 10-K, its first and second quarter Forms 10-Q, and its other reports and filings with the Securities and Exchange Commission and available on its website at www.sec.gov. Unless otherwise indicated, all forward-looking statements represent our judgment as of September 12, 2007, and we disclaim any obligation to update such statements.

MOLINA HEALTHCARE

Agenda

- Welcome & Opening Remarks
  - J. Mario Molina, MD, CEO
- Mercy CarePlus
  - John C. Molina, CFO
- Executive Panel 1 – Operations Discussion
  - Dr. James Howatt, CMO
  - Terry Bayer, COO
- break
- Vernon Smith, Ph.D.
- Executive Panel 2 – Financial Discussion
  - Joseph White, VP, CAO
  - John Molina, CFO
- lunch

MOLINA HEALTHCARE

Molina Healthcare, Inc.
September 12th, 2007
New York, NY

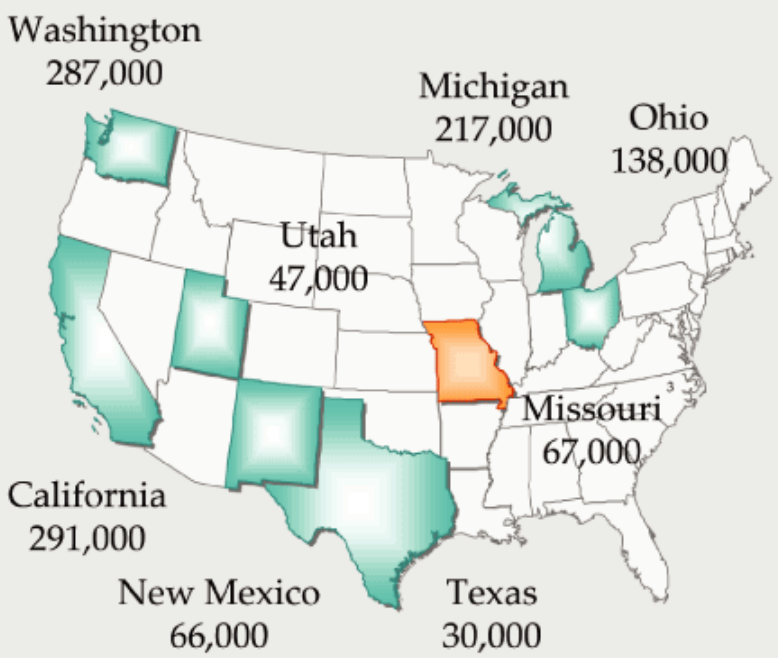
Strategic Plan

J. Mario Molina, MD
President & Chief Executive Officer

MOLINA HEALTHCARE

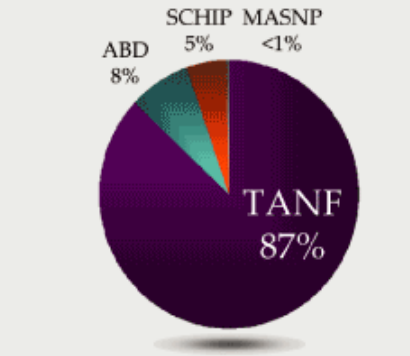
Business Snapshot

Markets and members served [1]



Membership growth [1]

Our members



1. 2005 and 2006 exclude Indiana operations discontinued as of 12/31/06.
2. Membership as of June 30, 2007.
3. Pending regulatory approval.

MOLINA HEALTHCARE

Vision Statement

- Molina Healthcare is an innovative health care leader providing quality care and accessible services in an efficient and caring manner.

Mission Statement

- Our mission is to promote health and provide health services to low-income families and individuals covered by government programs.

Core Values: Striving to be an Exemplary Organization

- We care about the people we serve and **advocate on their behalf**;
- We provide quality service and **remove barriers** to health services;
- We are healthcare innovators and **embrace change** quickly;
- We respect each other and value ethical business practices; and
- We are careful in the management of our financial resources and serve as prudent **stewards of the public's funds**.

MOLINA HEALTHCARE

Strategic Plan Elements

- Quality
- Growth
- Financial Strength
- Customer Service
- Compliance

MOLINA HEALTHCARE

Commitment to Quality

- All Molina's eligible health plans named among the **America's Best health plans** by US News & World Report

Goal 1:

Achieve/continue accreditation with NCQA

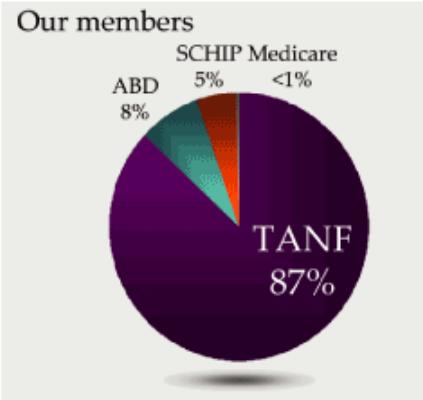
Goal 2:

Achieve HEDIS scores at 75% or above

MOLINA HEALTHCARE

Growth

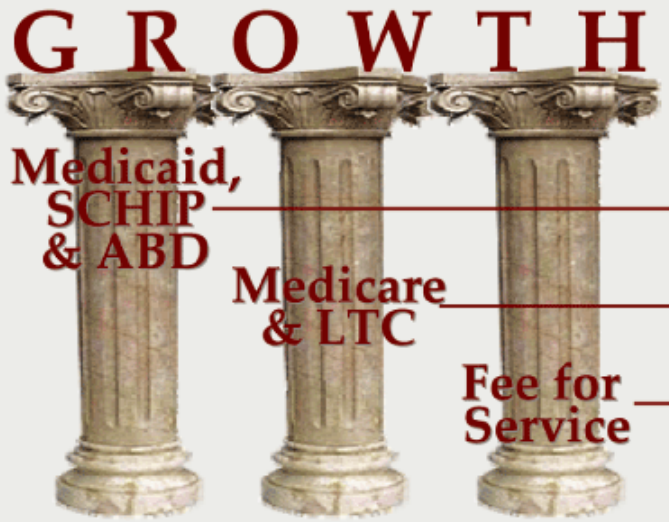
- Focus on **government** programs for poor and uninsured
- Goal: Revenues of **$4 billion** by end of 2010
- Increase **ABD** enrollment
- Increase **Medicare** enrollment
- **Acquisitions** will continue to play an important role



* Estimate Based on 2007 Guidance issued on September 11, 2007

MOLINA HEALTHCARE

Growth: Strategic Pillars



Medicaid & SCHIP contracts including ABD

Medicare for Low Income Seniors

Health related services on a fee for service basis

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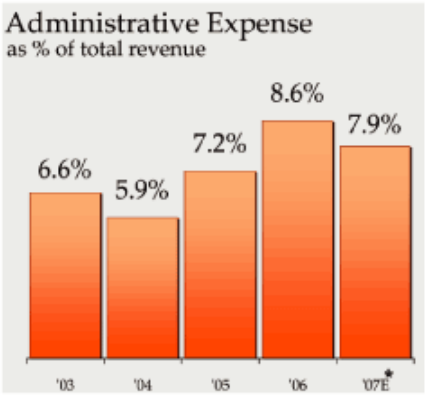
Financial Strength

- We must use the most **cost-effective** alternatives
- Limit our overhead costs
- No contract contributes more than **15% of revenue**
- Keep a **nickel** from every dollar of revenue
- We are the **stewards** of the public's money



* Estimate Based on 2007 Guidance issued on September 11, 2007

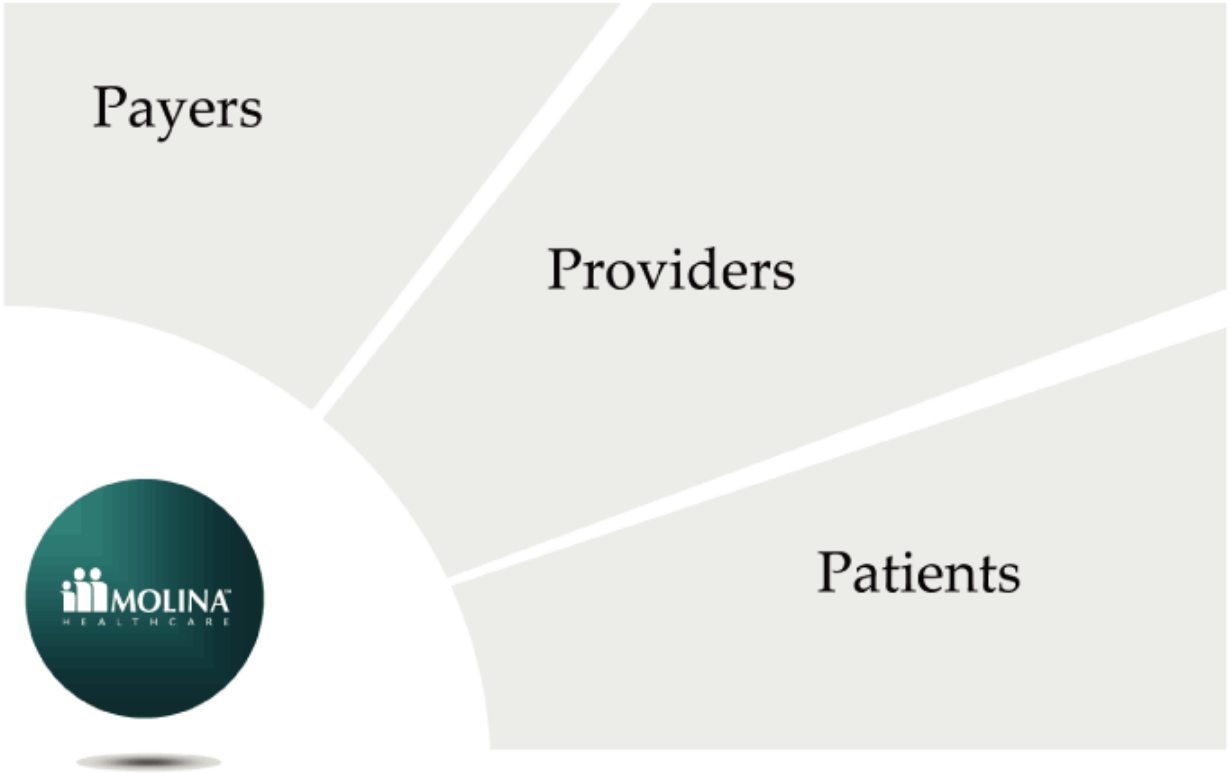
MOLINA HEALTHCARE

Our Aspirations for Our Shareholders

- Consistently communicate in an honest fashion with our investors.
- Generate a fair return for shareholders, while growing earnings per share at about 15% on average over time.
- Prudently limiting the amount of long-term debt we carry.

MOLINA HEALTHCARE

Keys to Customer Service



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Customer Service

- Payers want compliance, quality and to be shielded from complaints.
- Providers want quick and accurate payment.
- Members want us to overcome their barriers to care and to treat them with courtesy and respect.
- Our goal is to exceed industry standards.

MOLINA HEALTHCARE

Our Pledge to Our Employees

"We commit to our employees that we will endeavor to provide a work experience that is challenging, compensation and benefits that are competitive, and a management team that supports diversity and is respectful and ethical."

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Compliance

- Comply with contractual and regulatory requirements
- Put in place programs that demonstrate continued compliance
- Be an industry leader

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Strategic Path

If we accomplish the goals set forth in our strategic plan, then Molina Healthcare will have earned the continuing respect of our patients, our providers, and those with whom we conduct business.

Molina Healthcare, Inc.
September 12th, 2007
New York, NY

Mercy CarePlus
Health Insurance Made Easy

Missouri

John C. Molina
Chief Financial Officer

MOLINA HEALTHCARE

Mercy CarePlus ("MCP") Overview

- **Stand alone Medicaid-only managed care plan in MO**
- **Contracted through June 2009**
- **67,694 members as of August 2007**
  - By program: 91% TANF and 9% CHIP
  - By Region: 94% Eastern (St. Louis), 1% Central, and 5% Eastern (Kansas City)
- **Near and long-term member growth potential**
  - 46,000 additional mandatory managed care enrollment from 21 county expansion effective 1/1/08 (Estimated 9,000 – 14,000 additional members to MCP)
  - Additional membership growth from SB 577
  - Potential for additional mandatory managed care regions (only about 350,000 of state's total 825,000 Medicaid enrollment is in managed care)

MOLINA HEALTHCARE

See cautionary language above regarding the Company's guidance and other forward-looking statements under the heading Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995.

