MOLINA HEALTHCARE

Your Extended Family.

Investor Day 2012A

January 26, 2012
New York, New York

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Agenda

Time	Topic	Speaker
12:30pm-12:35pm	Opening Remarks	Juan José Orellana, VP Investor Relations
12:35pm-1:10pm	Business Overview	J. Mario Molina, MD, Chief Executive Officer
1:10pm-1:30pm	Q&A	
1:30pm-1:40pm	Break	
1:40pm-2:15pm	Operations Update	Terry Bayer, Chief Operating Officer
2:15pm-2:40pm	Capital Adequacy	Joseph White, Chief Accounting Officer
2:40pm-3:00pm	Q&A	
3:00pm-3:15pm	Break	
3:15pm-3:50pm	Outlook 2012	John Molina, Chief Financial Officer
3:50pm-4:30pm	Q&A	
4:30pm	End of Program	

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Cautionary Statement

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation and our accompanying oral remarks contain "forward-looking statements" regarding the Company's expected results for fiscal year 2012. All of our forward-looking statements are based on our current expectations and assumptions. Actual results could differ materially due to the unexpected failure of our assumptions or due to adverse developments related to numerous risk factors, including but not limited to the following:

- uncertainty regarding the effect of our Washington health plan's being named an "apparently successful bidder" by the Health Care Authority of Washington in that state's recent managed care procurement;
- significant budget pressures on state governments which cause them to lower rates unexpectedly or to rescind expected rates increases, or their failure to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate or Medicaid expansion, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including costs associated with unexpectedly severe or widespread illnesses such as influenza, and rates of utilization that are consistent with our expectations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and in dual eligible members;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine and Idaho;
- government audits and reviews;
- changes with respect to our provider contracts and the loss of providers;
- the establishment, interpretation, and implementation of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- the successful integration of our acquisitions;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, and the costs associated therewith;
- restrictions and covenants in our credit facility;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs and the costs and fees associated therewith;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information by us or our business associates;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates;

and numerous other risk factors, including those identified within this slide presentation and/or our accompanying oral remarks, and those discussed in our periodic reports and filings with the Securities and Exchange Commission. These reports can be accessed under the investor relations tab of our Company website or on the SEC's website at www.sec.gov. Given these risks and uncertainties, we can give no assurances that our forward-looking statements will prove to be accurate, or that any other results or events projected or contemplated by our forward-looking statements will in fact occur, and we caution investors not to place undue reliance on these statements. All forward-looking statements in this release represent our judgment as of January 26, 2012, and we disclaim any obligation to update any forward-looking statements to conform the statement to actual results or changes in our expectations.

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Business Overview

J. Mario Molina, MD
President & Chief Executive Officer

January 26, 2012
New York, New York

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Goal setting and results

- **Executed on our plans for 2011**
  - Health plan business remains stable
  - Medicare SNP business continues to grow
  - Improved profitability despite rate environment
  - First CMS certification achieved for fiscal agent contract
- **Positioned for strong growth in 2012**
  - New markets in Texas effective 3/12
  - Dual eligible care coordination integration

Solid progress on long-term value creation

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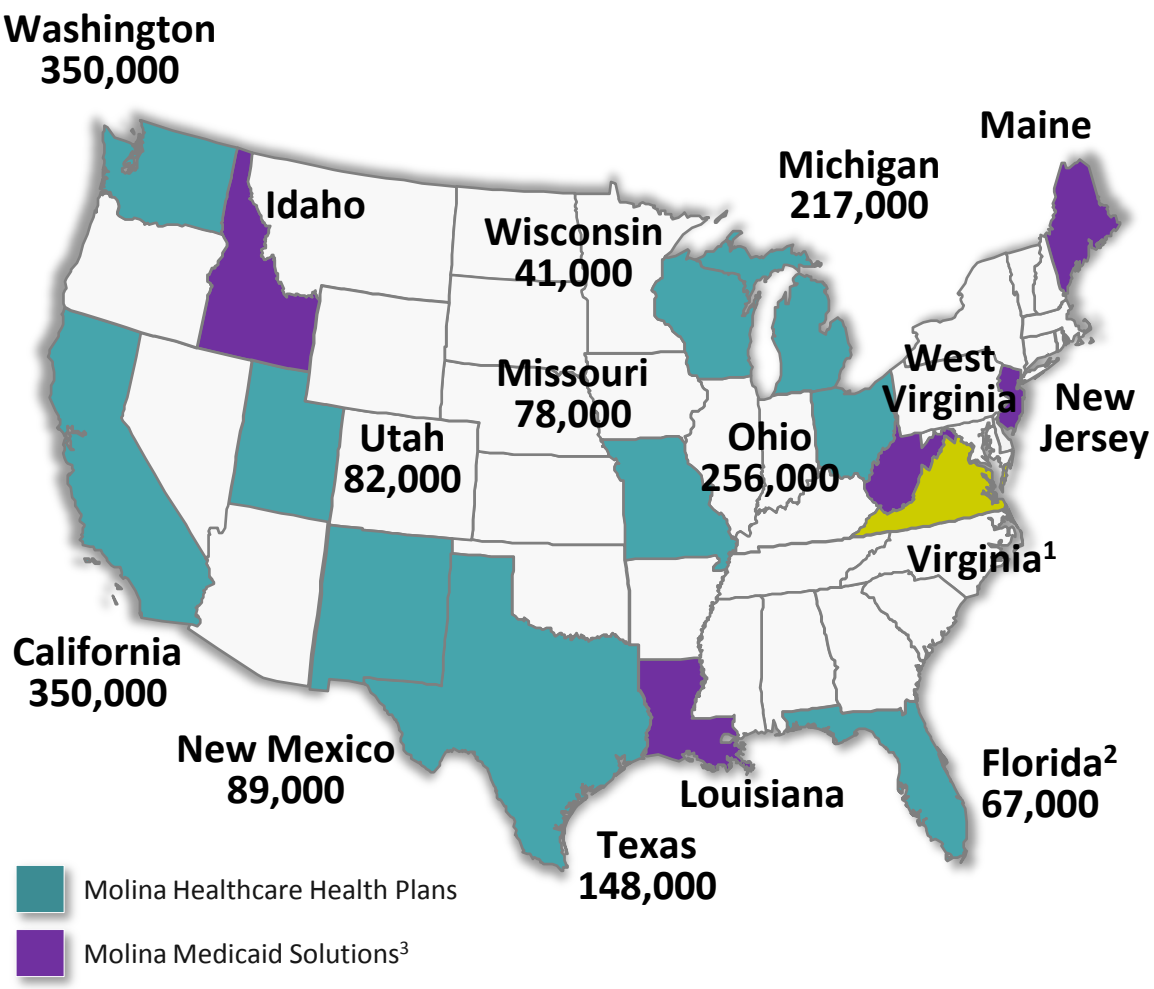
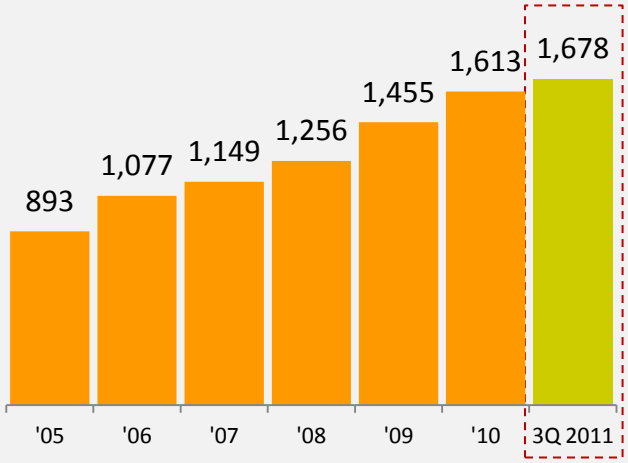
Business snapshot

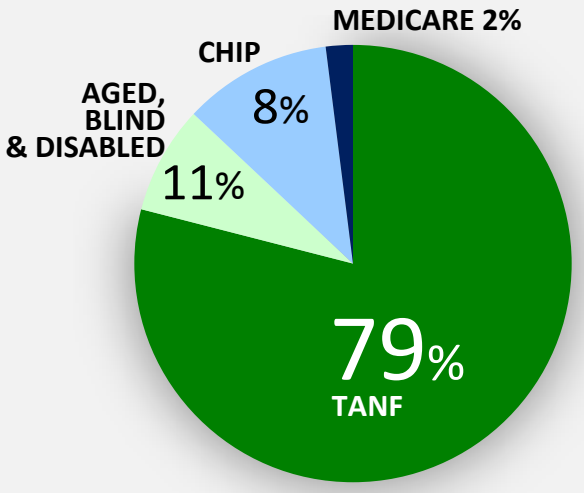
Markets and members served – 3Q 2011



Health plan enrollment
(in thousands)



Health plan membership profile

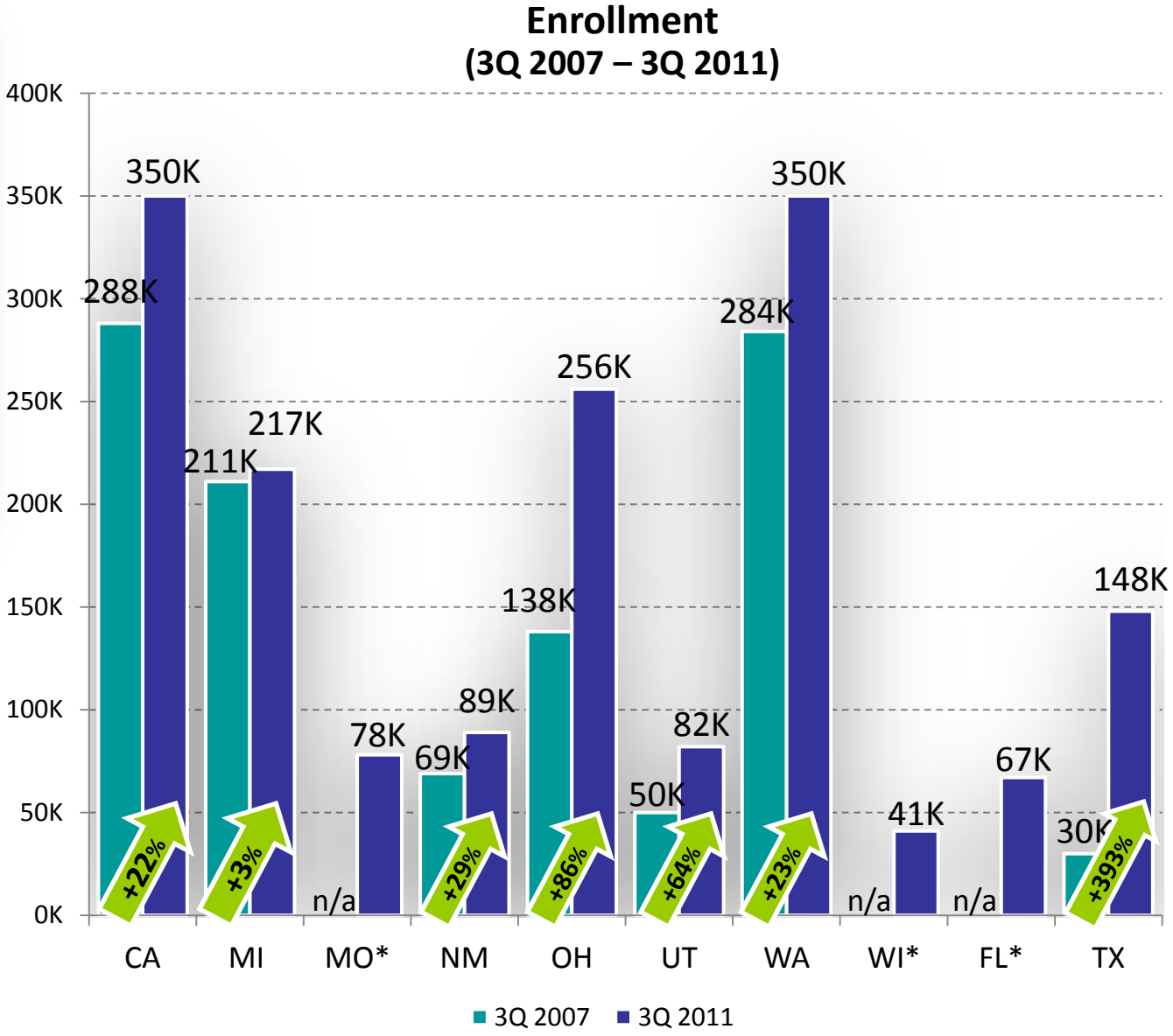


1. Virginia clinics provide Direct Delivery.
2. Florida has a managed care program as well as a Pharmacy Rebate Program.
3. Fee based fiscal agent business.