Transaction Evaluation

($ Millions, except membership, PMPM's and accretion / dilution)

	Actual Statutory TTM 6/30/2007 [1]	Forecasted GAAP FY 2008
Operating Results		
Membership @ End of Period	68,097	78,335
Premium Revenues	$166.8	$209.8
EBITDA	$18.4	$17.1
Net Income from Operations	$13.3	$10.3
Acquisition Adjustments (Net of Tax)		
Amortization of Intangibles		($3.1)
Interest Expense on Borrowings		($3.2)
Integration Expenses		($0.6)
Tax Shield on GW Amortization		$0.5
Total Acquisition Adjustments	**$0.0**	**($6.4)**
Net Income (Loss)	**$13.3**	**$3.8**
Accretion (Dilution)		**$ 0.13**
Price / EBITDA	**4.4x**	**4.7x**
EV / EBITDA	**4.0x**	**4.3x**
Operating Metrics		
Revenues PMPM	**$ 199.98**	**$ 226.42**
MCR	**82.3%**	**84.3%**

(1) The closing of the Mercy CarePlus acquisition and the successful operation of the Missouri health plan in 2008 is subject to numerous risks and uncertainties, including but not limited to: the obtaining of regulatory approvals and the satisfaction of other conditions to closing, the successful integration of the members, operations, and provider networks of Mercy CarePlus, attrition in membership pending the completion of the acquisition, and the timely and successful expansion of the MC+ Managed Care Program by the state of Missouri. The financial information presented was provided to us by Mercy CarePlus and has not been audited. Actual results in 2008 may differ materially from those projected.

MOLINA HEALTHCARE

MO Medicaid Managed Care Reform

- **SB 577 – "Missouri Health Improvement Act of 2007" – Primary Provisions**
  - Removes 7/1/08 Medicaid Managed Care sunset provision
  - Introduces "medical home" concept
  - Proposes 4 year phased-in increases to Medicaid reimbursement rates to align with Medicare fee schedule, starting 1/1/09 (in order to encourage provider participation)
    - $25M in state's FY 2008 budget to increase rates to 55% of Medicare
  - Expands current uninsured women's health plan (estimated 80,000 additional enrollees)
  - Creates a committee to develop a pay-for-performance plan
  - ABD populations prohibited from being required to enroll in a managed care plan

- **Implementation of bill left to MO Dept. of Social Services**
  - Significant latitude granted to department for provisions
  - "Health Care Home" not defined in bill

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Criteria for Acquisitions

- Size of Medicaid Population
- Competitive Provider Environment
- Favorable Regulatory Environment
- Mandatory Environment

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Q&A

MOLINA HEALTHCARE

Molina Healthcare, Inc.
September 12th, 2007
New York, NY

Product Development & Implementation

James Howatt, MD, MBA
Chief Medical Officer

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Access

- We are healthcare **innovators** and embrace change quickly.
- We provide quality service and **remove barriers to health services**.

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Overview

Can we provide better care to the chronically ill?

- Review of the opportunity to develop a new product line
- How Molina developed an effective model in the WMIP (Washington Medicaid Integration Partnership)
- Independent analysis of WMIP effectiveness by Center for Healthcare Strategies (CHCS)*

Washington

Care Coordination

Source: Evaluation of the Medicaid Value Program: Health Supports for Consumers with Chronic Conditions, August 2007; www.chcs.org

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Basic Challenges

- Can opportunity be translated to revenue growth for Molina?
- Can top-line growth be translated to bottom-line impact?

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Chronic Illness in Medicaid

- 40% of Medicaid enrollees are adults with chronic problems
- Represent 80% of Medicaid expenditures
- Largely unmanaged
- States are looking for help

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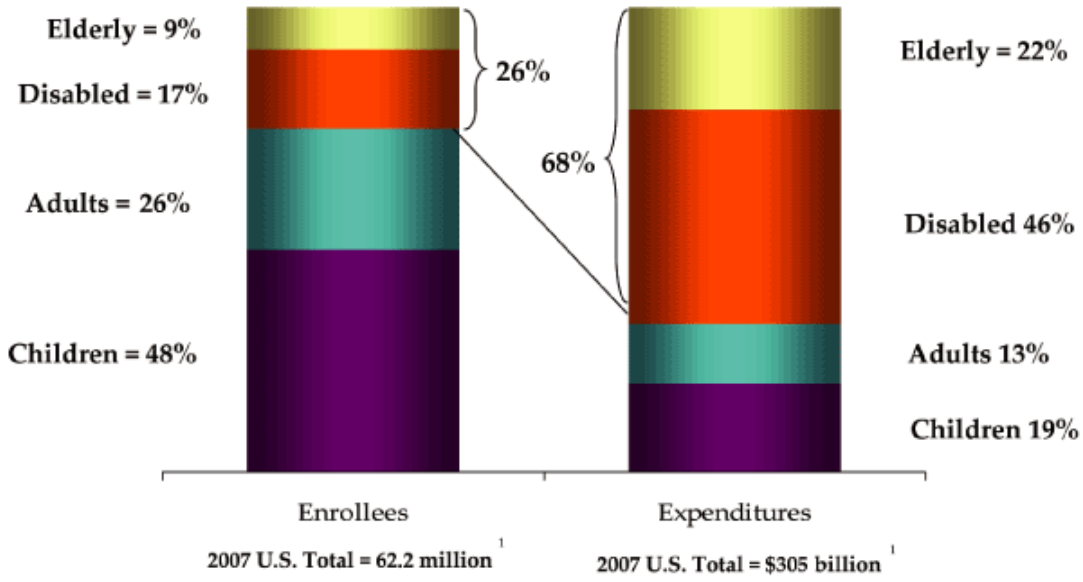
Medicaid Demographics & Expenditures

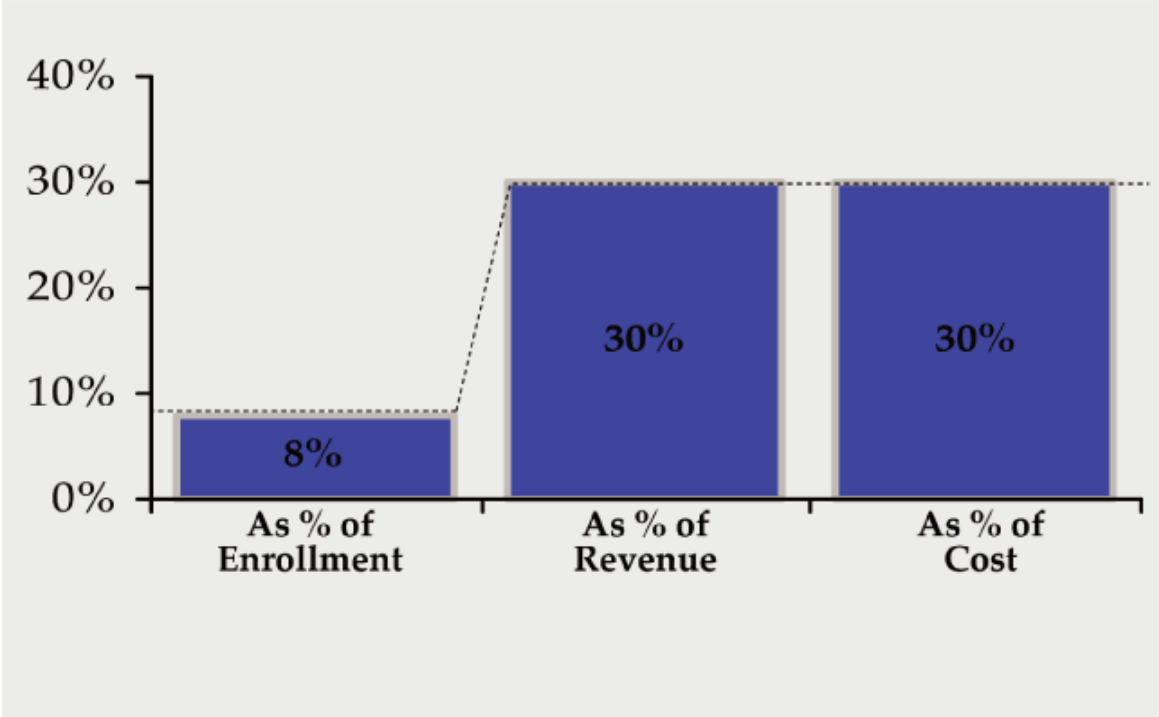


NOTE: Expenditure distribution based on spending for medical services only and excludes DSH, supplemental provider payments, vaccines for children and administration.

1. Source: Health Management Associates estimates based on CBO Medicaid Baseline, March 2007.

MOLINA HEALTHCARE

Adults with Chronic Conditions



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Molina and Washington State

- WMIP – A joint effort between State and Molina
- 5 Months underway – accepted by CHCS as one of 10 participants in Medicaid Value Program (MVP)
- CHCS (Robert Woods Johnson & Kaiser) funded organizational start-up and data collection

MOLINA HEALTHCARE

Highlights of WMIP

- Care Coordination versus Case Management
- Overcame initial resistance
- In-patient trending downward vs. comparison group
- ER use trending downward vs. comparison group
- Pharmaceutical use & out-patient care increased over baseline

MOLINA HEALTHCARE

Goals for This Population

- Improved utilization
- Increased independence
- Increased self-advocacy
- Lowest level of care
- Least restrictive care environment

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Demonstration of Competence

- CHCS hired Mathematica Policy Research (MPR) to evaluate
- Ten projects evaluated
- Molina / WA DSHS (WMIP) clearly had superior scores
- Molina has demonstrated ability to export concepts and care model

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Scoring of Projects

RATINGS OF GRANTEES' INTERVENTION DESIGNS, IMPLEMENTATION, AND IMPACT ANALYSES

	Patient-based Interventions							Provider-based Interventions		System Redesign
	CareOregon	DCMAA	Hopkins	McKesson	Memorial	UCSD	Molina Healthcare of Washington & WMIP	CNS	Partnership	MHS
Intervention										
Design	Low	Medium	Medium	Medium	Medium	High	**High**	Medium	High	N.A.
Implementation	Medium	Medium	Medium	Medium	Medium	Low	**High**	Medium	Medium	N.A.
Impacts Analysis										
Research Design	Low	Low	Low	Low	Low	Low	**High**	High	Low	Low
Impacts on Outcomes	Unknown	Unknown	Unknown	Unknown	Unknown	Unknown	**Yes**	No	Unknown	N.A.

N.A. = Not applicable

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CHCS/MPR Statements

- The approach appears relevant to other states.
- The focus on integration addresses an important area of long-standing interests and provides evidence that care could potentially be improved.
- Intervention had relatively strong evidence of effectiveness.

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CHCS/MPR Statements (Cont.)

- Medicaid Value Program generated evidence suggesting that well-conceived efforts to better integrate care across the range of services . . . have promise.

- This promise is best reflected in the WMIP.

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Conclusions

- There is significant opportunity to grow revenue through products focusing on Aged, Blind and Disabled as well as those with chronic conditions.
- Molina has demonstrated the ability to build an integrated care coordination model ideal for these populations.
- The effectiveness of the Molina model has been verified by CHCS/MPR.
- Molina has developed a competency that is reproducible and exportable.

MOLINA HEALTHCARE

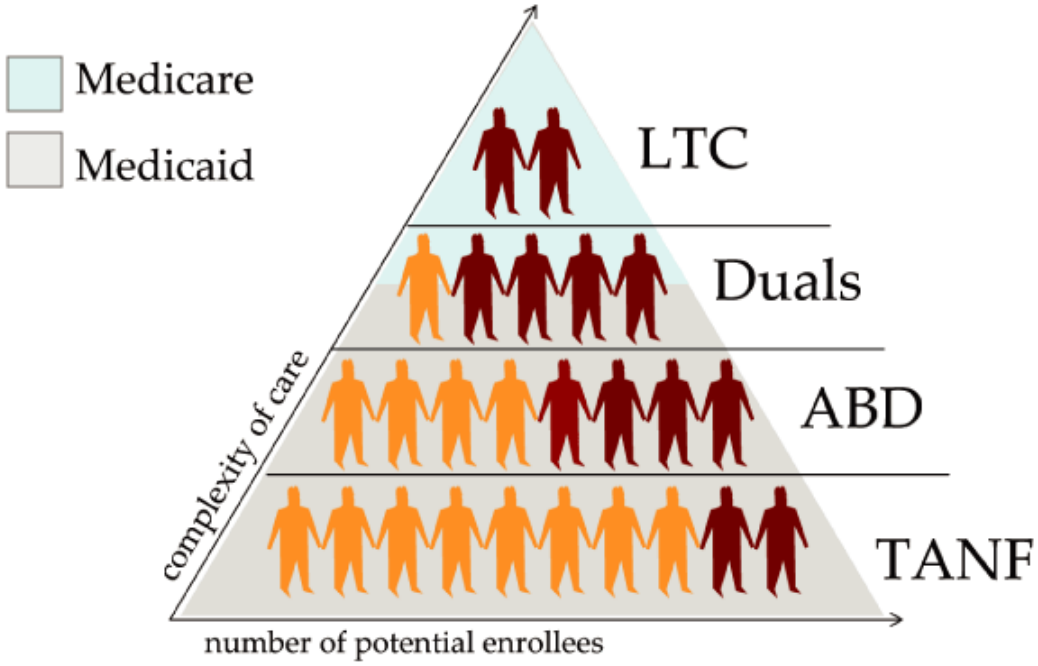
Molina Healthcare, Inc.
September 12th, 2007
New York, NY

Health Plan Operations

Terry Bayer
Chief Operating Officer

MOLINA HEALTHCARE

Segmentation



= patients in need of more complex care; for illustrative purposes only not an actual percentage

Medicare Products

MASNP

- Full Dual eligibles

MOLINA MEDICARE OPTIONS PLUS

MAPD

- Low income (annual income less than $25,000) Medicare beneficiaries

MOLINA MEDICARE OPTIONS

New 2008

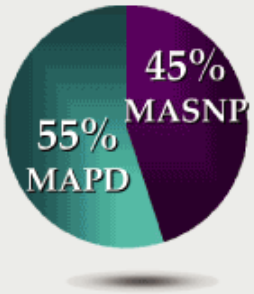
Duals		General Medicare
37%	Under 65	17%
62%	Female	55%
33%	Live Alone	28%
59%	Income Below Poverty	9%

MOLINA HEALTHCARE

2008 Medicare Markets

MOLINA MEDICARE

2.4 Million[1] eligibles in Molina service areas



1. Total market size based on company estimates.

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What We Need to Support Medicare

- Dedicated centralized support resources
- Leveraging of IT resources
- Dedicated sales force (new to MOH)
  - Training and development
  - CMS oversight and compliance
- Enhanced Marketing & Communications
- Dedicated Medicare Compliance Program

MOLINA HEALTHCARE

Contracting for Medicare

- Leverage existing hospital networks
- Build on existing physician networks
- Lead with Medicare

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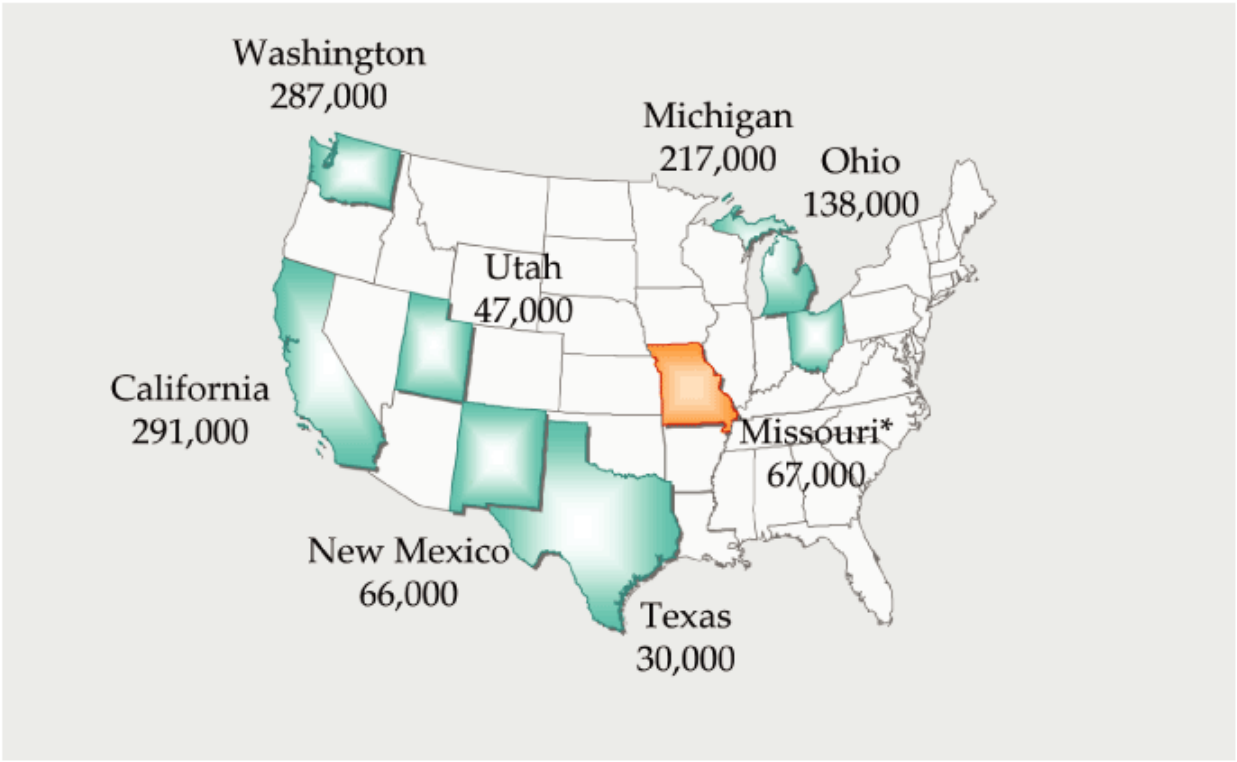
Integration of Mercy CarePlus

- Continue to operate under Mercy CarePlus for 1 year
- Retain management & employees
- Simpler health plan
  - Fewer contracts than San Diego acquisition
- Information System
  - Similar to Washington acquisition conversion
- Due Diligence
  - Better claims history

Mercy CarePlus
Health Insurance Made Easy

MOLINA HEALTHCARE

Growth Opportunities in Existing States



*Transaction pending regulatory approval

MOLINA HEALTHCARE

Coffee Break

MOLINA HEALTHCARE

Medicaid in 2007: Current Trends and Implications for Medicaid Managed Care

Vernon K. Smith, Ph.D.

for

Molina Healthcare Investor Day

New York City
September 12, 2007

vsmith@healthmanagement.com
HEALTH MANAGEMENT ASSOCIATES

Outline for Presentation

- Medicaid spending and enrollment trends
- State policy directions
  - Cost containment
  - New Coverage Initiatives
- Outlook for the future
  - Implications for Medicaid Managed Care

"Medicaid…

…has always been under-appreciated, particularly for the role that it plays in the lives of so many Americans."

– John Iglehart, Editor, *Health Affairs*

Medicaid Nationally in 2007: A State – Federal Partnership

$340 billion for over 62 million individuals, the largest health program in America …

- 30 million children
  - including 1.5 million deliveries and infants
- 16 million adults in families
- 10 million persons with disabilities
- 6 million persons age 65 or older

Medicaid accounts for 44% of federal funds to states, the largest single component

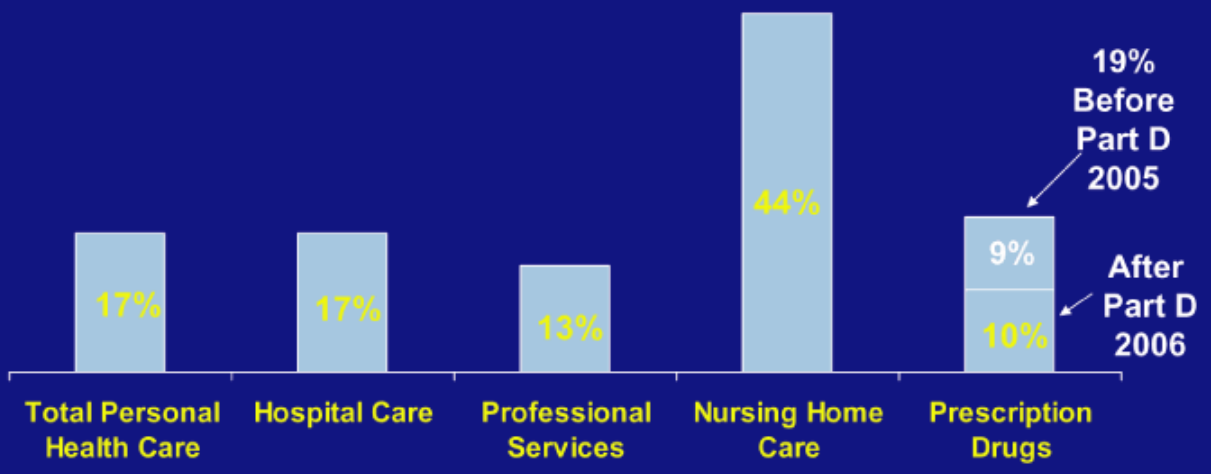
Sources: CBO March 2007 Medicaid Baseline; HMA projections of 2007 total spending. All data for federal fiscal year 2007. NASBO, *State Expenditure Report*, 2006.

9/10/2007

Medicaid is the "Financial Glue" of the U.S. Health Care Safety Net

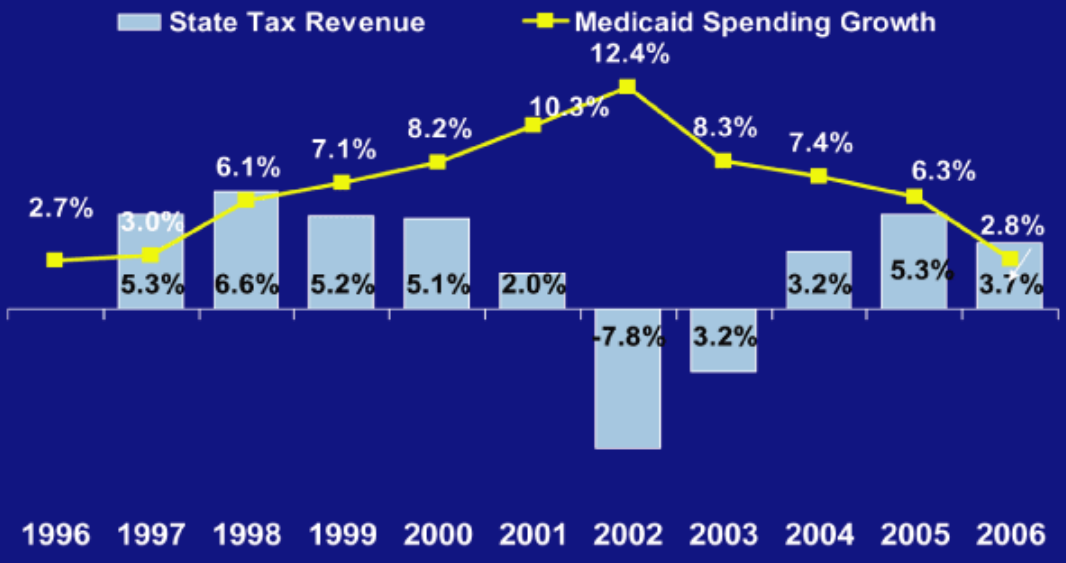
- *Mental health*
  - over half of publicly financed care
- *Public health and schools*
- *Hospitals that serve the uninsured*
  - special Medicaid "DSH" payments $16 billion in 2007
- *Community Health Centers*
  - Medicaid averages 40% of CHC revenues
- Medicare
  - 7 million low-income elderly and disabled are "dual eligibles"– i.e., on both Medicaid and Medicare
  - "Duals" account for about 40% of Medicaid spending

Medicaid is 1/6 of U.S. Health Spending (and 2.7% of GDP)



Note: Data for 2005.
SOURCE: Aaron Catlin, et.al., "National Health Spending in 2005," *Health Affairs*, January/February 2007. Based on National Health Care Expenditure Data for 2005, CMS, Office of the Actuary, 2007. Part D allocation by Health Management Associates.

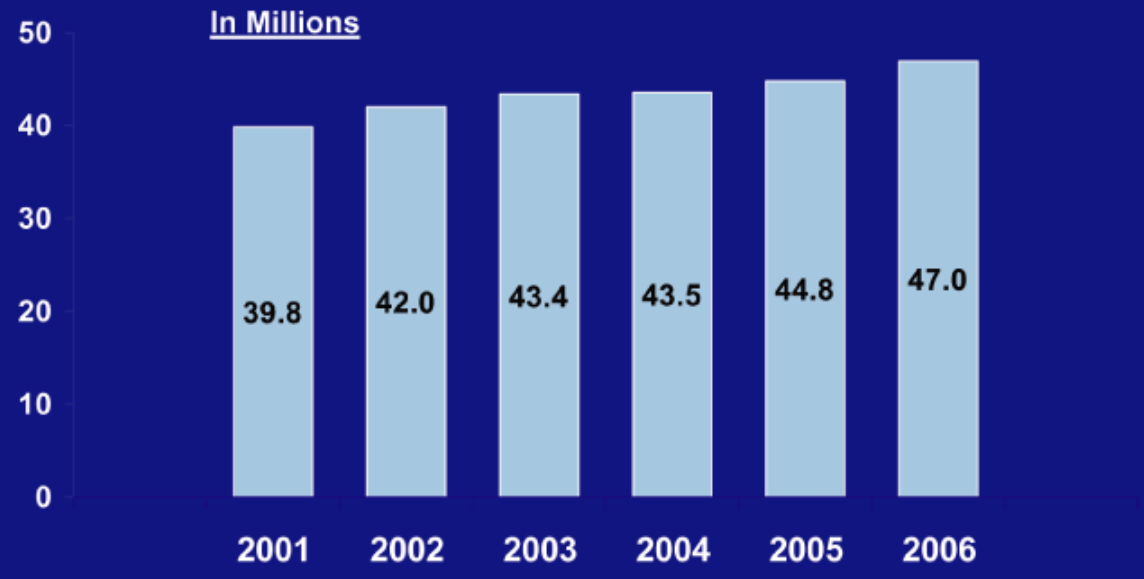
The State Medicaid Challenge: Spending Increases When Tax Revenue Drops Annual Percentage Changes 1996-2006



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimate for 2006.

SOURCE: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal 2007 Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006..kff.org/Medicaid/7569.cfm

Number of Uninsured in U.S. Continues to Increase



SOURCE: U.S. Census, August 28, 2007.