Delivering enrollment growth by market

As our enrollment grows, Molina remains committed to delivering quality health care. Except for Wisconsin, all of our eligible health plans have earned NCQA accreditation.

Molina health plans ranked in Consumer Reports Magazine, November 2011.



*Molina did not have a presence in these markets in 2007.

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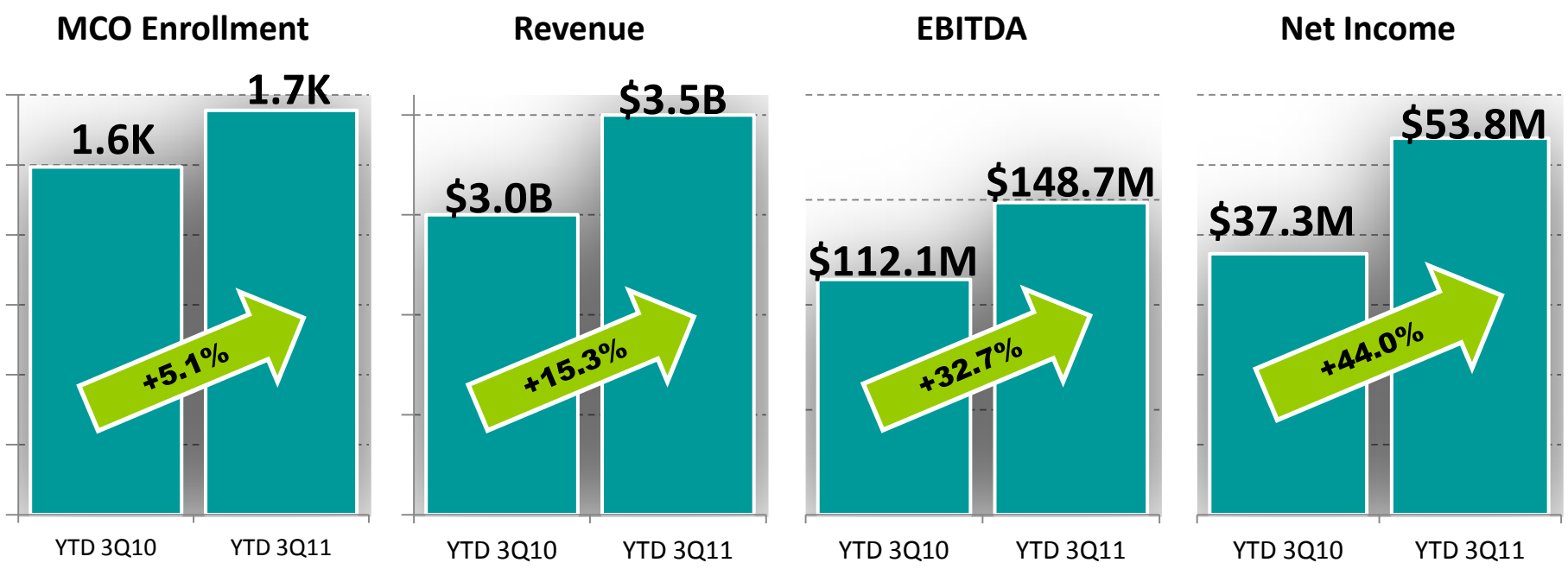
Executing on our plan

YTD 3Q 2010 vs. YTD 3Q 2011



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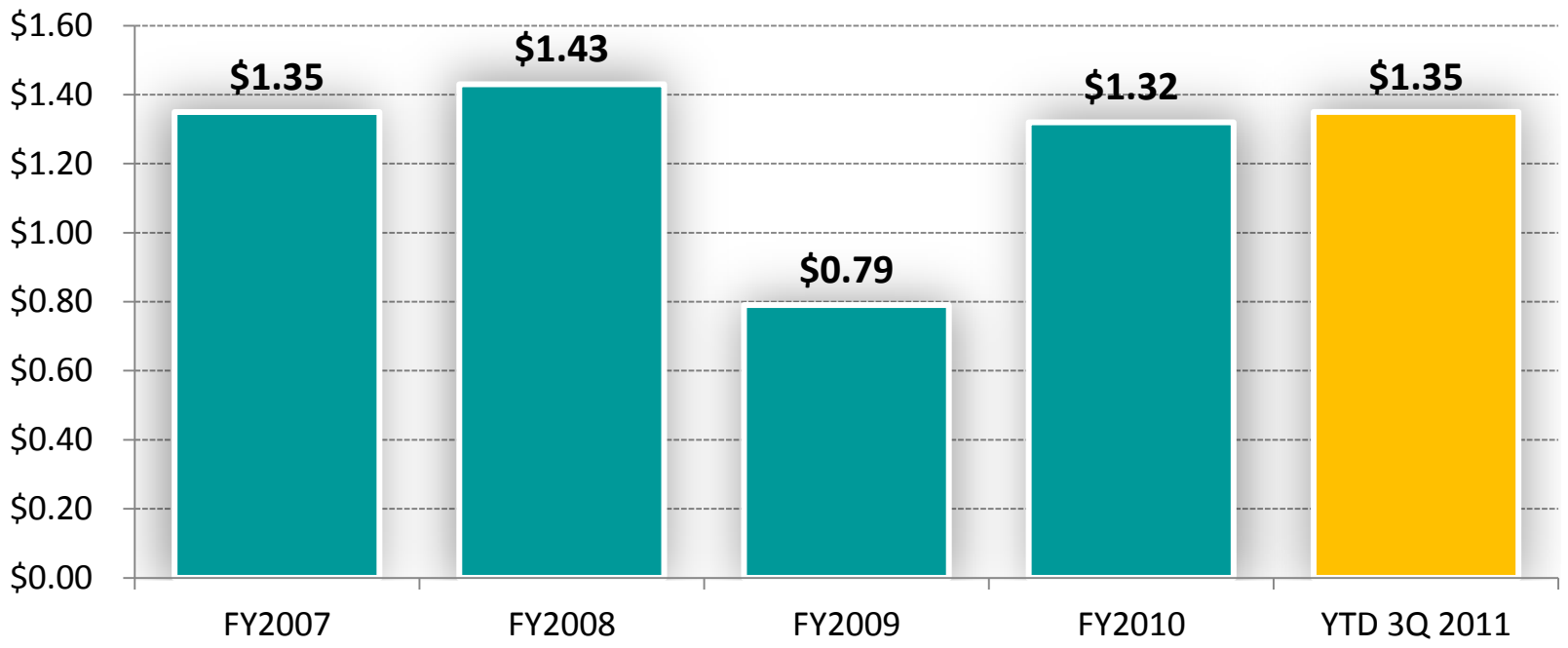
Molina earnings per share

Split adjusted



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Positioned for growth

- Building on momentum from new business wins and retention of existing contracts
- Leveraging established SNP (duals) growth platform
- Investing in Company-owned direct delivery footprint
- Continue developing and up-selling our fiscal agent offering
- Investing in corporate infrastructure (Molina Center)

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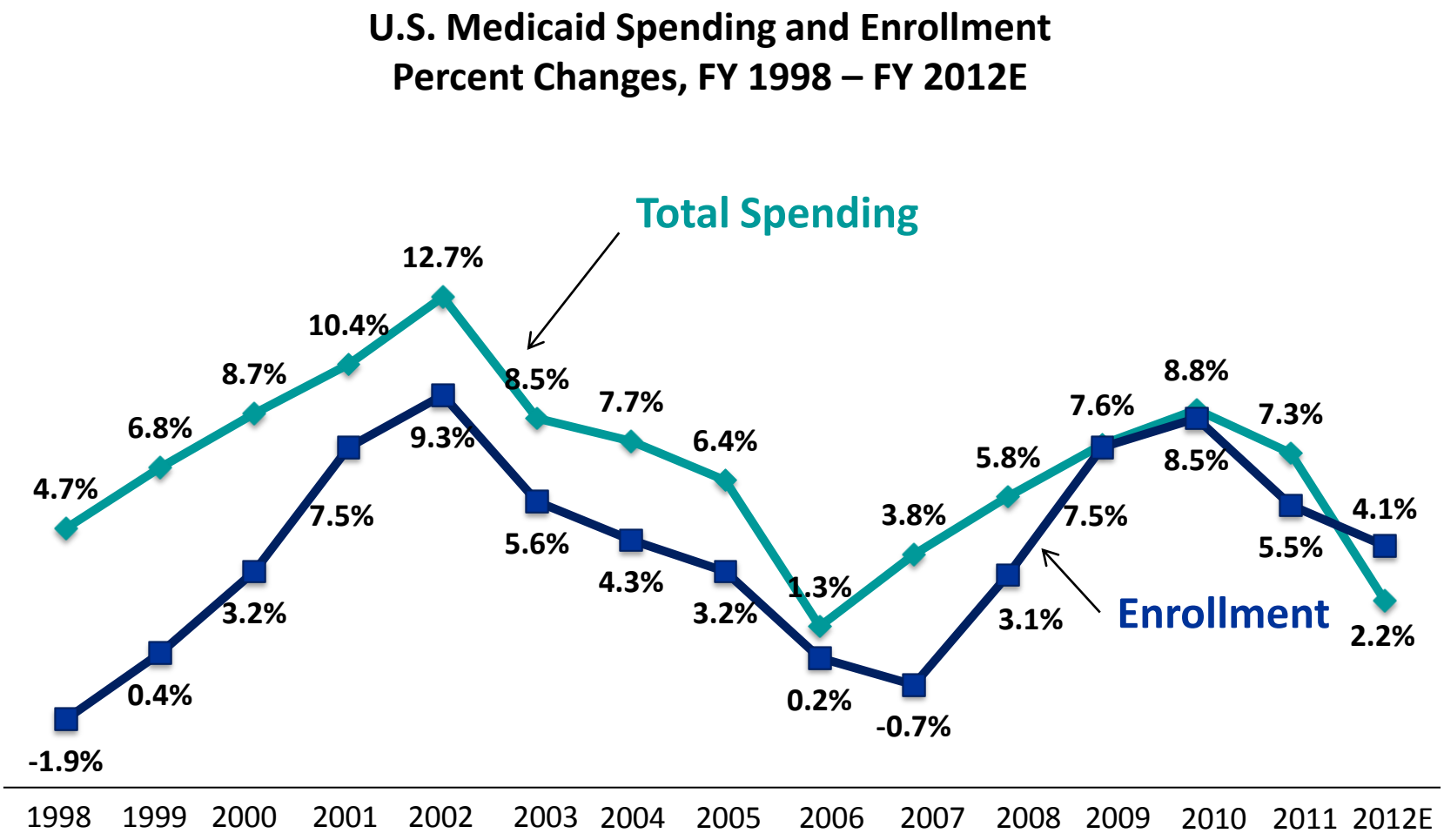
U.S. Medicaid spending and enrollment



Source: Medicaid Enrollment June 2010 Data Snapshot, KCMU, February 2011. Spending Data from KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates. FY 2011 and FY 2012 data based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2011.
Note: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