9/10/2007

Growth in the Uninsured Contributes to Growth in Medicaid

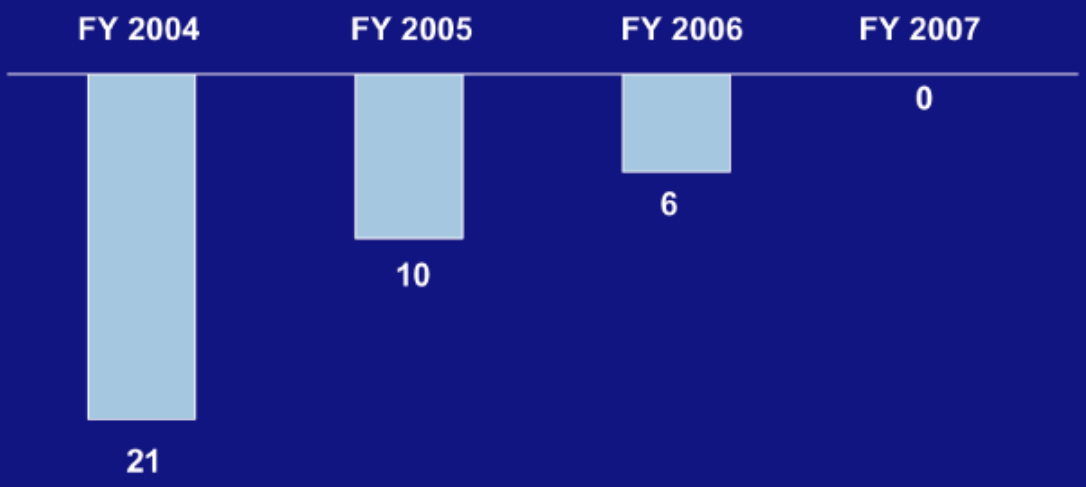
- Percent uninsured increased to 15.8% in 2006, up from 15.2% in 2005
- Number of uninsured jumped by 2.2 million in 2006 to 47 million
- Number of uninsured children increased by 600,000 in 2006 to 8.7 million, following a 400,000 increase in 2005
  - Only two years of growth in uninsured children since SCHIP
- 11.7% of all children were uninsured, including 19% of children in poverty – level families
- The share of full-time workers uninsured increased to 17.9% from 17.2% in 2005

9/10/2007

SOURCE: U.S. Census, August 28, 2007.

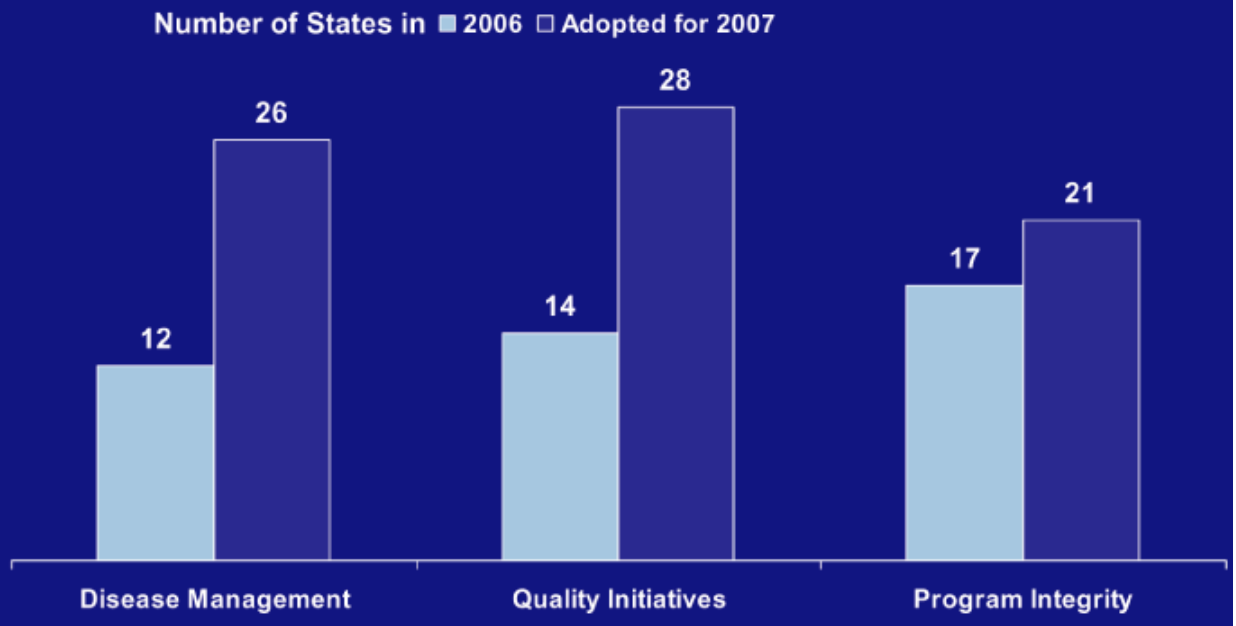
Improving State Revenues Decreased Likelihood of Medicaid Rate Cuts, 2004 - 2007

Number of States Cutting Medicaid Rates for Inpatient Hospitals, Doctors, Nursing Facilities or Managed Care Organizations



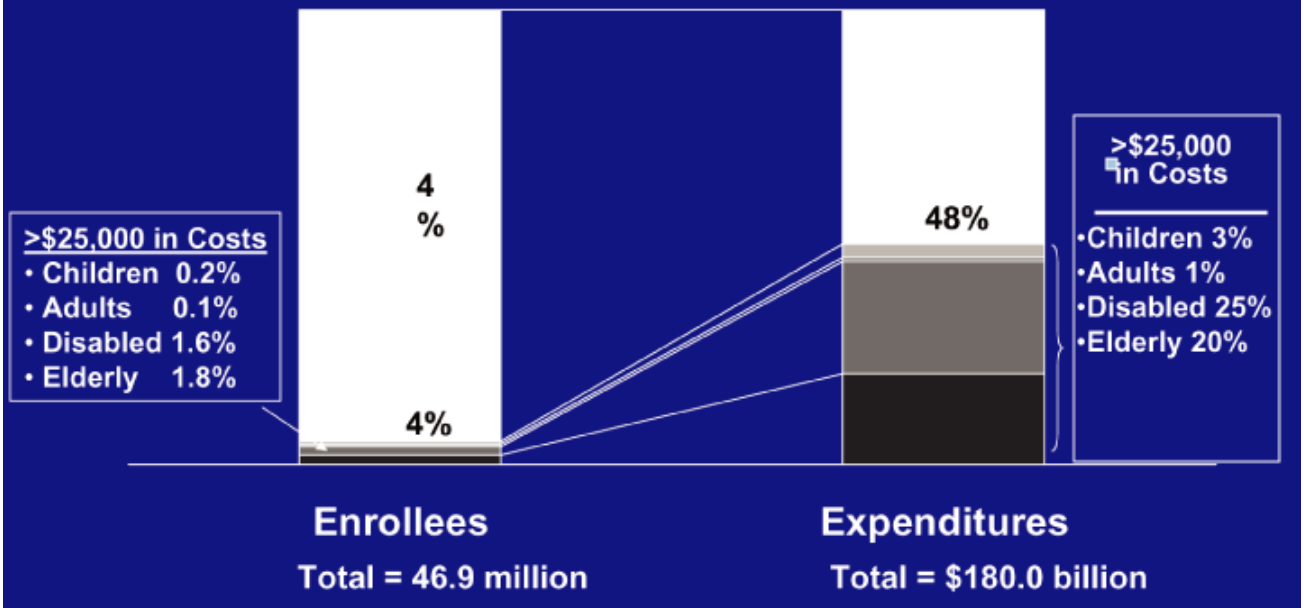
SOURCE: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006. www.kff.org/Medicaid/7569.cfm

In 2006 and 2007, States Increasingly Turned to Program and Quality Improvement



SOURCE: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006.

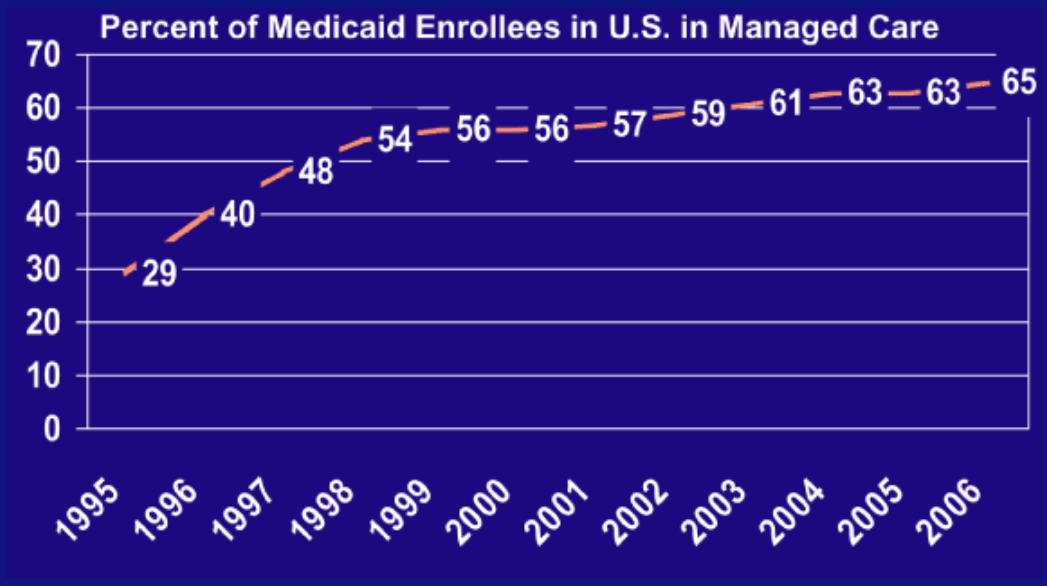
4% of Medicaid Enrollees Account for 48% of Expenditures



SOURCE: Urban Institute estimates for Kaiser Commission on Medicaid and the Uninsured based on MSIS 2001 data, 2005.

9/10/2007

Almost 2/3 of U.S. Medicaid Enrollees Are Now in Some Form of Managed Care



Source: CMS, Medicaid Managed Care Reports, 1996-2005

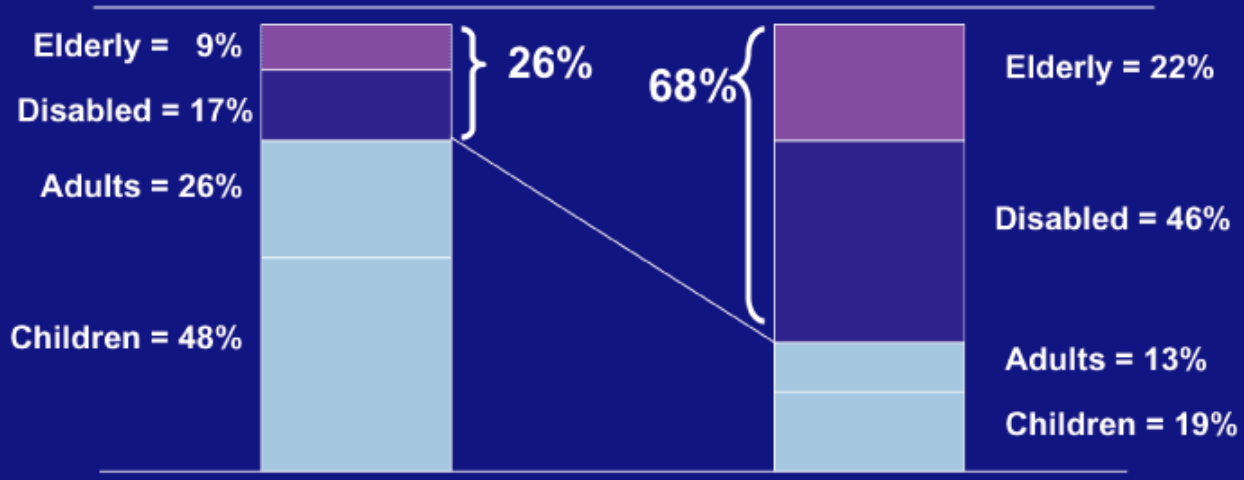
9/10/2007

FY 2007 State Policy Directions Show Commitment to Medicaid Managed Care

- Expansions to additional populations, usually the disabled and dual eligibles
- Extensions to additional geographic areas, usually rural
- Shifts to mandatory enrollment
- Enhancements to quality measurement, monitoring and improvement

SOURCE: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006. www.kff.org/Medicaid/7569.cfm

Elderly and Disabled Account for 68% of Medicaid Spending, 2007



Enrollees **Expenditures**

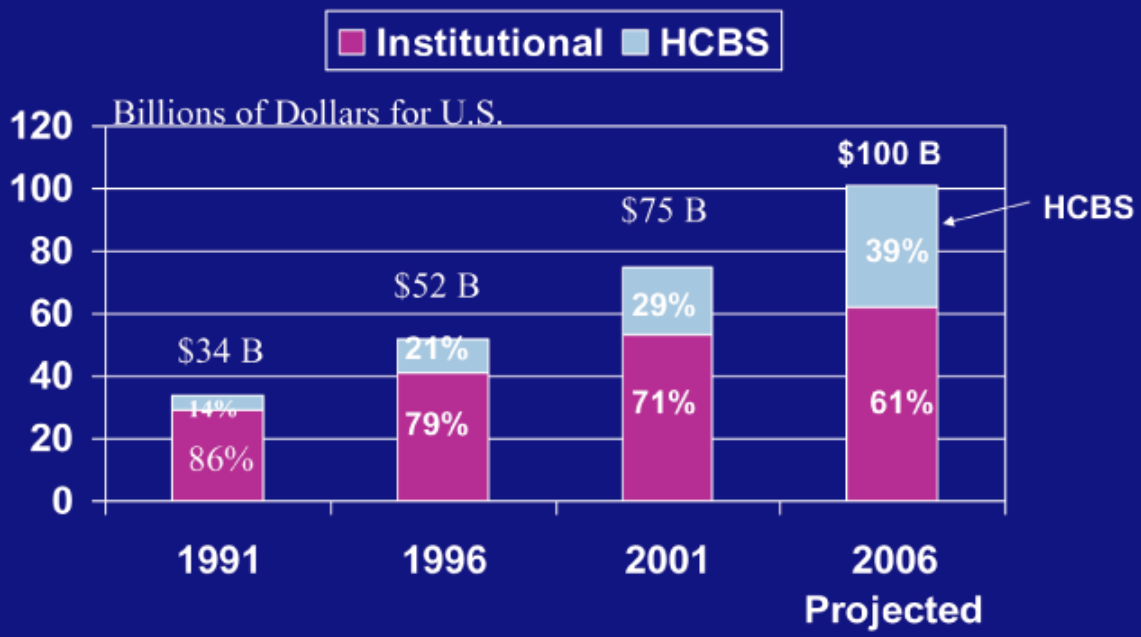
2007 U.S. Total = 62.2 million **U.S. Total = $305 billion in 2007***

*Expenditure distribution based on spending for medical services only and excludes DSH, supplemental provider payments, vaccines for children and administration.