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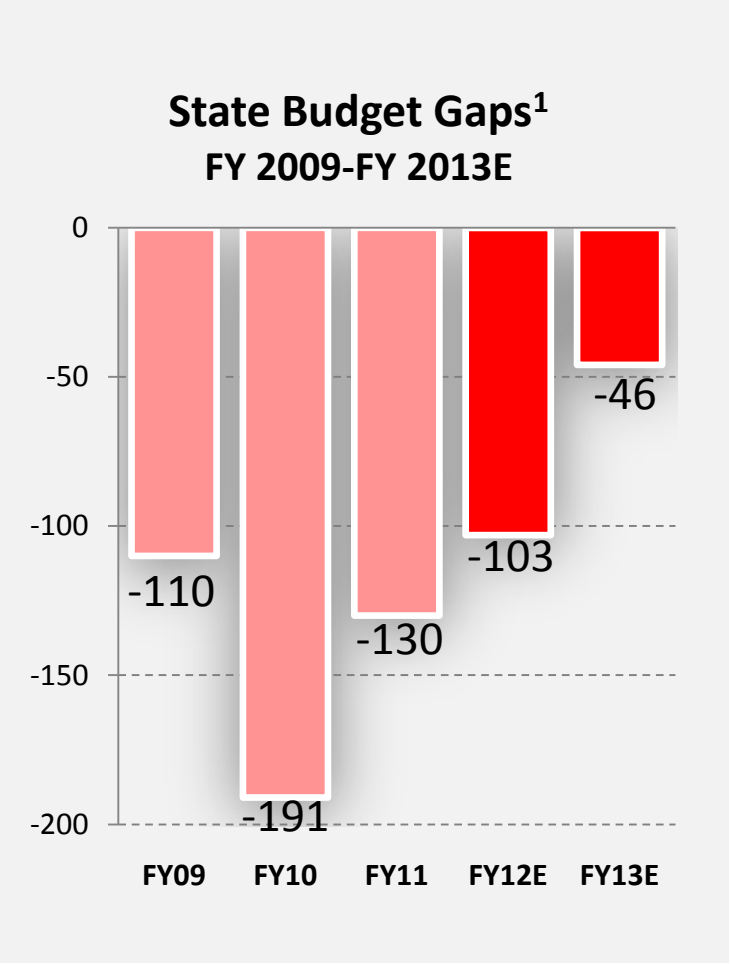
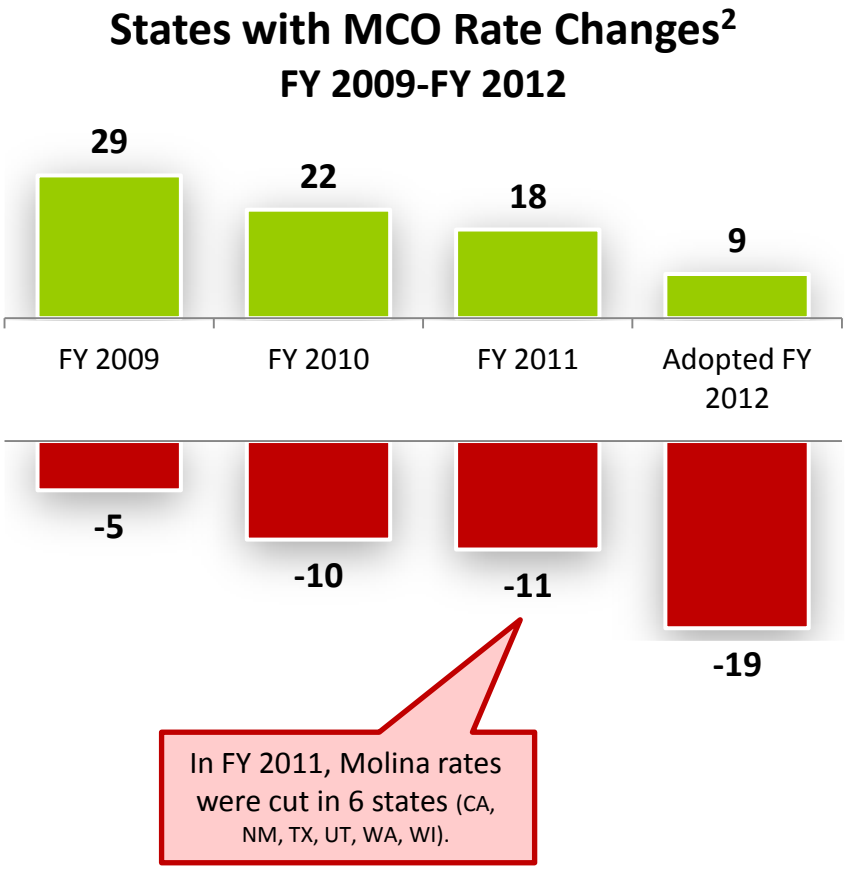
Key challenges for 2012

Although some states project improved cash flows over the next few years as the economy recovers, states' fiscal conditions remain very weak.





Sources:
1. "States Continue to Feel Recession's Impact." Center on Budget and Policy Priorities, June 17, 2011.
2. KMCU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2009, September 2010, and September 2011.

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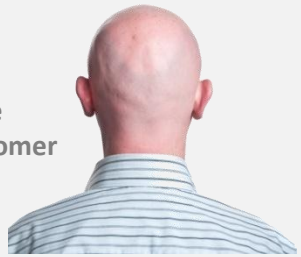
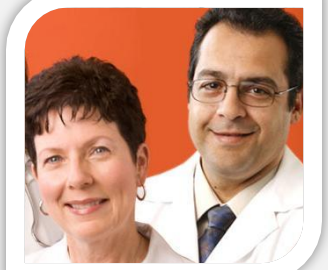
Short term growth opportunities

Economic, healthcare, and technology trends will translate into revenue opportunities in the short run.

- Dual Eligible Integration
- ABD Integration
- Managed Care RFPs
- Care Management
- Quality & P4P
- Primary Care Shortage



MCO State Customer



Health Plans
- Medicaid
- Medicare

Fiscal Agent
- MMIS

Direct Delivery
- Primary Care

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- HIPAA 5010 Readiness
- ICD-10 Implementation
- Health Information Exchange (HIE)
- Electronic Health Record
- New Fraud & Abuse Requirements

FA State Customer

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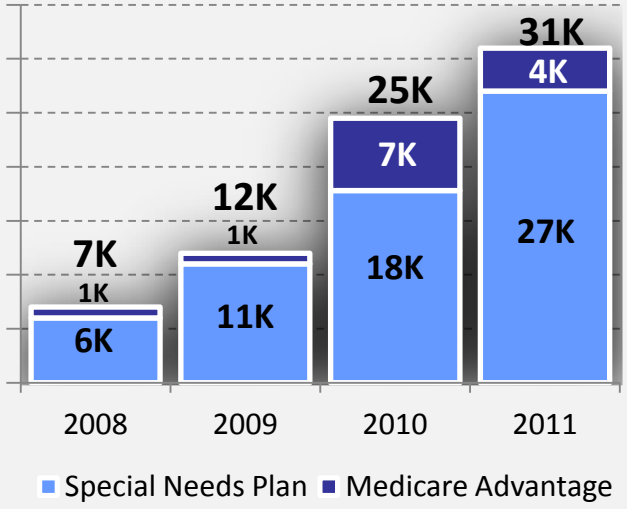
Unprecedented new focus on dual eligibles

Nearly 9 million Medicaid beneficiaries are dual eligibles: low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs.

Molina Medicare Enrollment[1]
2008-2011



Source: 1. CMS Special Needs Plan Data
https://www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage
2. Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles" fact sheet, December 2010.
http://www.kff.org/medicaid/upload/4091-07.pdf

- Recognition that dual eligibles are the most costly group of beneficiaries for both Medicaid and Medicare
- Dual eligibles account for approximately 15% of Medicaid enrollees but contribute to 39% of all Medicaid spending[2]
- Medicaid/Medicare spending averages $20K per dual per year, 5X greater than other Medicare beneficiaries
- Dual eligible population will highly benefit from managed care

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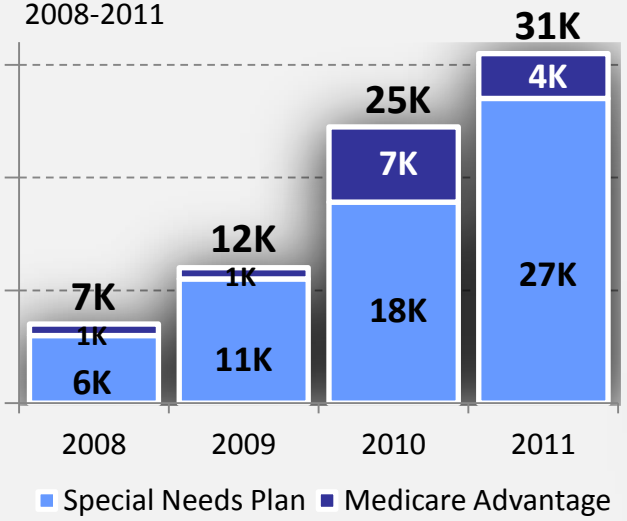
Our Medicare business is growing

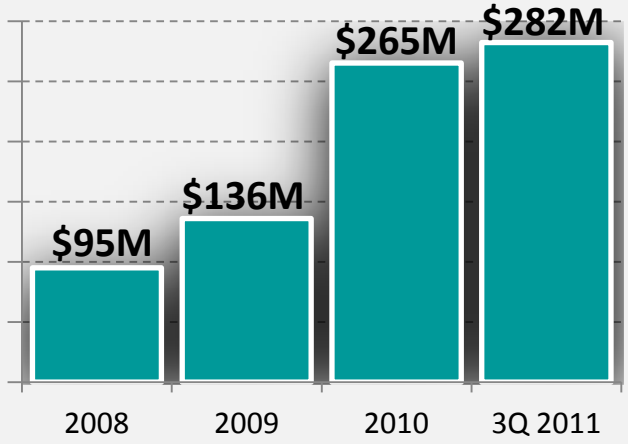
Molina Medicare Enrollment

2008-2011



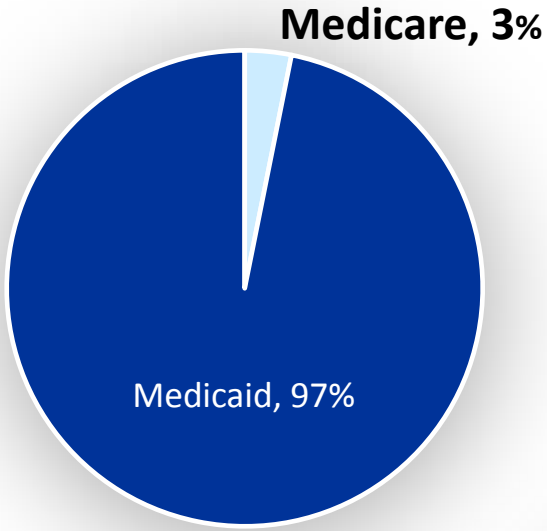
Molina Medicare Revenue

2008-YTD 3Q 2011



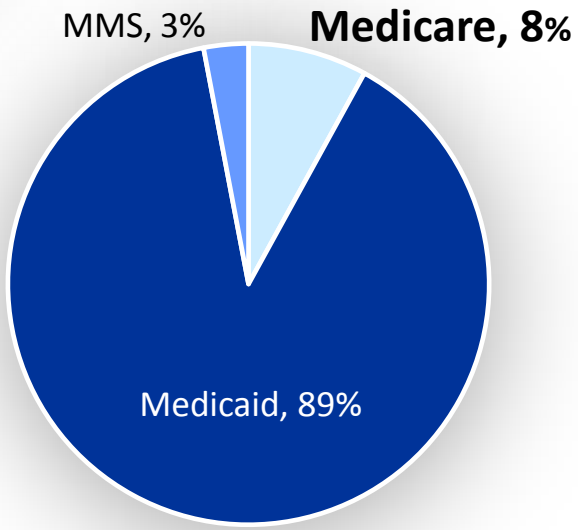
Revenue Distribution

3Q 2008



Revenue Distribution

3Q 2011



Source: Company Data and CMS Special Needs Plan Data
https://www.cms.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage

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Molina's dual eligible enrollment

Top 10 SNP Dual Eligible Plans Nationwide*		
Rank	Plan	Membership
1	UnitedHealth Group[1]	203k
2	HUMANA[2]	75k
3	HealthSpring	75k
4	Kaiser Permanente	68k
5	Health First	53k
6	WellCare	42k
7	Gateway Health Plan	28k
8	**Molina Medicare**	**27k**
9	Health Net A Better Decision	18k
10	University of Pittsburgh at Johnstown	16k

1. United includes PacifiCare, Evercare, APIPA and Secure Horizons products
2. Humana includes Arcadian, Care Plus, Arta, and MD Care.

Molina has well established SNPs serving the financially vulnerable

Source: CMS Health Plan Management System as of 12/2011. Information sourced quarterly.