SOURCE: Health Management Associates estimates based on CBO Medicaid Baseline, March 2007.

9/10/2007

Medicaid Long Term Care: Trend Is To Home and Community Care 1991 - 2006



Source: 1991-2001, Brian Burwell, Kate Sredl and Steve Eiken, Thomson Medstat, 2002
2006 projection by Health Management Associates, 2007.

In 2006, the Deficit Reduction Act Provided New Medicaid Options to States

New Flexibility Options
- Benefits or Cost Sharing
- New HSA-like "Health Opportunity Accounts"

New Long Term Care Options
- LTC Partnership to encourage LTCI
- Self-Directed Personal Assistance Service
- Money Follows the Person programs
- HCBS waivers could become regular Medicaid

About half of all states considering LTC options

SOURCE: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006. www.kff.org/Medicaid/7569.cfm

A Few States Have Adopted Options Created by the DRA in 2006

Benefit Flexibility:	WV, KY, FL, KS
Cost Sharing Flexibility:	KY
Targeted disease management:	VA, WA
Health Opportunity Acct:	SC
HCBS State Plan Option:	IA
Cash & Counseling, LTC Partnership :	Several

SOURCE: Vernon Smith, Kathleen Gifford, Eileen Ellis, Amy Wiles, Robin Rudowitz, Molly O'Malley and Caryn Marks, *Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007*, Kaiser Commission on Medicaid and the Uninsured, October 2006. www.kff.org/Medicaid/7569.cfm; and CMS reports, 2007.

In 2006, Two States Leveraged Medicaid to Move toward Broader, Near-Universal Health Coverage

Massachusetts Health Plan

- Universal coverage, with individual and employer mandates / assessments
- Subsidies for low-income individuals
- Health insurance "Connector"
- Strong quality component

Vermont – Catamount Health Plan

- Near-universal coverage, with Premium Assistance for low-income uninsured
- New individual product for uninsured
- Employer assessment
- Chronic care management initiative

In 2007, Over 2/3 of All States Offered New Proposals

Governors in 34 states offered plans to reduce the number of uninsured children, parents, adults, aged and disabled in their state through

- Medicaid expansions
- SCHIP expansions
- DRA waivers
- Comprehensive Section 1115 waivers
- Market-based approaches
- Improving quality through prevention and better management of chronic conditions

9/10/2007

Source: NASBO, *The Fiscal Survey of States*, June 2007.

One example: Pennsylvania

Comprehensive, 47-point health plan:
"Prescription for Pennsylvania"

Coverage for all children

"…affordable health insurance to all adults, with payments based on income."

Focus on personal responsibility and quality

No mandates.

California …The Boldest Proposal Yet

Proposed to cover 6.5 million uninsured through

- Expanded Medicaid coverage for all children
- Mandates for Employers (with 10 or more employees) and individuals
- Assessments on providers
  - 2% for doctors, 4% for hospitals

"California will be the first state, I guarantee you, where we will have universal health coverage, where we will insure everybody."

--Gov. Arnold Schwarzenegger, speaking to the California Medical Association, May 2, 2007

An Emerging Consensus: Look at Medicaid within the Overall Health System

"Medicaid is one purchaser in a larger health care market … the most effective way to control Medicaid spending growth is to pursue strategies to control overall health care spending growth."

--Richard Kronick and David Rousseau, "Is Medicaid Sustainable? Spending Projections for the Program's Second Forty Years," *Health Affairs – Web Exclusive,* February 23, 2007.

In the long run, to slow the growth in costs, slow the growth of demand for treatment

Chronic disease is the number one cause of death and disability in the U.S.

- accounts for 70 percent of all deaths and more than 75 percent of health care spending

"We should be moving into an era now… that puts much more emphasis on keeping people well and not just paying for costly complications after they happen."

--Mark McClellan, former CMS Administrator, July 17, 2007.

A Key Example: Obesity is linked to Disease Prevalence and Health Care Spending

- Total diabetes prevalence increased 53% over the past 20 years
- "All the increase in diabetes is linked to the doubling of obesity prevalence among adults."
- 27% of the increase in all health care spending is accounted for by the increase in obesity prevalence.

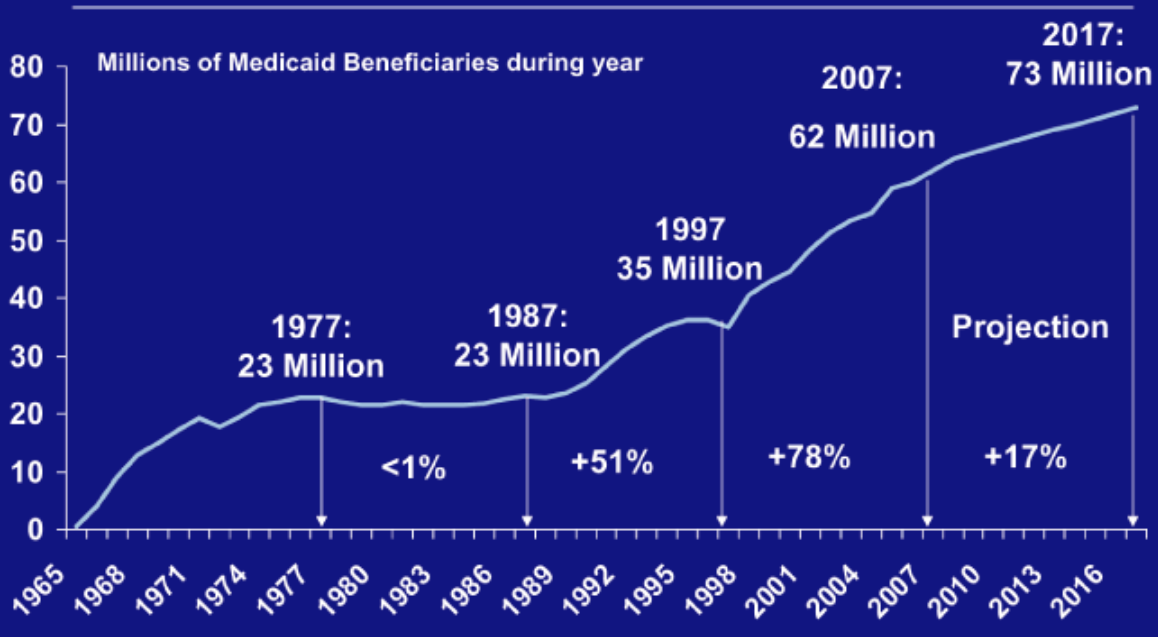
Source: Kenneth Thorpe, 2006

States Are Focusing on Improving Health Care Quality

- Studies show chronically ill Americans receive the recommended treatment on average only 56% of the time; examples
  - Congestive heart failure…64% get recommended treatment
  - Depression ……58%
  - Asthma ……54%
  - Diabetes ……45%
- States are focused on disease management and other care management approaches to improve care
- States increasingly are using reimbursement systems to reward higher performance

Source: SOURCE: Vernon Smith, et al, *Low Medicaid Spending Growth Amid Rebounding State Revenues*, Kaiser Commission on Medicaid and the Uninsured, October 2006.
Also: EA McGlynn, SM Asch, J. Adams, et al, "The Quality of Health Care Delivered to Adults in the United States." New England Journal of Medicine, June 26, 2003.

Looking to the Future: Medicaid Enrollment Growth Projected to Slow



SOURCE: Historical enrollment from Kaiser Commission on Medicaid and the Uninsured analysis of data from the Centers for Medicare and Medicaid Services. 2005-2017: HMA calculations based on CBO March 2007 Medicaid Baseline.

The Future: Medicaid Cost Increases Are Expected to Parallel Overall Health Spending

"Medicaid spending as a share of national health spending will average 16.6 percent from 2006 to 2025 – roughly unchanged from the 16.5 percent in 2005."

Even after accounting for "… the anticipated decline in employer-sponsored health insurance and the long term care needs of the baby boomers…"

--Richard Kronick and David Rousseau, "Is Medicaid Sustainable? Spending Projections for the Program's Second Forty Years," *Health Affairs – Web Exclusive,* February 23, 2007.

Medicaid Spending Projections

Average annual Medicaid spending growth:

Ten-year forecast

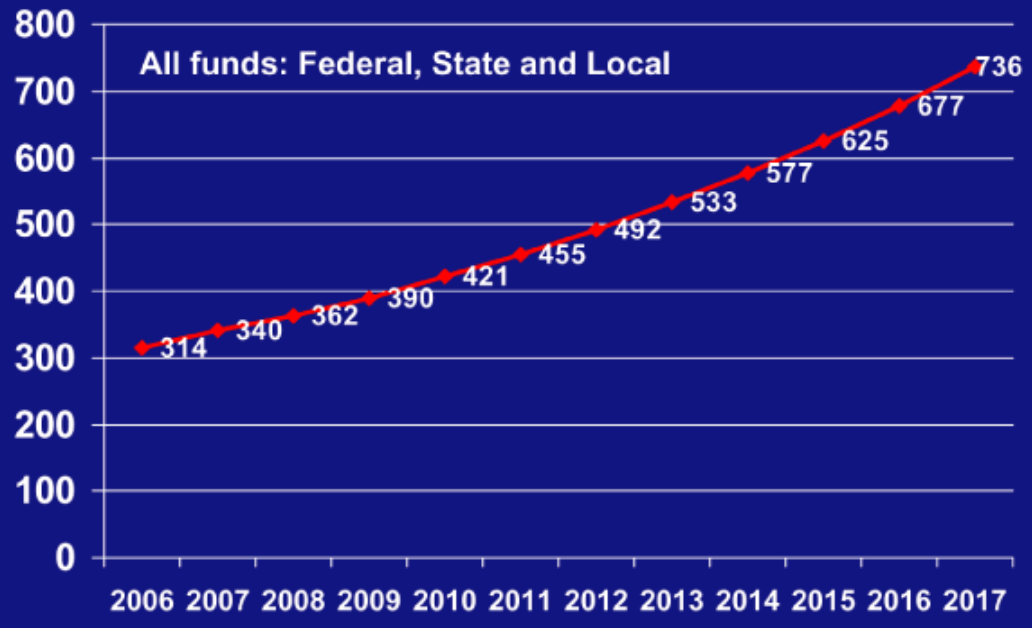
- CMS: 8%
- CBO: 8%
  - 9% for long term care

State budgets

- increase on average by 6.5%
  - Based on actual growth over the past 30 years.

Sources: Source: John Poisal, et al., "Health Spending Projections Through 2016: Modest Changes Obscure Part D's Impact," *Health Affairs*, 21 February 2007; CBO, Medicaid Baseline 2007; NASBO, Fiscal Survey of States, June 2007.