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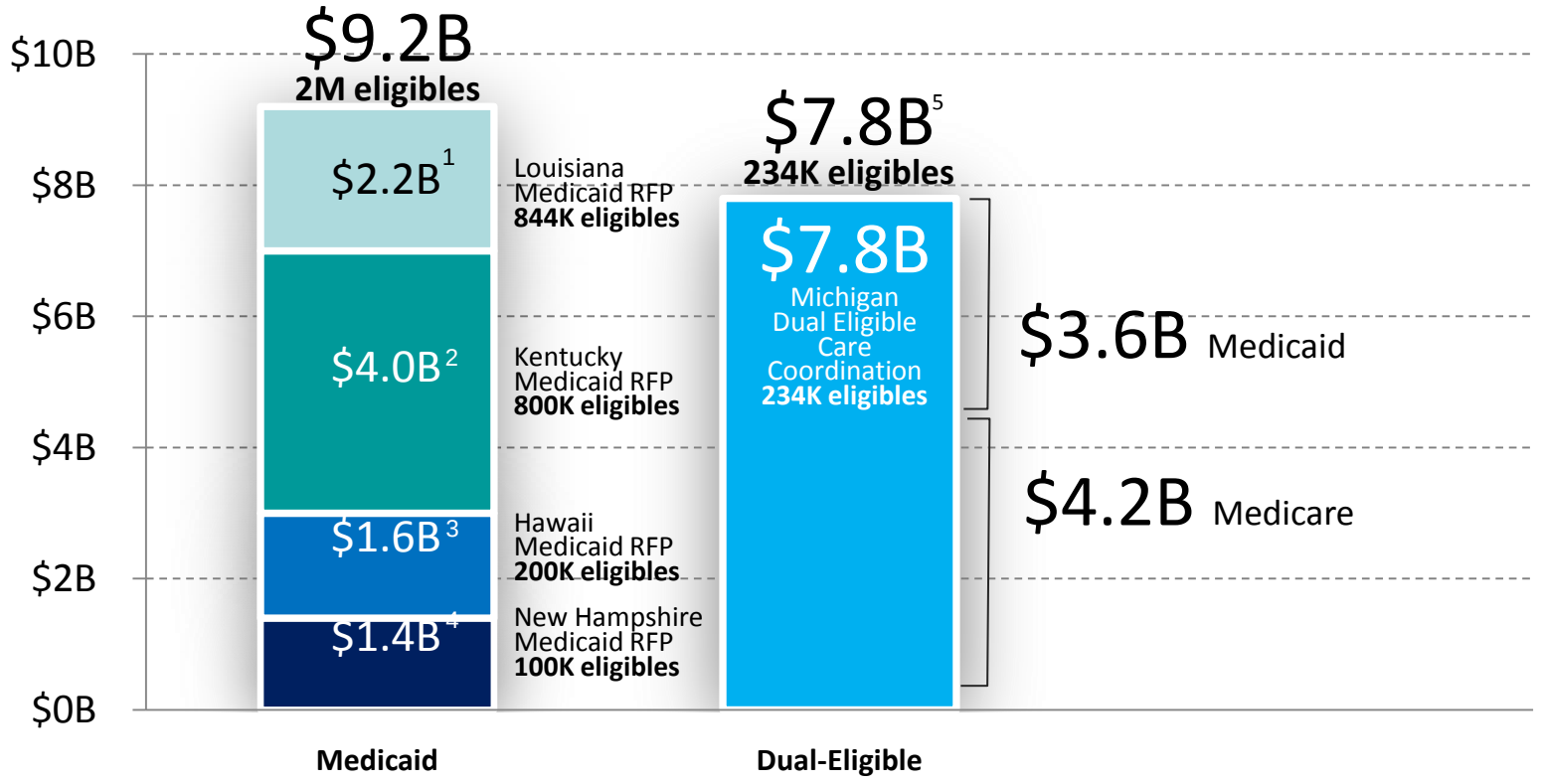
Opportunities in perspective

Michigan is among the 15 states selected to receive up to $1 million to support the design of programs to integrate care for the dual eligible.

Select Expansion Opportunities



Molina already serves nearly 7,000 SNP beneficiaries in Michigan

1. The Advocate, "Contract Winners want to protect data." August 2, 2011
2. Insider Louisville, Multiple mega firms pursue Kentucky's $4 billion Medicaid contract ." June 23, 2011
3. Pacific Business News, $1.65B in Medicaid contracts will expire in June." May 6, 2011. (http://www.bizjournals.com/pacific/print-edition/2011/05/06/165-billion-in-medicaid-contracts.html)
4. Union Leader, "State reviewing proposals for massive Medicaid contract." January 2, 2012. (http://www.unionleader.com/article/20120102/NEWS06/701029974)
5. CMS document, "Michigan's Response to CMS Solicitation State Demonstrations to Integrate Care for Dual Eligible Individuals "

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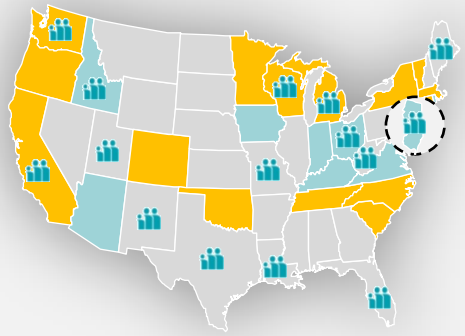
Supporting integrated care for duals

Medicare and Medicaid are each governed by their own policies and procedures, Dual eligibles are forced to navigate a system with two sets of providers, benefits, and even enrollment cards. This fragmentation can result in unnecessary, duplicative, or missed services.



- Molina States
- States awarded funding for dual eligible coordination
- States submitting proposals to CMS (partial list)

CMS selected 15 states to receive up to $1M to **support the design of programs to integrate care** and to design shared savings initiatives.

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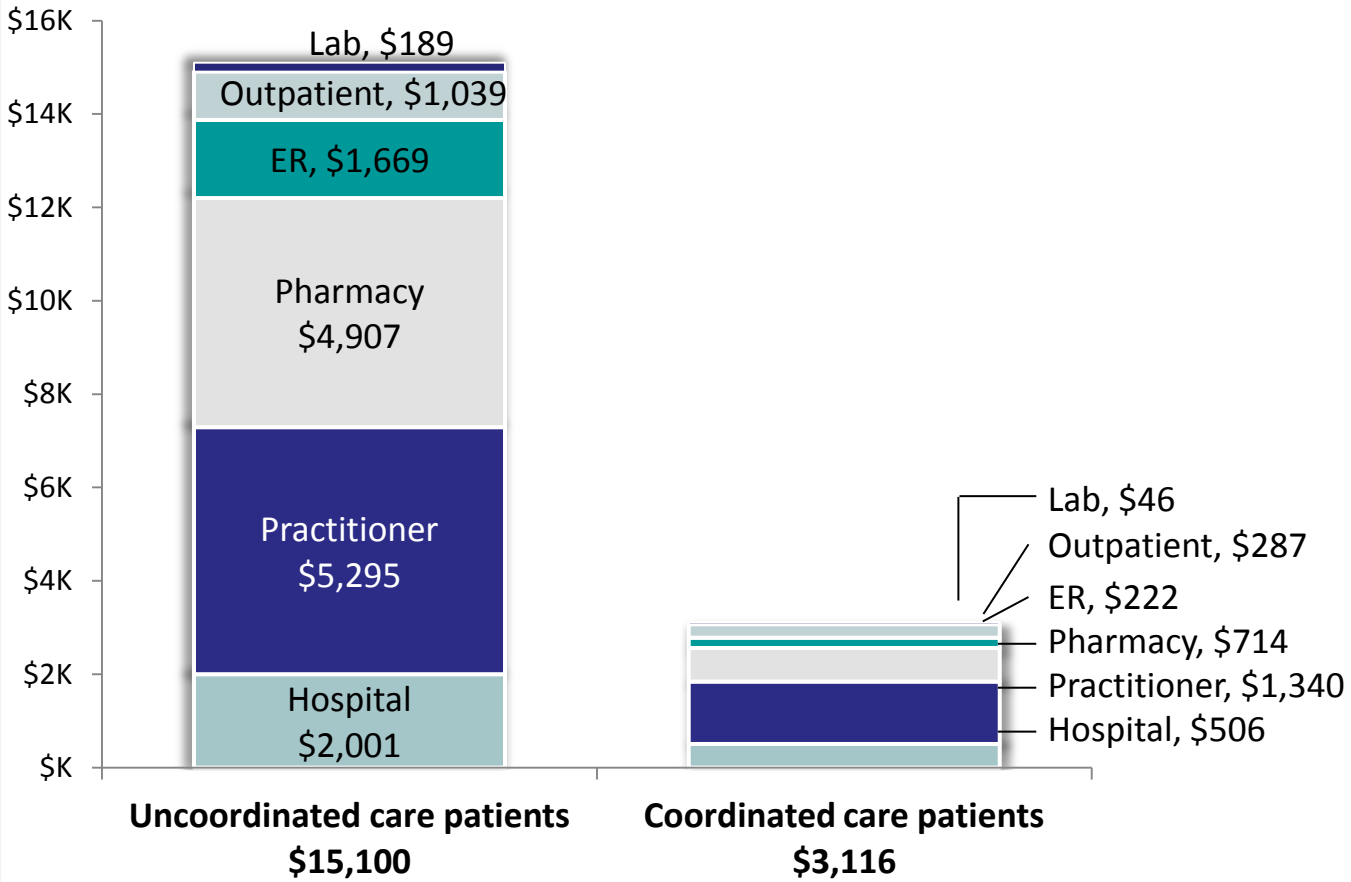
Cost of uncoordinated care

Medicaid patients with extremely uncoordinated care account for a disproportionate share of costs. These patterns are even more significant among dual patients who experience a greater prevalence of chronic diseases and co-morbid conditions.

Source: The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Southeastern Consultants, Inc. (SEC) performed comprehensive claims analyses on over 9 million Medicaid only and Medicaid/Medicare dually enrolled patients in five large states or various periods from 2000 through 2006. These analyses included use and expenditure analyses of drugs and medical services, a disease profile of the population, and the identification of access and care patterns indicative of uncoordinated care in a subset of the population.

Medicaid only group total annual expenditures

Patients with and without uncoordinated care.*



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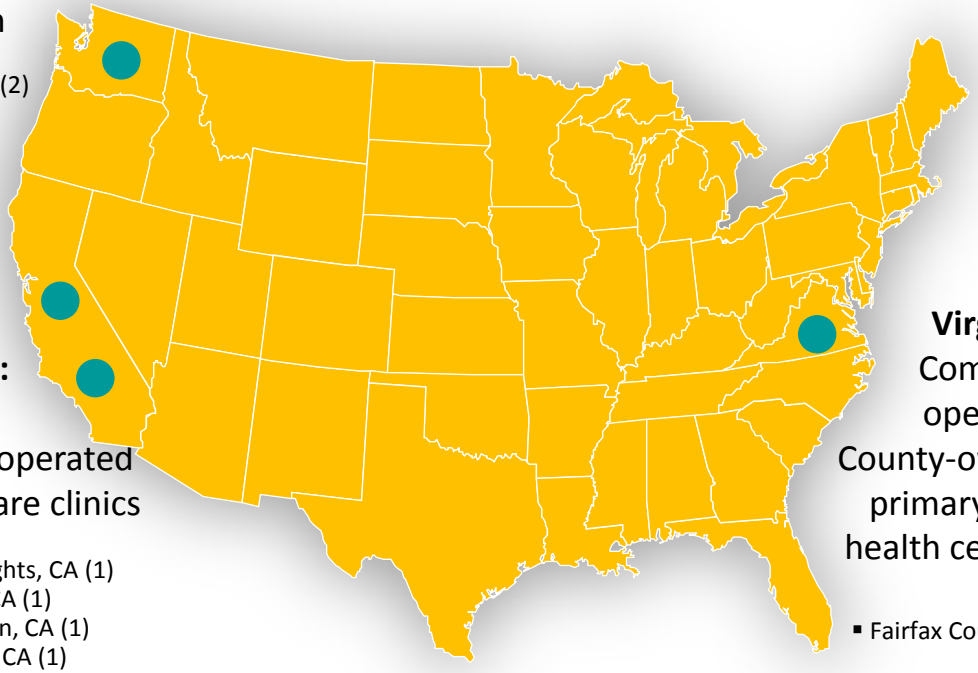
Direct Delivery

Our approach to direct delivery is flexible and can accommodate changes in local market requirements and needs. We currently operate 21 clinics and plan to continue expanding.

Washington: mental health & primary care integration

- Everett, WA (2)



California: MSO owned & operated primary care clinics

- Citrus Heights, CA (1)
- Fontana, CA (1)
- Wilmington, CA (1)
- Lancaster, CA (1)
- Long Beach, CA (3)
- Moreno Valley, CA (1)
- Ontario, CA (1)
- Pomona, CA (2)
- Riverside, CA (1)
- San Bernardino, CA (1)
- Sacramento, CA (3)

Virginia: Company operated County-owned primary care health centers

- Fairfax County (3)

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Why build clinics at all?

- Augment network in areas of provider scarcity
- Supplement provider capacity issues
- Greater emphasis on quality and outcomes
- States continue to cut rates
- Nurtures patient loyalty to the health plan
- Brand awareness & community engagement

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Why not build more clinics?

- Need to augment the network not replace the network
- Can be perceived as competing directly with network providers
- Identifying right locations can be a challenge
- Hiring doctors to serve Medicaid patients is not easy
- Get it right from the beginning

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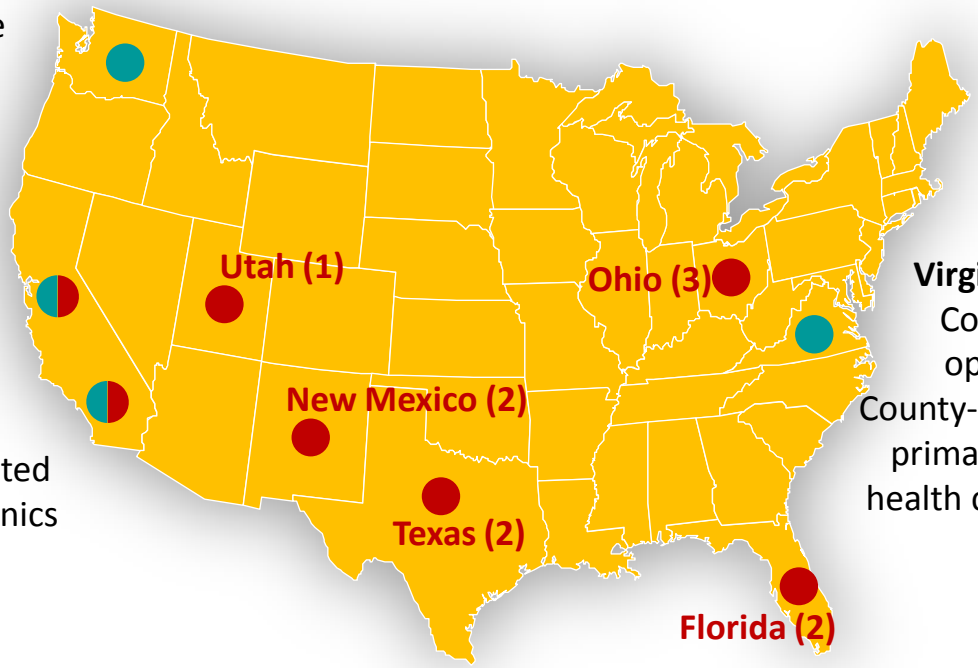
Direct Delivery: expanding our footprint

15 new clinics planned for 2012

Washington (2)
Mental health & primary care integration



Virginia (3)
Company operated County-owned primary care health centers

California (20)
Health plan owned & operated primary care clinics

- Current (16)
- *Future (4)*

Current Molina clinics

Future Molina clinics

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Direct Delivery – Rx solutions

A 2007 U.S. survey reported that nearly 31% of those polled had not filled a prescription they were given by their physician.[1]

Molina now offers patients on-site medication dispensing to increase the likelihood that patients will fill their prescription and undergo the physician's medical treatment plan.

- Value added benefit for Molina members
- Acute care scripts only
- Wait time: 10 -15 min
- Direct member customer service line
- Over 50,000 scripts already dispensed

1. Source: Enhancing Prescription Medicine Adherence: A National Action Plan, National Council on Patient Information and Education August 2007

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Direct Delivery – transportation solution

Transportation to and from a physician's office remains a key problem for Medicaid beneficiaries. The use of public transportation often results in missed appointments or late arrivals.

Transportation solution

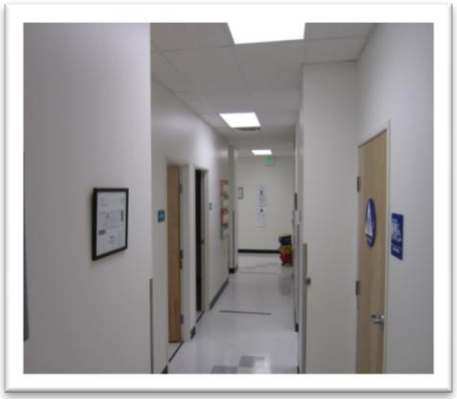
Free shuttle service offers a ride between various key community access points, including our clinics. (Long Beach, Inland Empire.)

Direct Delivery – our facilities

pre build-out

- Typically leased facilities about 4,000 sq/ft
- 4-5 employees
- 1-2 Primary Care Physicians per office
- Contracted: Lab, X-Ray, and Specialty services

after build-out



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~~Arco Towers~~ Molina Center

Molina acquires office complex in Long Beach, California.

- Purchase price of $81 million
  - Two connected 14-story towers
  - 461,263 square feet
  - Class A building

- Preparation for anticipated growth
- Rent vs. own decision (MOH already occupied 40% of complex)
- Advantageous real estate market conditions

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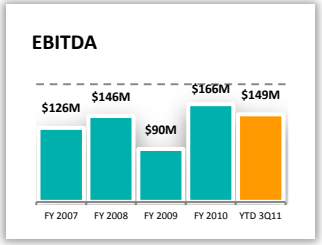
Summary of investor areas of interest

RFP pipeline & retention of existing business

- TX RFP Momentum (wins in El Paso, Jefferson & Hidalgo)
- Retention of WA contract
- Selective RFP participation
- Established presence in key growth states (CA, FL & TX)

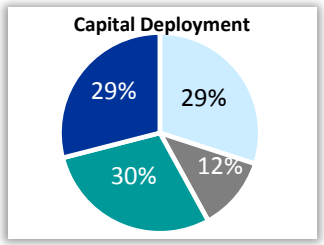
Stabilization of MMIS/fiscal agent business

- Maine contract certified by CMS
- Idaho completed CMS certification visit
- $40M in new upsell revenue



Profitability

- Patient mix migration towards higher revenue members (SNP, ABD)
- Pharmacy carve-ins (OH & TX)
- Medical cost reduction plan in FL and TX



Capital allocation & access to capital

- Credit facility right-sized ($170M)
- Subsidiaries well-capitalized

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Q&A

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Your Extended Family.

Operations Update

Terry Bayer
Chief Operating Officer

January 26, 2012
New York, New York

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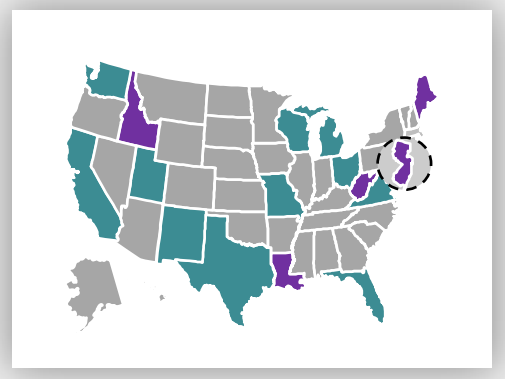
Operations update



- **Highlights from our health plans**
  - Florida
  - Texas
  - Ohio
  - Washington
- **Dual eligible opportunity**
  - Michigan duals
  - California budget
- **Carve-in trends**
- **MMS certification**

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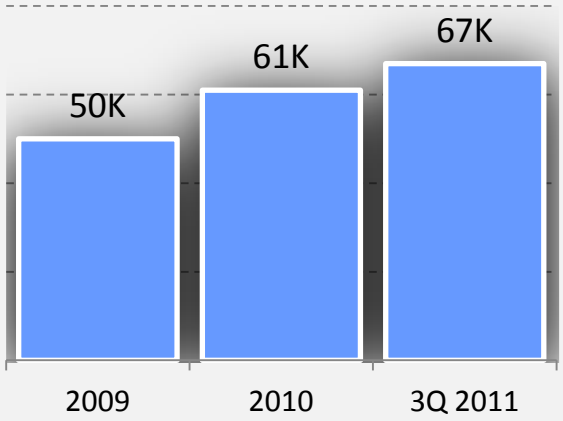
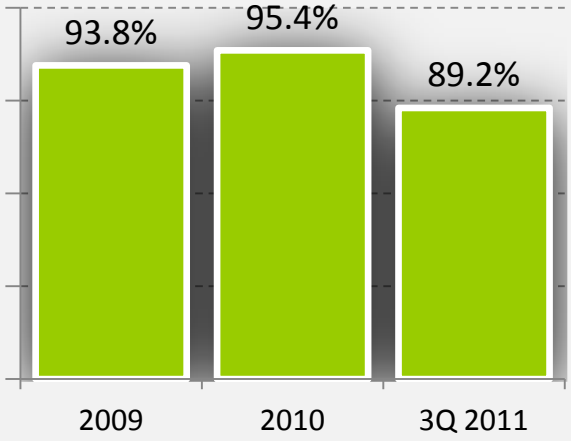
Florida

Molina Healthcare of Florida
Historical and YTD Enrollment
2009-3Q2011



Molina Healthcare of Florida
Historical and YTD MCR
2009-3Q2011



Improved financial performance due to:

- Reduced unit costs
- Utilization improvement
- Premium rate increase effective 9/1/11

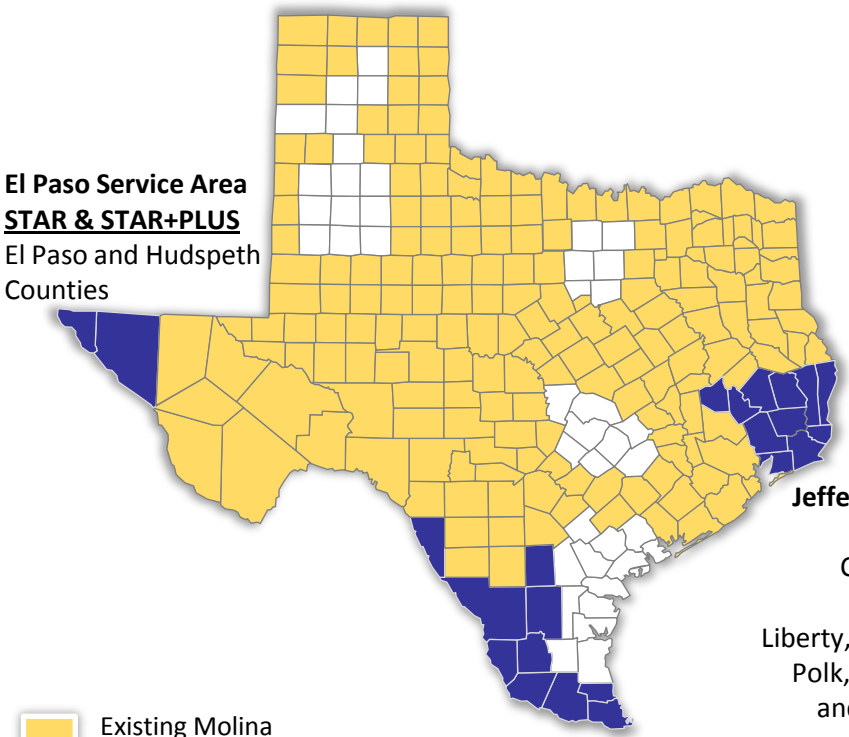
Texas overview

In addition to Molina's already expansive footprint in Texas, effective March 1, 2012, Molina will have three new service delivery areas (SDAs).

Profitability Improvement Plan:

- Rate Increases
- Care Coordination
- Utilization Management
- Unit Costs-recontracting

Molina New SDAs
(effective 3/1/2012)



El Paso Service Area
STAR & STAR+PLUS
El Paso and Hudspeth Counties

Jefferson Service Area
CHIP
Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacinto, Tyler and Walker counties

Existing Molina footprint

Molina new SDAs effective 3/1/2012

Hidalgo Service Area
STAR & STAR+PLUS
Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, and Zapata counties

Source: Texas Health and Human Services Commission

MOLINA HEALTHCARE

Ohio

- **Improved financial performance due to:**
  - Premium rate increase (effective 1/1/11)
  - Utilization management
  - Care coordination
  - Reducing unit costs by improving contracts
- **RFA issued January 11, 2011:**
  - Re-procurement statewide
  - Addition of disabled children

MOLINA HEALTHCARE

Ohio RFA

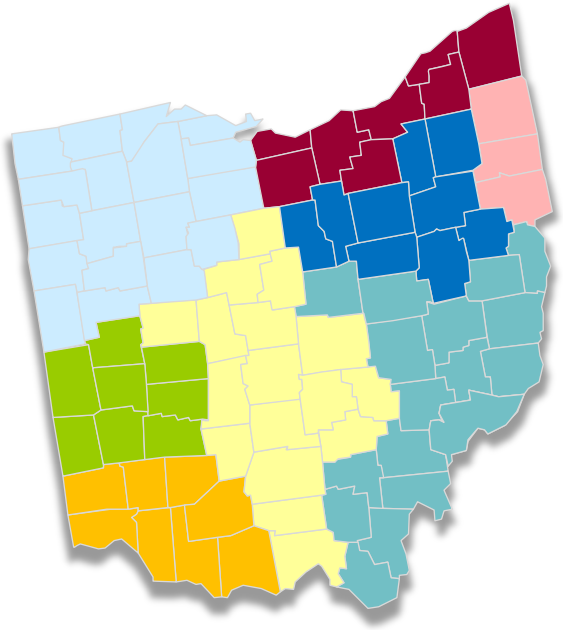
On January 11th, the Ohio Department of Job and Family Services issued a Request for applications under which it will rebid the current managed care population and expand managed care to the aged, blind, or disabled (ABD) population.