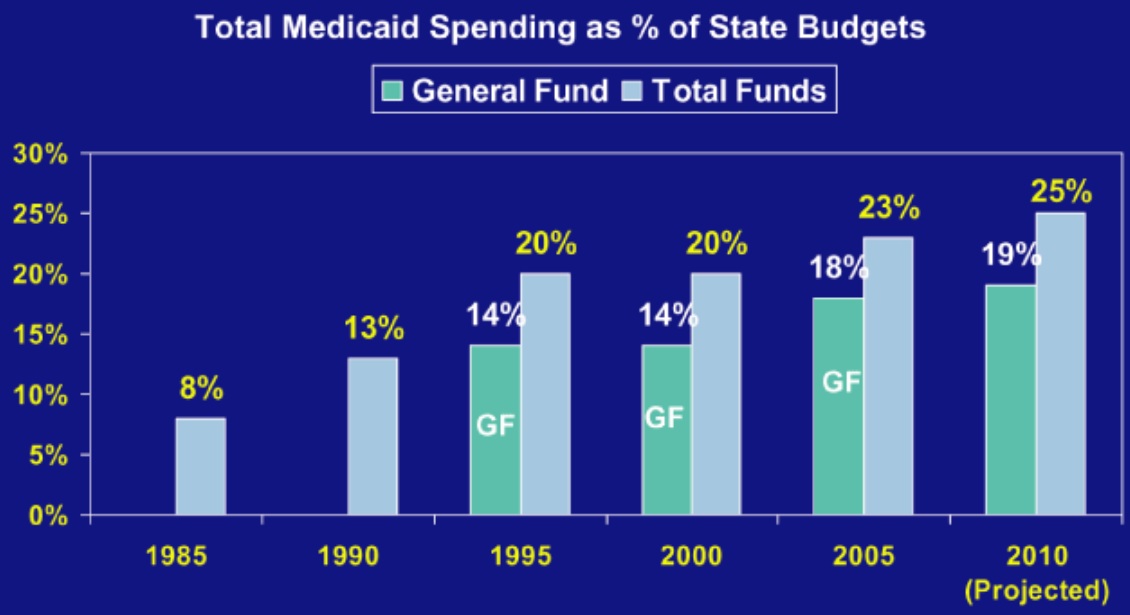
Medicaid Spending Projected to More than Double to Over $700 Billion in Ten Years: 2007 - 2017



Source: Health Management Associates estimates based on data from CBO and CMS, 2007.

9/10/2007

Medicaid Projected to Continue to Grow as a Share of State Budgets: 1985 - 2010



Source: National Association of State Budget Officers, *State Expenditure Reports*, 2005 and earlier reports; 2010 percentages projected by HMA.

Summary and Conclusion

Medicaid is the largest health program in America and one of the most significant programs administered by states.

States are now using Medicaid to

- Help finance strategies to reduce the uninsured
- Improve quality of care
- Improve the health of beneficiaries that could help slow Medicaid costs & overall health costs

Emerging opportunities in Medicaid include

- Serving persons with disabilities, and complex, chronic conditions
- Serving dual Medicare-Medicaid eligibles
- Cost-effective care for families and children

Molina Healthcare, Inc.
September 12th, 2007
New York, NY

Financial Reporting & Metrics

Joseph White
Chief Accounting Officer

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Financial Statement Disclosure

What is Important?

- **Provide investors with an understanding of our financial results**
  - Operations perspective – how is the business changing?
  - Accounting estimates – where are the uncertainties?
  - Differentiation from competitors – what makes our business (or its financial reporting) different?
  - Predictive value – what information says the most about the future?
- **Recognize the limitations of disclosure:**
  - Accounting information is always backwards looking.
  - When estimates are involved, aggregated information is usually more reliable.
  - Investors need information, not raw data.

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We strive to improve our disclosure

- More states and more populations
- Improved understanding of what investors want
- Added disclosure was at first qualitative
- This year we have added much more quantitative disclosure.
- The added disclosure (and the reaction to it) has led us to look more closely at the presentation of our core financial statements.

We decided to change the presentation of our income statement disclosure

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Medical Cost Disclosure

Molina's Medical Cost Disclosure

We currently report three categories of medical expense

Medical Services	Capitation, clinic, quality assurance, reinsurance and some injectible expenses.
Hospital & Specialty Services	All expenses paid through our claims system, including any PCP and drug costs paid as claims.
Pharmacy	All pharmacy costs paid through our pharmacy benefit manager.

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Molina's Medical Cost Disclosure

Our business has evolved and now much more complex

We need to be clear about overlap between categories:

- Capitation costs cover primary care, specialty and hospital services.
- Hospital and specialty services include the costs of drugs administered in hospital and physician settings.

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Molina's Medical Cost Disclosure

Critical attributes of medical expense:

- **Reliability of Estimate –**
  - How much judgment is needed to estimate this cost?
- **Timeliness of Information –**
  - How current is the information?
- **Financial Significance –**
  - How significant is the cost to our financial performance?
- **Cost Stability –**
  - How volatile is this cost over the near term?
- **Predictive Value -**
  - What does this cost tell us about the future?

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Four Proposed Categories of Medical Cost

Pharmacy

- Current and very reliable information;
- Indicator of trends; and
- Includes injectibles (specialty drugs) and immunizations.

Capitation

- Current and reliable information;
- Minimal retroactive changes; and
- Transferred risk to another entity.

Fee for Service

- Information is dependent upon actuarial estimates;
- Largest and most volatile; and
- Frequent retroactive adjustments.

Other Medical Costs

- Clinic, quality assurance, and reinsurance cost;
- Administrative component of medical expense; and
- Current and reliable.

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Attributes of Medical Cost Categories

What Do These Categories Tell an Investor?

	Reliability of Estimate	Timeliness of Information	Financial Significance	Cost Stability	Predictive Value
Pharmacy	High	High	Moderate	Moderate	High
Capitation	High	High	Moderate	High	Moderate
Fee For Service Cost	Low	Low	High	Low	Low
QA / Clinic / Reinsurance Cost	High	High	Low	High	Low

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Why Four Categories?

- The break out of fee-for-service costs allows investors to focus on the relative uncertainty of our cost estimates.
- The break out of pharmacy costs provides investors with a measure widely believed to track medical cost trends overall and to provide an indication of the direction of those trends.
- The breakout of capitation costs allows investors to understand the degree to which we have transferred risk to other parties.
- The breakout of other medical costs allows the other categories to remain "pure", isolating clinic costs, which are unique to Molina, and quality assurance costs, which are reported differently among health plans.

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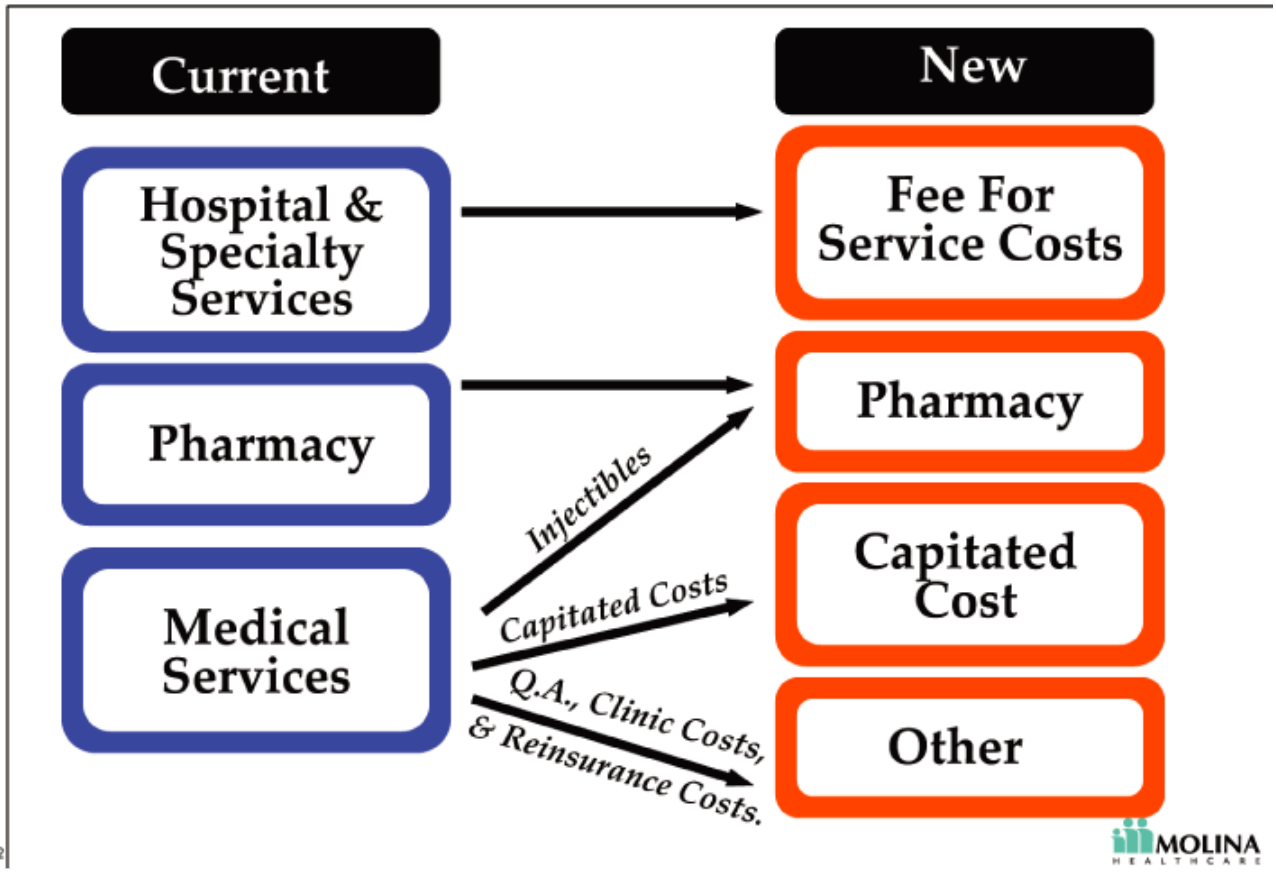
Expense Category Crosswalk



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Two Options

Option #1 – Too cluttered:

Replace the existing sub-categories for medical care costs with:

- Fee for Service Costs
- Capitation
- Pharmacy
- Other

Option #2 – Streamlined but expanded disclosure:

Replace the existing sub-categories for medical care costs with:

- A single line item
- Include four categories of medical cost in supplemental schedules

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Revised Disclosure (Supplemental Schedule)

Income Statement Recast (Unaudited) YTD June 30, 2007

Original:		Recast:	
Medical Services	$228,208	Fee for Service Costs	$645,437
Hospital & Specialty Services	$644,729	Capitation	$180,864
Pharmacy	$120,405	Pharmacy	$125,606
		Other	$41,435
Total Medical Care Costs	**$993,342**	**Total Medical Care Costs**	**$993,342**

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New Medical Cost Disclosure & Effective Date

- Replace the existing sub-categories for medical care costs with a single line item and include four categories of medical cost in supplemental schedules.
- Effective date for the change: 3rd Quarter '07 Form 10-Q
- All periods presented in future SEC filings will be recast in the new format.

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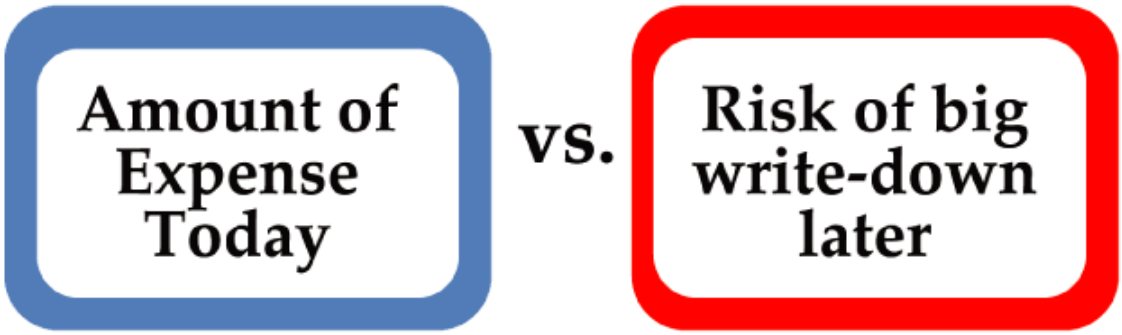
Purchase Accounting
and
Amortization Expense

Purchase Accounting Affects Income

- **Purchase accounting requires judgment**
  - Allocation of purchase price to assets
  - Amortization period
- **Purchase accounting can make a big difference on the income statement**
  - Percentage of purchase price assigned to amortized assets
  - Period over which those assets are amortized

Purchase accounting is about balance



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Publicly Traded Pure Play Medicaid Acquisitions '03-'06

	Total Health Plan Acquisitions (1)	% of Goodwill	% of Identifiable Intangibles
MOH	**$152.4M**	**31%**	**69%**
CNC	$140.4M	92%	8%
AGP	$252.1M	90%	10%
WCG	$230.3M	83%	17%
Average excl.Molina	**$207.6M**	**88%**	**12%**

SOURCE: SEC Filings.
Note: (1)Total health plans acquisitions: purchase price and additional considerations paid in accordance with merger / acquisition agreements for acquisitions excluding specialty businesses between 2003 and 2006.

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Amortization Expense per Share

	2003	2004	2005	2006
MOH	**$0.08**	**$0.09**	**$0.17**	**$0.21**
CNC	$0.02	$0.02	$0.03	$0.05
AGP	$0.08	$0.04	$0.09	$0.05
WCG	$0.09	$0.09	$0.07	$0.11
Pure Play Average excl. MOH	**$0.06**	**$0.05**	**$0.07**	**$0.07**
Pure Play Average	**$0.06**	**$0.06**	**$0.09**	**$0.10**

SOURCE: SEC Filings.
Note: Amortization expense per share: tax effected amortization expense divided by diluted shares outstanding

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Q&A

MOLINA HEALTHCARE

Molina Healthcare, Inc.
September 12th, 2007
New York, NY

Financial Outlook

John Molina
Chief Financial Officer

MOLINA HEALTHCARE

Cautionary Statement

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This presentation contains numerous "forward-looking statements" regarding the Company's 2007 earnings guidance. Any statements that refer to guidance, projections, expectations, strategies, challenges, and opportunities, or their underlying assumptions, or other characterizations of future events or circumstances, are forward-looking statements. All of our forward-looking statements are based on current expectations and assumptions that are subject to numerous known and unknown risks, uncertainties, and other factors that could cause our actual results to differ materially. Such factors include, without limitation, risks related to: the achievement of a decrease in the medical care ratio of our start-up health plans in Ohio and Texas; the achievement of projected savings from a decrease in the medical care ratio of our California and Washington health plans; an increase in enrollment in our Ohio and California health plans and in our dual eligible population consistent with our expectations; our ability to reduce administrative costs in the event enrollment or revenue is lower than expected for the remainder of the year; increased administrative costs in support of the Company's efforts to expand its Medicare membership; risks related to our minimal experience with Ohio, Texas, and dual eligible members and attendant claims estimation difficulties; our ability to accurately estimate incurred but not reported medical costs across all health plans; the securing of premium rate increases in the states of California and Michigan; the adverse effect of the DRG rate rebasing in Washington being greater than expected; the payment of savings sharing income by the state of Utah to our Utah health plan being consistent with our expectations; the successful renewal and continuation of the government contracts of all of our health plans; the availability of adequate financing to fund and/or capitalize our acquisitions and start-up activities, and applicable interest rates that are consistent with our expectations; the successful and cost-effective integration of our acquisitions, including Mercy CarePlus; membership eligibility processes and methodologies; unexpected changes in member utilization patterns, healthcare practices, or healthcare technologies; high dollar claims related to catastrophic illness; changes in federal or state laws or regulations or in their interpretation; funding decreases in the Medicaid, SCHIP, or Medicare programs or the failure to timely renew the SCHIP program; the favorable resolution of pending litigation; and other risks and uncertainties as detailed in our reports and filings with the Securities and Exchange Commission and available on its website at www.sec.gov. All forward-looking statements in this release represent our judgment as of September 12, 2007. We disclaim any obligation to update any forward-looking statement to conform the statement to actual results or changes in our expectations.

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See cautionary language above regarding the Company's guidance and other forward-looking statements under the heading Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995.

2007 Earnings Guidance (September 11, 2007)

Premium Revenue	≈ $2.4B
Medical Care Ratio	≈ 84.9%
G&A Ratio	≈ 11.2%
Core G&A	≈ 7.9%
Net Income	≈ $52.9M - $55.8M
Diluted EPS	≈ $1.85 - $1.95
Diluted Shares Outstanding	≈ 28.6M
Effective Tax Rate	≈ 38.2%

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See cautionary language above regarding the Company's guidance and other forward-looking statements under the heading Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995.

2007 Revised Guidance versus 2006 Results

	2007 (estimated)	2006	Increase/ (Decrease)
Premium Revenue	$2.4B	$2.0B	$0.4B
Medical Care Ratio	84.9%	84.6%	0.3%
G&A Ratio	11.2%	11.4%	(0.2%)
Core G&A	7.9%	8.4%	(0.5%)
Net Income	$52.9M– $55.8M	$45.7M	$8.7M *
Diluted EPS	$1.85 - $1.95	$1.62	$0.28 *
Diluted Shares Outstanding	28.6M	28.2M	0.4M
Effective Tax Rate	38.2%	37.8%	0.4%

* Represents mid-point of guidance.

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2007 Earnings Guidance Revised versus Original

	2007 (estimated) Revised	2007 (estimated) Original	Increase/ (Decrease)
Premium Revenue	$2.4B	$2.6B	($0.2B)
Medical Care Ratio	84.9%	86.2%	(1.3%)
G&A Ratio	11.2%	10.3%	0.9%
Core G&A	7.9%	7.0%	0.9%
Net Income	$52.9M- $55.8M	$50.5M- $54.9M	$1.7M*
Diluted EPS	$1.85 - $1.95	$1.75 - $1.90	$0.08*
Diluted Shares Outstanding	28.6M	28.9M	(0.3M)
Effective Tax Rate	38.2%	38.4%	(0.2%)

* Represents mid-point of guidance.

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See cautionary language above regarding the Company's guidance and other forward-looking statements under the heading Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995.

How has 2007 Guidance changed?

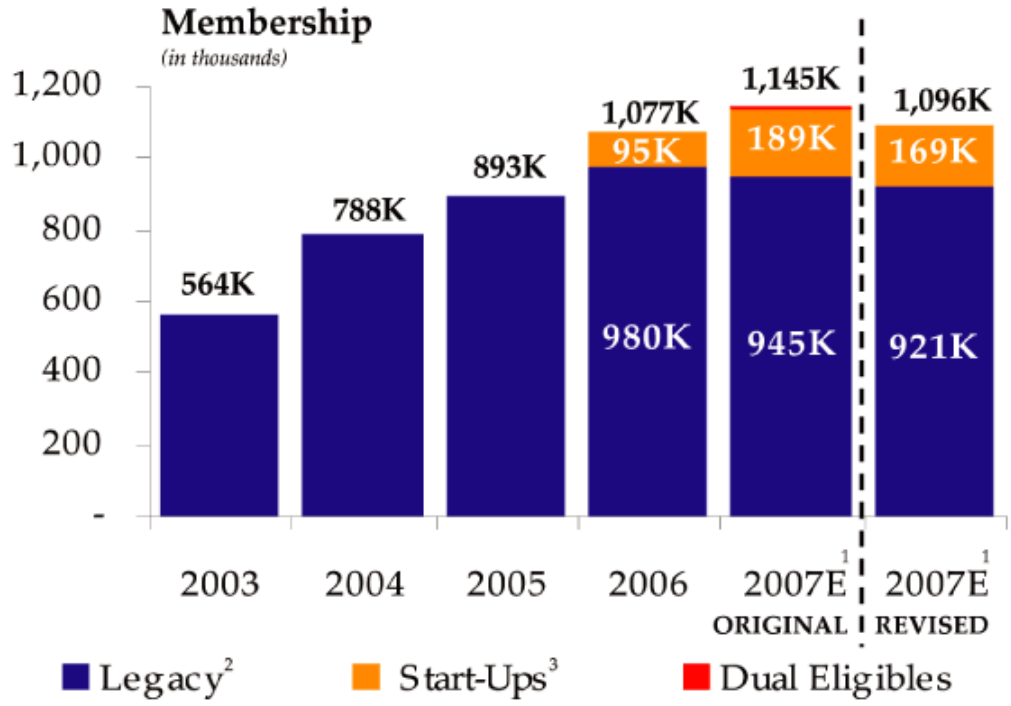
	Revised Guidance	Original Guidance	Drivers
Premium Revenue	$2.4B	$2.6B	▪Lower Membership in Ohio ▪Lower Medicare Membership ▪Lower Membership in WA & UT
Medical Care Ratio	84.9%	86.2%	▪California Improvement ▪Lower Medical Cost in Washington ▪New Mexico Contract Amendment
Core SG&A	7.9%	7.0%	▪Lower Revenue ▪Medicare Investment ▪Continued Infrastructure Investment
Investment Income	$27.2M	$25.0M	▪ Higher Invested Balances
Interest Expense	$3.8M	$7.0M	▪ Delayed and lower borrowings to fund capital infusions into subs ▪ Amended credit facility
D & A	$26.7M	$23.2M	▪ Increased IT Investment
Tax Rate	38.2%	38.4%	
Diluted Shares Outstanding	28.6M	28.9M	

MOLINA HEALTHCARE

See cautionary language above regarding the Company's guidance and other forward-looking statements under the heading Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995.

How will we grow in 2007?

Membership growth will come primarily from Ohio and Texas.



(1) "E" represents estimated. (2) Legacy health plans include California, Indiana, Michigan, New Mexico, Utah and Washington. Indiana operations terminated 12/31/2006. (3)"Start-Up" health plans include Ohio and Texas.

MOLINA HEALTHCARE

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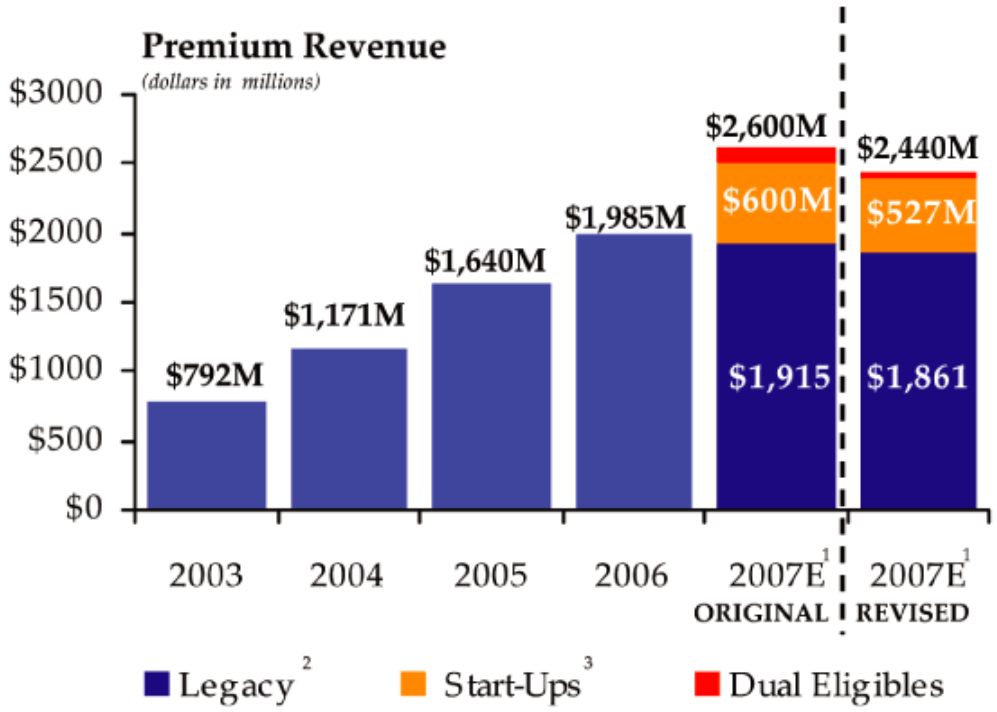
How will we grow in 2007?

Premium revenue growth will come from Ohio and Texas.



(1) "E" represents estimated . (2) Legacy health plans include California, Indiana, Michigan, New Mexico, Utah and Washington. Indiana operations terminated 12/31/2006. (3)"Start-Up" health plans include Ohio and Texas.

MOLINA HEALTHCARE

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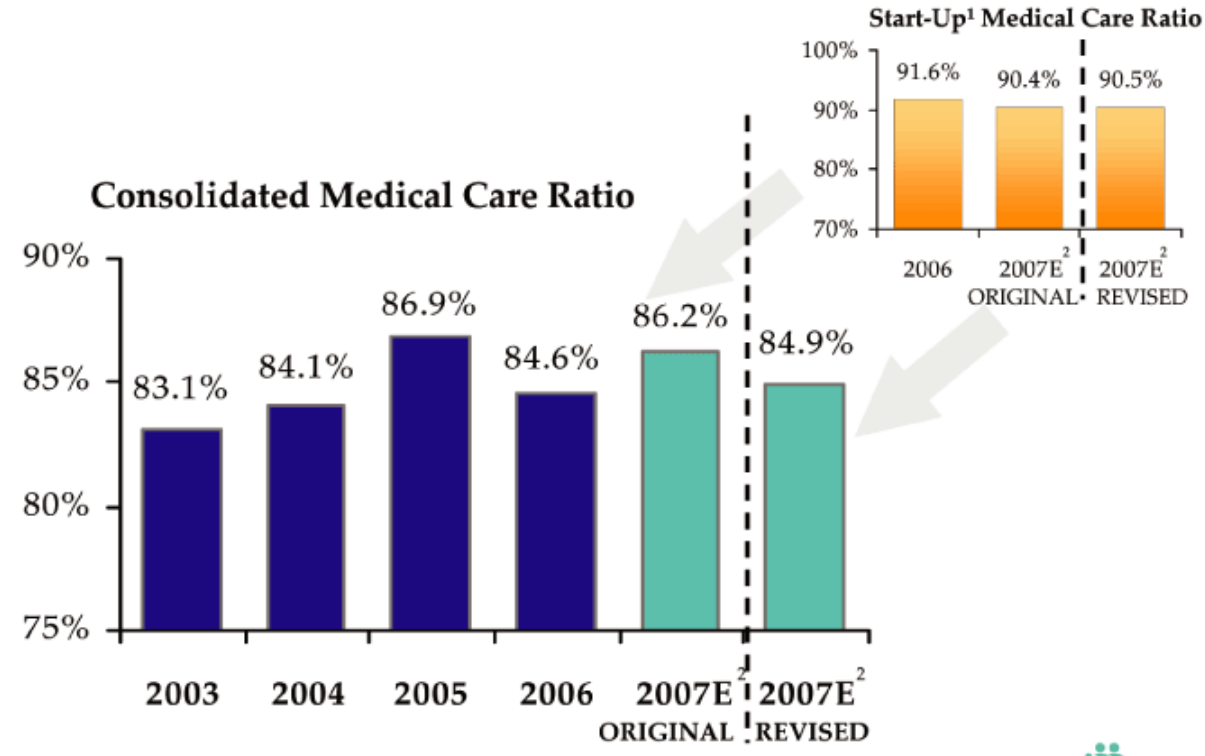
Medical Care Ratio

Our guidance assumes a decrease in our Start-Ups' medical care ratios.