- **$5.1 billion rebid**
- **Implementation expected January 1, 2013**
- **1.5M covered families and children (CFC) lives, 125K ABD lives, and 37K children with disabilities**
- **Mandates ABDs, including children, into managed care**
  - Beneficiaries currently enrolled in the covered families and children (CFC) program will continue to be mandatorily enrolled
- **Divides state into three regions each with four managed care plans**
  - Three regions each with a unique health plan, therefore allowing three distinct MCOs to operate statewide.
- **Bids are due March 19, 2012**
- **Not a rate bid (compliance, HEDIS, experience 60% of bid)**

MOLINA HEALTHCARE

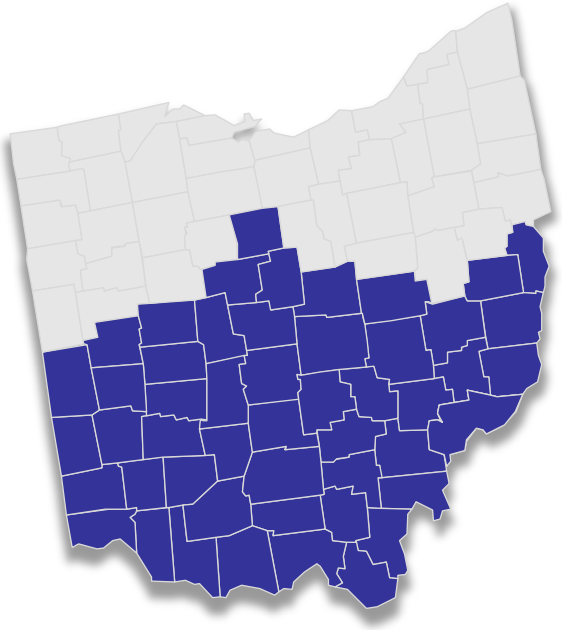
Ohio RFA

Pre-2012 RFA
Ohio Managed Care Regions
(8 regions)



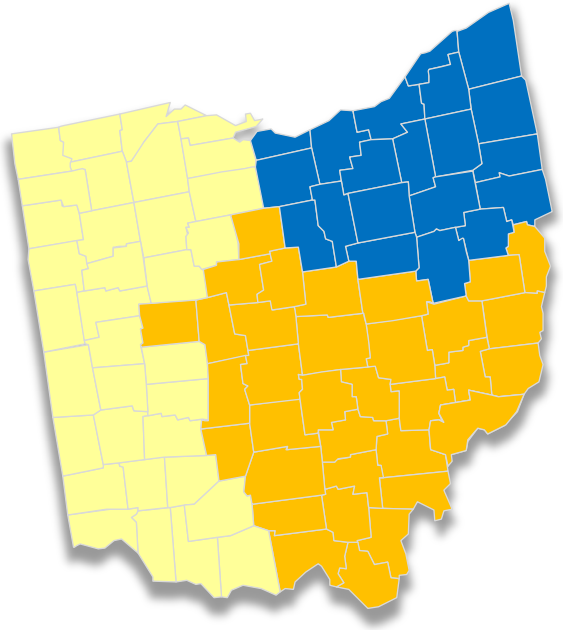
- East Central region
- North East region
- South West region
- N. East Central region
- West Central region
- North West region
- Central region
- South East region

Pre-2012 RFA
Current Molina Service Area
(4 regions)



- Current Molina service area

Post-2012 RFA
Ohio Managed Care Regions
(3 regions)



- West region
- Northeast region
- Central/Southeast region

Source: Ohio Department of Job and Family Services
(http://jfs.ohio.gov/rfp/JFSR1213078019/JFSR1213078019.stm)

MOLINA HEALTHCARE

Washington

- **RFP results announced January 17, 2012**
- **Qualified as one of five "apparently successful" bidders**
- **New population:**
  - 100,000 SSI members included in Healthy Options program effective 7/1/12.
- **MCO's exiting program 7/1/12 (123,000 members)**
  - Columbia United Providers (CUP)
  - Group Health
  - Regence
  - Kaiser

MOLINA HEALTHCARE

Michigan duals

- State began enrolling dual eligibles in Medicaid (12/11)
- Dual eligibles in SNP automatically enrolled with opt-out
- Michigan Department of Community Health (MDCH) developing Dual Eligible Integrated Care Plan
- CMS submission target (4/1)
- Implementation target (1/2013)

MOLINA HEALTHCARE

California Budget

On January 5th, Governor Brown released initial California budget proposal.

Proposed changes to Medi-Cal (Medicaid)

- Phased-in transfer of duals to managed care starting in January 2013. Medi-Cal benefits transition in first year; Medicare benefits over three years. (approx. $670M projected savings in SFY 2013)
- Statewide expansion of Medi-Cal managed care starting in June 2012; fee-for-service transition to managed care in 2014-15.
- Annual open enrollment and lock-in period for Medi-Cal managed care.
- Extension of gross premiums tax on Medi-Cal managed care plans and hospital fee on hospitals.
- 3.61% proposed rate increase in Medi-Cal rates.

Proposed changes to Healthy Families (CHIP)

- Aggregate 25.7% managed care plan rate cut effective Oct. 1, 2012. Because of varying contract rates, the effective rate change for health plans may be significantly different.
- Transfer of all Healthy Families members (approx. 875,000) to Medi-Cal over a 9 month period beginning in Oct. 2012.
- Elimination of the Managed Risk Medical Insurance Board (MRMIB) by July 2013.

Final budget terms may vary materially.

MOLINA HEALTHCARE

Carve-in trends

- **Ohio Rx: 10/11**
- **Texas Rx: 3/12**
- **Texas inpatient: 3/12**

Maine MMIS certification

Centers for Medicare and Medicaid Services (CMS) awarded Molina Medicaid Solutions full federal certification in Maine in December 2011.

Since September 1, 2010, the Maine Integrated Health Management Solution (MIHMS) system has been processing approximately 1 million claims per month and paying nearly 3,000 providers each week.

- Certification allows state to receive maximum federal funding for Maine Integrated Health Management Solution (MIHMS) by meeting federal standards for claims management system.
- State of Maine can claim 75% federal reimbursement for ongoing operations retroactive to September 1, 2010.
- MIHMS was designed and implemented by Molina Healthcare's wholly owned subsidiary, Molina Medicaid Solutions.

MOLINA HEALTHCARE

Molina Medicaid Solutions upsells

Our fiscal agent business has pursued various new revenue opportunities (upgrades, add-ons, new services and products), producing $40M in additional sales in 2011.*

West Virginia

Please refer to the Company's cautionary statements.

Item	Narrative	When Sold (Qtr/Yr)
Provider Incentive Payments	Incentive payments made to the medical community	3Q 2011
Provider Enrollment Application	Enhancement of provider portal application	3Q 2011
5010	HIPAA standards for installation of 5010	3Q 2011

Louisiana

Item	Narrative	When Sold (Qtr/Yr)
InterQual	Application of InterQual criteria to state operated facilities	1Q 2011
5010/ ICD-10	10th Revision of the International Code of Diagnoses Compliance Project	1Q 2011/3Q 2011

*This revenue will be recognized through 2014.

MOLINA HEALTHCARE

Q&A

MOLINA HEALTHCARE

Your Extended Family.

Capital Adequacy

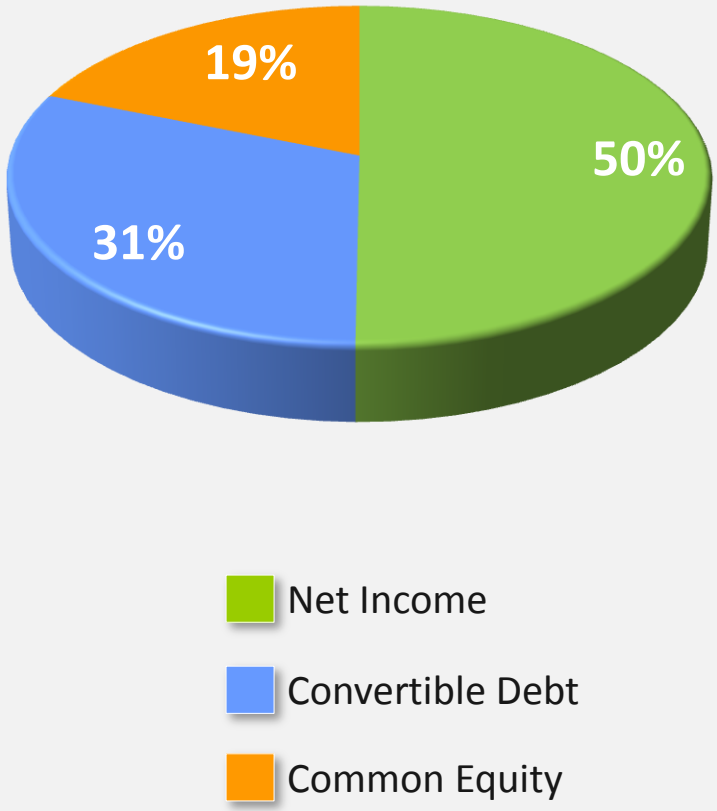
Joseph White
Chief Accounting Officer

January 26, 2012
New York, New York

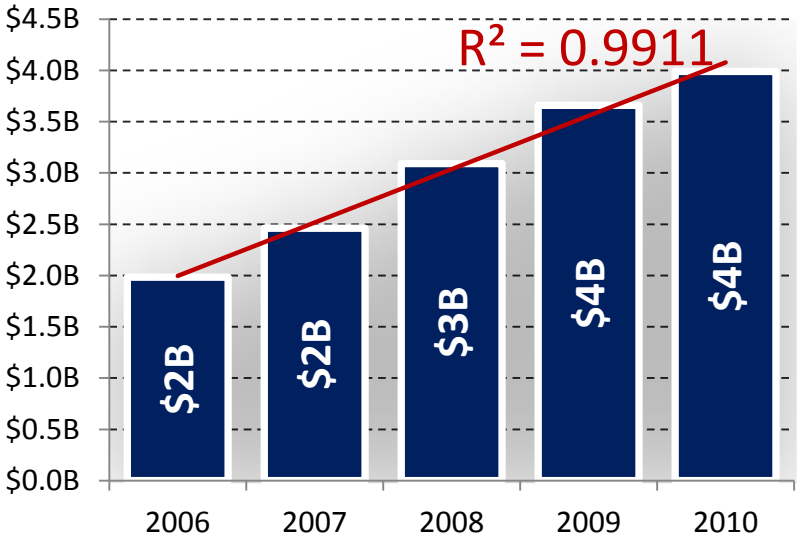
MOH LISTED NYSE

Molina earnings have funded past growth

Sources of Capital
2006 through 3Q2011



Total Revenue
2006-2010

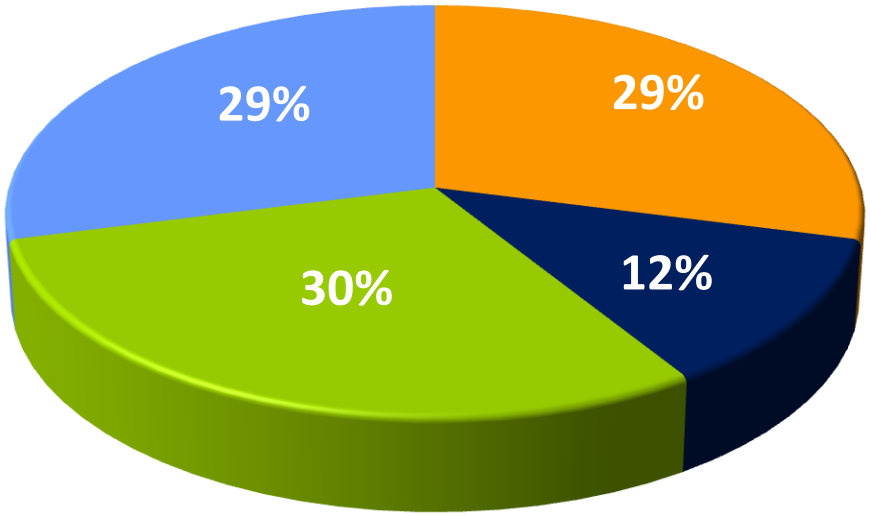


Source(s): SEC Filings

MOLINA HEALTHCARE

Molina has invested to grow its business

Capital Deployment
2006 through 3Q2011



- Cash Paid for Acquisitions
- Contributions to Subsidiaries
- Capital Expenditures
- Share Repurchases

Source(s): SEC Filings and Company Data

MOLINA HEALTHCARE

Capital deployment: acquisitions

Our deployment of capital has included strategic acquisitions that enable the company to increase its market penetration in existing markets, or enter new markets and new programs. (risk and fee based)

Please refer to the Company's cautionary statements.