(1) "Start-Up" includes operations in Ohio and Texas. (2)"E" represents estimated.

MOLINA HEALTHCARE

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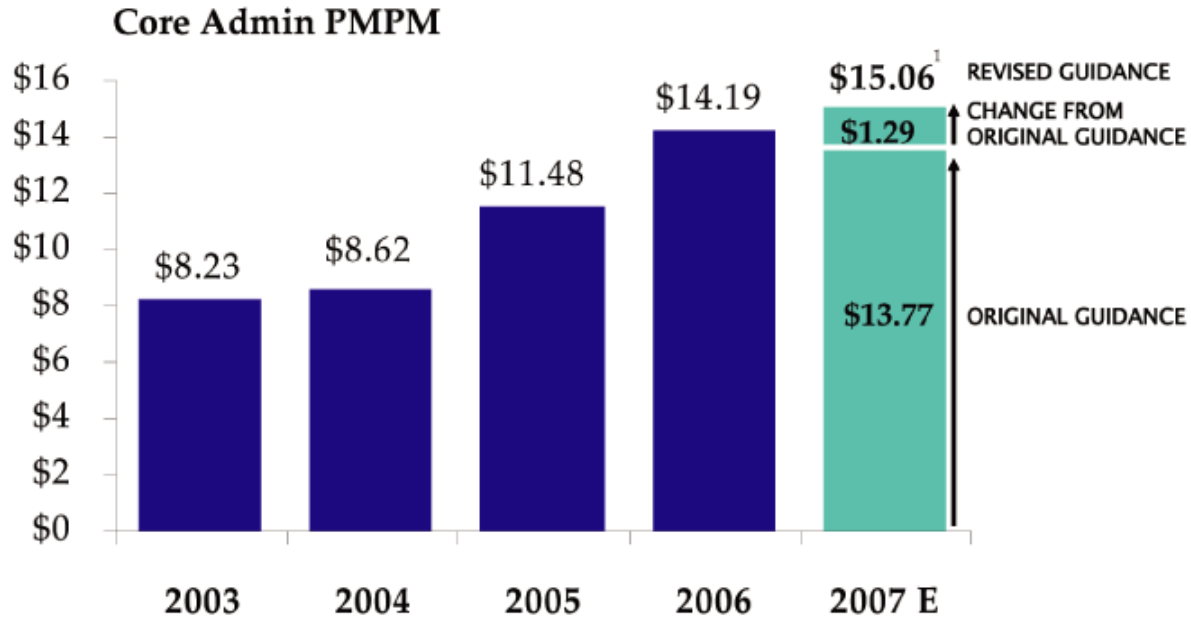
Continued Investment in our Infrastructure

Investing in growth and strengthening our existing operational efficiency



Core Admin is administrative expenses excluding premium taxes. "E" represents estimated.

1. Excludes impairment charge related to commercial software no longer used for operations.

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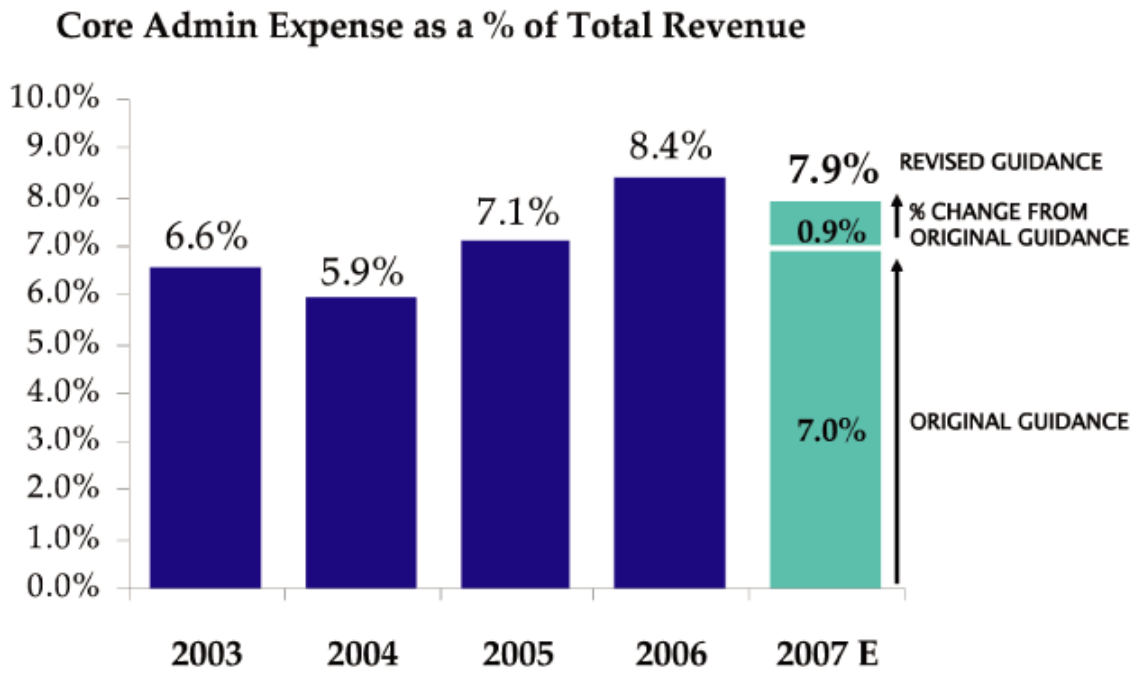
Continued Investment in our Infrastructure

Investing in growth and strengthening our existing operational efficiency

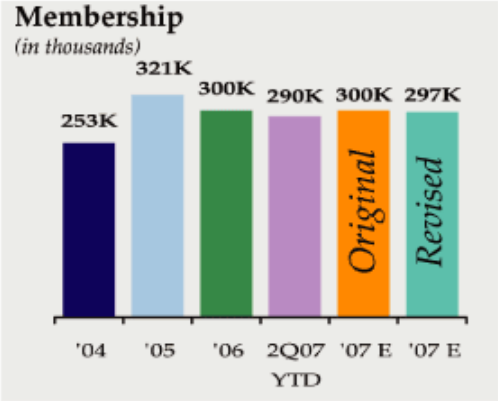


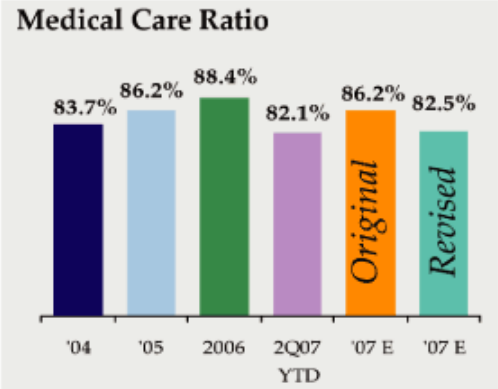
Core Admin is administrative expenses excluding premium taxes. "E" represents estimated.

Selected Health Plan Outlook

See cautionary language above regarding the Company's guidance and other forward-looking statements under the heading Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995.

California excluding Dual Eligibles





Opportunities:

- Revised guidance does not include any rate increase for Los Angeles or Inland Empire.
- Utilization is well managed.
- Excess clinic capacity can reduce capitation expense.

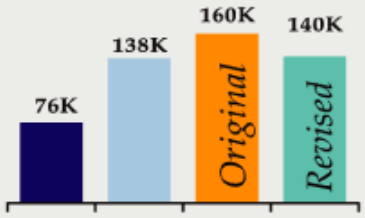
Challenges:

- Revised guidance assumes an increase in enrollment of 7K over 6/30/07 enrollment.
- Improved financial results may trigger provider pressure for higher contract rates.
- Formulary is being made more competitive.

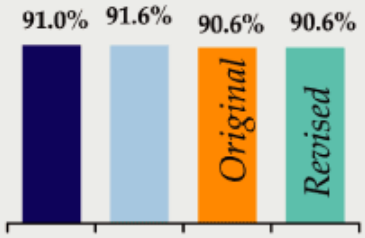
MOLINA HEALTHCARE

Ohio

Membership
(in thousands)



Medical Care Ratio



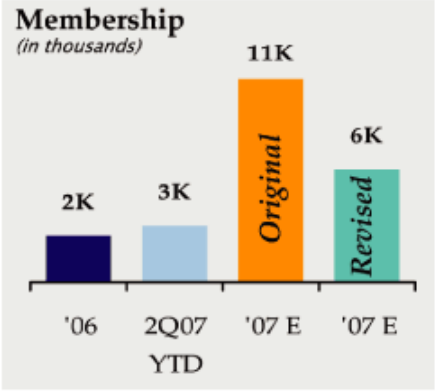
Opportunities:

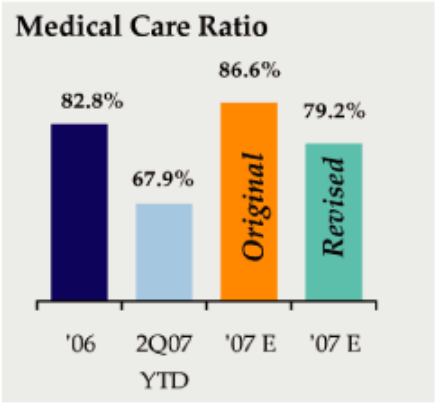
- Large TANF and ABD populations.
- Enrollment concentrated among competitors despite state wish to limit enrollment for any single health plan to 40%.

Challenges:

- Healthcare costs through 6/30/07 are consistent with original guidance but more improvement is needed in the second half of 2007.
- Paid claims data is not fully developed, making cost estimates uncertain.

Dual Eligibles





Opportunities:

- High per member per month revenue.
- Large populations in CA and MI.
- Providers have extensive managed care experience.
- Medical costs in UT have been better than expected.

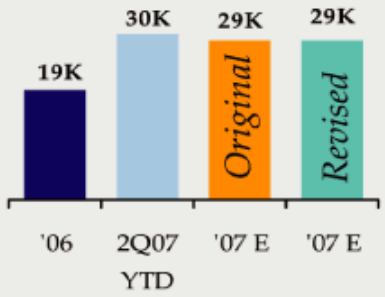
Challenges:

- Enrollment has been lower than anticipated.
- High member acquisition cost.
- Limited Company experience with product.
- Limited cost data to set rate bids and claims reserves.
- Continues to require large infrastructure investment.

MOLINA HEALTHCARE

Texas

Membership
(in thousands)



Medical Care Ratio

Opportunities:

- LTC benefit for STAR Plus.
- TX PMPM revenue is higher than Company average.

Challenges:

- Healthcare costs through 6/30/07 are higher than anticipated in original guidance.
- Paid claims data is not fully developed, making cost estimates uncertain.

MOLINA HEALTHCARE

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Risks and Opportunities

Risks/Opportunities	Update
Start-Up Medical Costs	▪ Consistent with original Guidance ▪ But paid claims data remains incomplete
Start-Up Enrollment	▪ Ohio membership less than anticipated ▪ Texas consistent with original guidance
California Medical Costs	▪ Utilization under control ▪ Re-contracting has been successful ▪ Improved profitability may create provider pressure for increases
SNP Growth	▪ Slower than anticipated ▪ Company continues to invest in Medicare for 2008
Start-Up Capital Requirements	▪ Slightly less than anticipated due to Ohio lower growth

MOLINA HEALTHCARE

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Risks and Opportunities

Risks/Opportunities	Update
New Mexico Contract Amendment	▪ New contract gives some relief on medical cost floor and measurement period
Washington DRG Rebasing	▪ Substantial negative impact on medical care costs
Admin Leverage	▪ Lower than anticipated revenue has reduced leverage ▪ Company continues to invest in Medicare and other infrastructure
Utah Savings Sharing	▪ $4.7M receivable accrued as of June 30, 2007 ▪ In discussions with the state
Reducing Interest Costs	▪ Amended credit facility

MOLINA HEALTHCARE

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EPS Build Out: Illustration Based on Guidance Mid-Point

(All figures and estimates are approximate)	ORIGINAL GUIDANCE	REVISED GUIDANCE
Earnings per diluted share for year ended Dec 31, 2006	**$1.62**	**$1.62**
Exclude 2006 positive prior period development	($0.11)	($0.11)
Starting Point	$1.51	$1.51
Expected Incremental changes in 2007:		
▪ Ohio Impact	$0.21	$0.05
▪ California Impact	$0.18	$0.46
▪ Texas Impact	$0.12	$0.10
▪ Additional Corporate Interest Expense, Net of Investment Income	($0.09)	($0.04)
▪ Net Changes in Other Plans (excl. WA & NM items below)	($0.11)	($0.09)
▪ Washington DRG re-basing	n/a	($0.14)
▪ New Mexico One Time Reserve Adjustment	n/a	$0.05
2007 Guidance Mid-Point Diluted EPS	**$1.82**	**$1.90** *

* Represents mid-point of guidance.

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Q&A

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