1997
Entered **Michigan** by acquiring Minority Interest

1999
Acquired controlling interest in **Michigan** Plan

2000
Entered **Washington** by acquiring Qualmed Washington Health Plan

2004
Entered **New Mexico** by acquiring Health Care Horizons the parent company of Cimarron Health Plan

2004
Acquired members in **Washington** from Premera Blue Cross

2004
Acquired the rights to serve **Wellness Plan** members in Michigan

2005
Entered San Diego County, CA by acquiring **Sharp & Universal Plan** members

2006
Acquired HCLB the parent company of **CAPE** Health Plan in Michigan

2007
Entered Missouri by acquiring **Mercy CarePlus**

2008
Entered Florida by acquiring **Florida NetPASS**

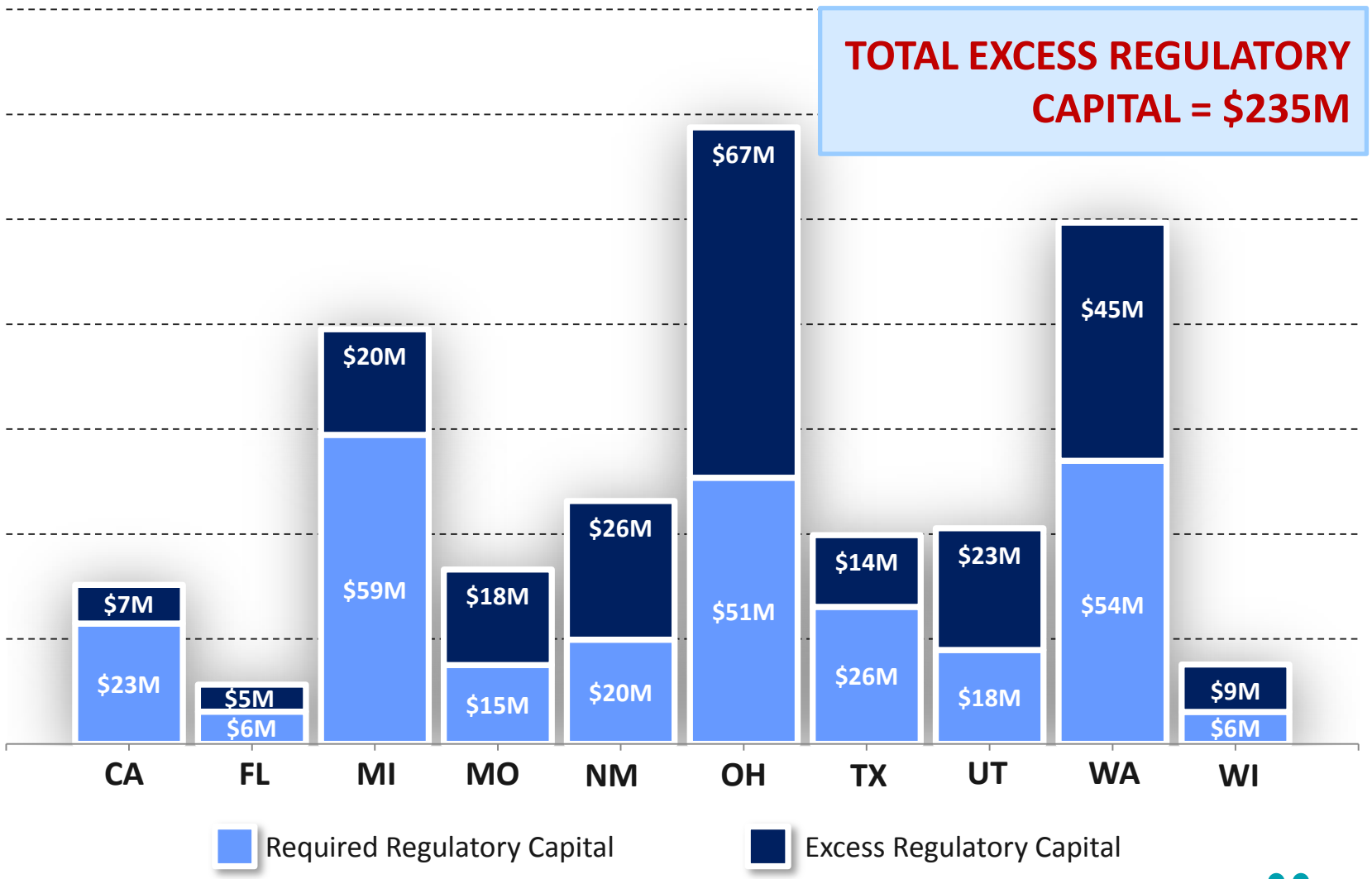
2010
Acquired the Health Information Management business from Unisys, now **Molina Medicaid Solutions**

2010
Acquired **Abri Health Plan** in Wisconsin

2011
Acquired the **Arco Towers** in Long Beach, CA

Molina health plans are well capitalized

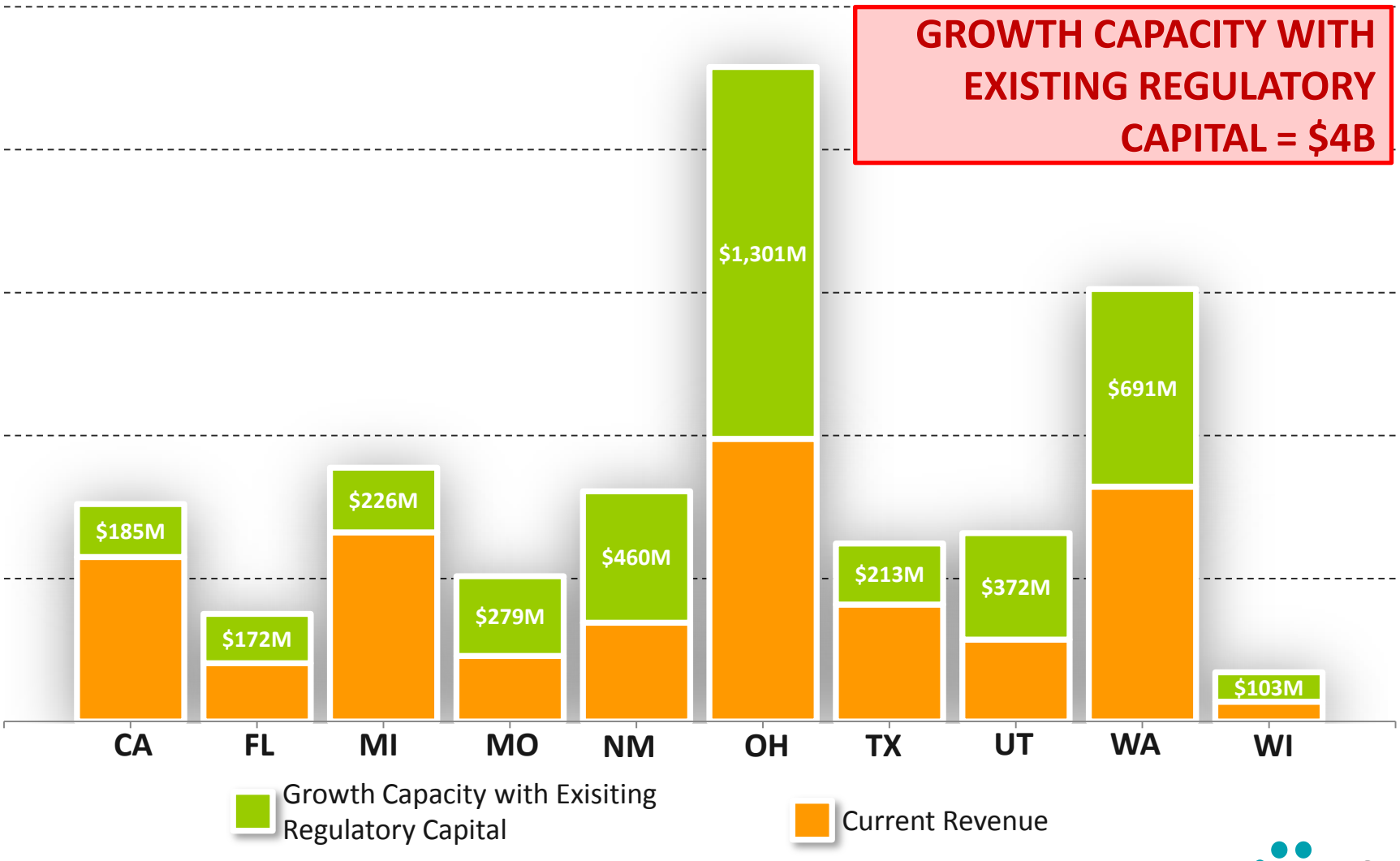
Regulatory Capital
2011E*



*E denotes estimate.
Source(s): Company Estimates

Molina health plans have capital to support growth

Health Plan Growth Potential without New Capital
2011E*



*E denotes estimate.
Source(s): Company Estimates

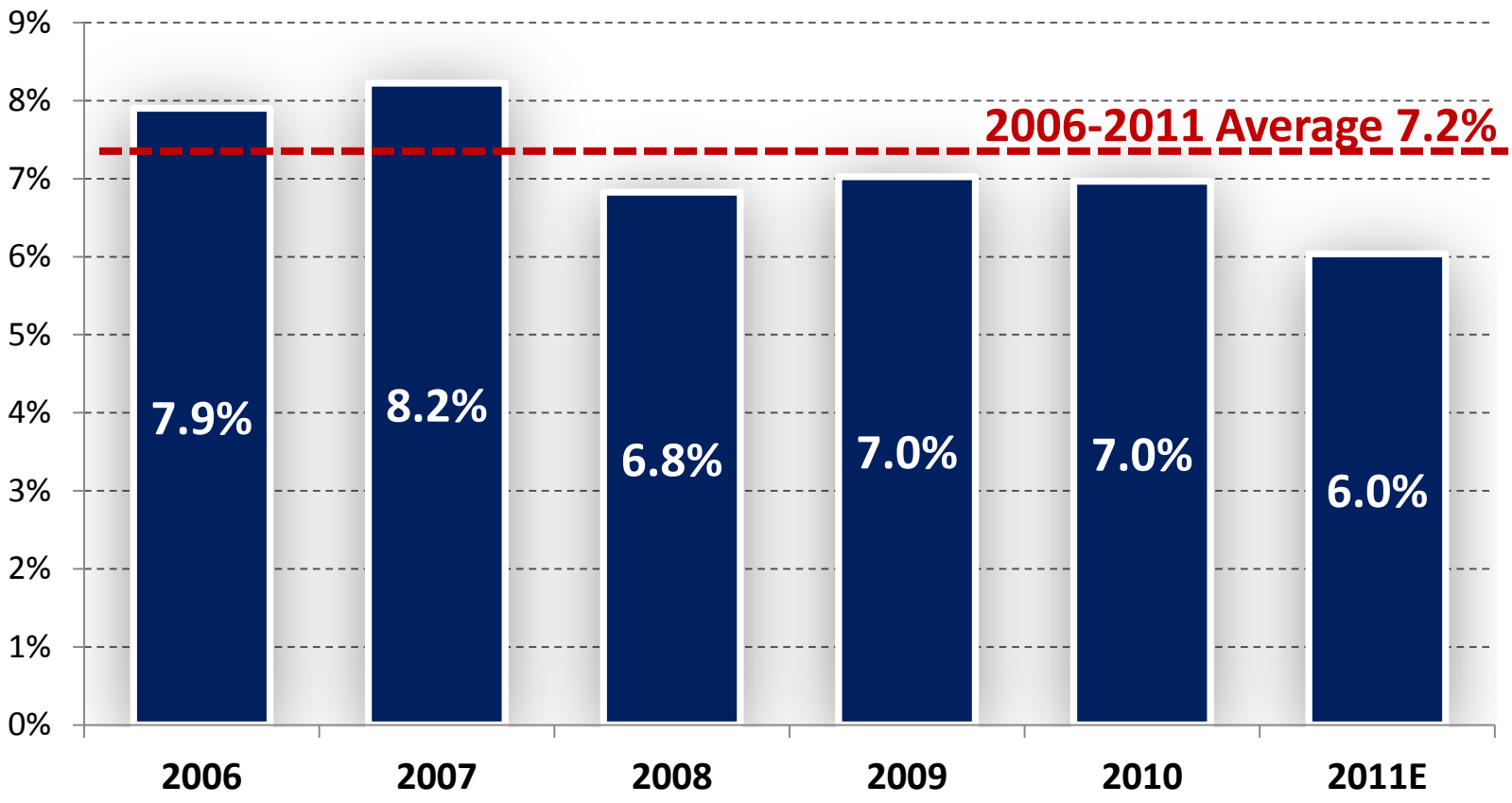
Start-up operations need capital

- Regulatory capital
- Systems development and configuration
- Start up costs/initial operating losses
- Direct Delivery set up
- Molina Medicaid Solutions development costs

MOLINA HEALTHCARE

Required regulatory capital as % of revenue

Required Equity as % of Premium Revenue
2006-2011E*



On average our health plans need regulatory capital of approximately 7% of premium revenue.

*E denotes estimate.
Source(s): Company Data

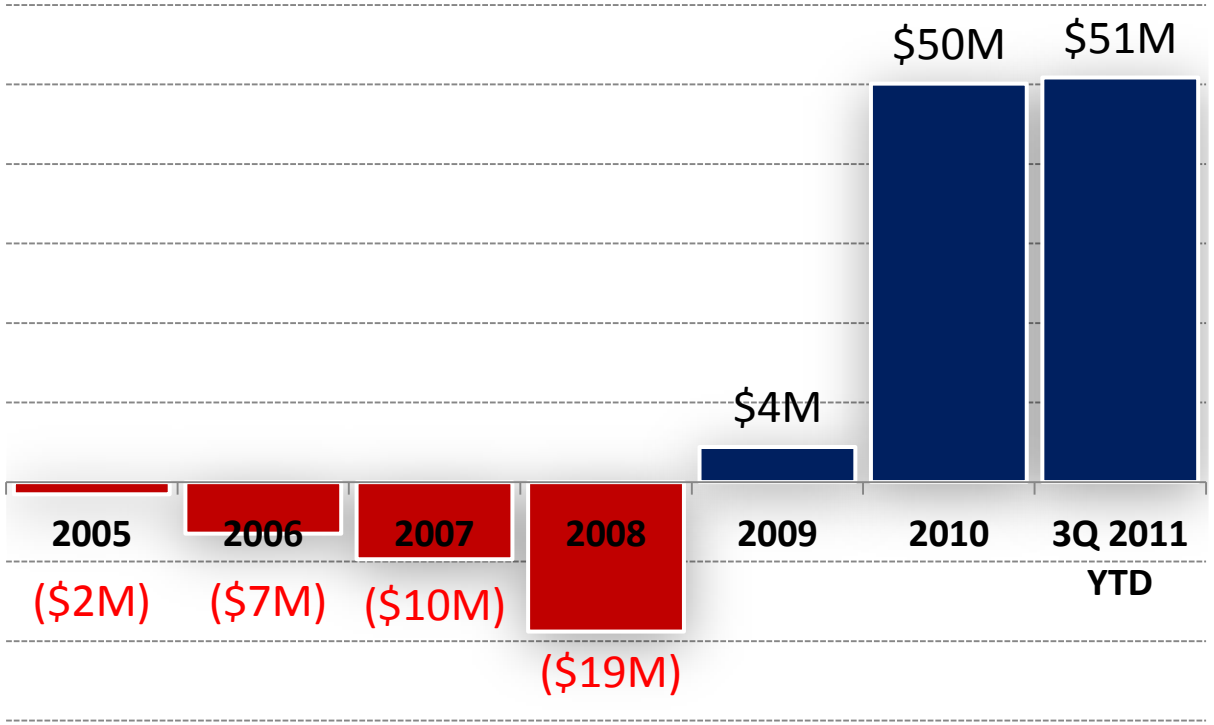
MOLINA HEALTHCARE

Startup costs and initial operating losses

"It takes time and money to build a profitable health plan."

Joseph White
May 29, 2008
Molina Healthcare
Investor Day, NY

Molina Healthcare of Ohio
Operating Income or (Loss)
2005-3Q 2011 YTD



Source(s): NAIC Statutory Filings

MOLINA HEALTHCARE

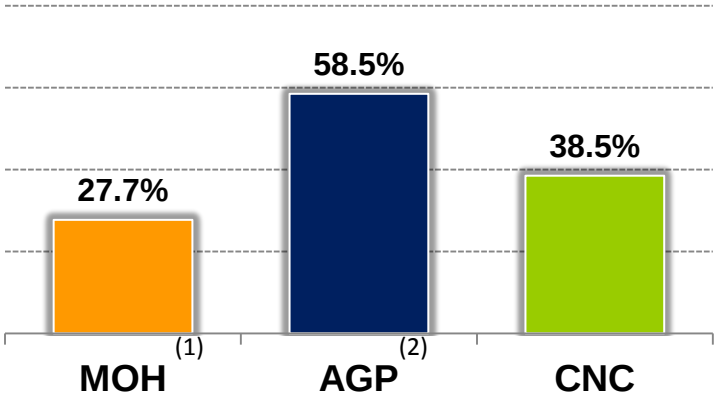
Other costs to start a health plan

- **Systems Development and Configuration**
  - Approximately $2M for HMO system development and configuration

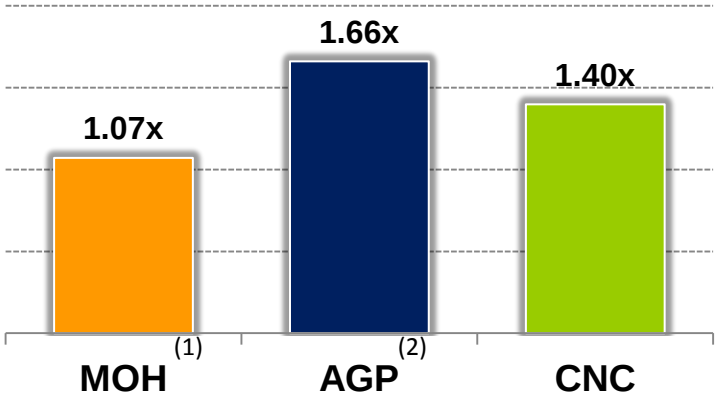
- **Direct Delivery set-up**
  - On average build out cost for a typical clinic is $750K

Access to additional capital

Pure Play LT Debt to Equity Ratio
Last Twelve Months as of Sept. 30, 2011 (1),(2)



Pure Play Long Term Debt / EBITDA
Last Twelve Months as of Sept. 30, 2011 (1),(2)



Note:
(1) MOH Long Term Debt includes $48.6M term loan issued December 7, 2011 to finance the Molina Center acquisition.
(2) AGP Long Term Debt includes $400M Senior Notes issued November 16, 2011 and $75M Senior Notes issued January 18, 2012.

Molina $170M Credit Agreement

usbank
UnionBank
CITY NATIONAL BANK The way up.
EAST WEST BANK
M&I
BANK OF ALBUQUERQUE LONG LIVE YOUR MONEY.
SANTA BARBARA BANK & TRUST
土地銀行 LAND BANK
華南銀行 HUA NAN BANK

Source(s): SEC Filings

MOLINA HEALTHCARE

Q&A

MOLINA HEALTHCARE

Your Extended Family.

Financial Outlook 2012

John Molina
Chief Financial Officer

January 26, 2012
New York, New York

MOH LISTED NYSE

Cautionary Statement

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation and our accompanying oral remarks contain "forward-looking statements" regarding the Company's expected results for fiscal year 2012. All of our forward-looking statements are based on our current expectations and assumptions. Actual results could differ materially due to the unexpected failure of our assumptions or due to adverse developments related to numerous risk factors, including but not limited to the following:

- uncertainty regarding the effect of our Washington health plan's being named an "apparently successful bidder" by the Health Care Authority of Washington in that state's recent managed care procurement;
- significant budget pressures on state governments which cause them to lower rates unexpectedly or to rescind expected rates increases, or their failure to maintain existing benefit packages or membership eligibility thresholds or criteria;
- uncertainties regarding the impact of the Patient Protection and Affordable Care Act, including its possible repeal, judicial overturning of the individual insurance mandate or Medicaid expansion, the effect of various implementing regulations, and uncertainties regarding the impact of other federal or state health care and insurance reform measures;
- management of our medical costs, including costs associated with unexpectedly severe or widespread illnesses such as influenza, and rates of utilization that are consistent with our expectations;
- the success of our efforts to retain existing government contracts and to obtain new government contracts in connection with state requests for proposals (RFPs) in both existing and new states, and our ability to grow our revenues consistent with our expectations;
- the accurate estimation of incurred but not reported medical costs across our health plans;
- risks associated with the continued growth in new Medicaid and Medicare enrollees, and in dual eligible members;
- retroactive adjustments to premium revenue or accounting estimates which require adjustment based upon subsequent developments;
- the continuation and renewal of the government contracts of both our health plans and Molina Medicaid Solutions and the terms under which such contracts are renewed;
- the timing of receipt and recognition of revenue and the amortization of expense under the state contracts of Molina Medicaid Solutions in Maine and Idaho;
- government audits and reviews;
- changes with respect to our provider contracts and the loss of providers;
- the establishment, interpretation, and implementation of a federal or state medical cost expenditure floor as a percentage of the premiums we receive, administrative cost and profit ceilings, and profit sharing arrangements;
- the interpretation and implementation of at-risk premium rules regarding the achievement of certain quality measures;
- the successful integration of our acquisitions;
- approval by state regulators of dividends and distributions by our health plan subsidiaries;
- changes in funding under our contracts as a result of regulatory changes, programmatic adjustments, or other reforms;
- high dollar claims related to catastrophic illness;
- the favorable resolution of litigation, arbitration, or administrative proceedings, and the costs associated therewith;
- restrictions and covenants in our credit facility;
- the availability of financing to fund and capitalize our acquisitions and start-up activities and to meet our liquidity needs and the costs and fees associated therewith;
- a state's failure to renew its federal Medicaid waiver;
- an inadvertent unauthorized disclosure of protected health information by us or our business associates;
- changes generally affecting the managed care or Medicaid management information systems industries;
- increases in government surcharges, taxes, and assessments;
- changes in general economic conditions, including unemployment rates;

and numerous other risk factors, including those identified within this slide presentation and/or our accompanying oral remarks, and those discussed in our periodic reports and filings with the Securities and Exchange Commission. These reports can be accessed under the investor relations tab of our Company website or on the SEC's website at www.sec.gov. Given these risks and uncertainties, we can give no assurances that our forward-looking statements will prove to be accurate, or that any other results or events projected or contemplated by our forward-looking statements will in fact occur, and we caution investors not to place undue reliance on these statements. All forward-looking statements in this release represent our judgment as of January 26, 2012, and we disclaim any obligation to update any forward-looking statements to conform the statement to actual results or changes in our expectations.

2012 EPS outlook

Please refer to the Company's cautionary statements.

$1.80

Guidance Issued January 26, 2012

- **Re-procurements in WA & MO**
- **Benefit carve-ins in TX and OH**
  - TX inpatient and pharmacy
  - Ohio full year of pharmacy
- **Change in mix: CA SPDs, TX STAR+PLUS & WA ABDs**
- **TX expansion commencing March 2012**
- **Continuing rate pressure**
- **Infrastructure build for 2012 and beyond**
  - Molina Center
  - ICD-10
  - Healthcare reform
  - Additional clinics

MOLINA HEALTHCARE

2012 guidance

Please refer to the Company's cautionary statements.

	2012G*
Premium Revenue	$5.9B
Service Revenue	$185M
Investment Income	$6M
Total Revenue	**$6.1B**
Medical Care Costs	$5.1B
Medical Care Ratio	**86%**
Service Costs	$158M
Service Revenue Ratio	85%
G&A Expense	$476M
G&A Ratio	**7.8%**
Premium Tax Expense	$169M
Depreciation	$35M
Amortization	$17M
Interest Expense	$17M
Income Before Tax	$137M
Net Income	**$85M**
Diluted EPS	**$1.80**
Weighted Average Diluted Shares Outstanding	47.3M
EBITDA	**$220M**
Effective Tax Rate	38%

Note: "G" denote guidance. Amounts are estimates and subject to change. Actual results may differ materially. See cautionary statement.

MOLINA HEALTHCARE

2012 MOH segment guidance

Please refer to the Company's cautionary statements.

	Health Plans	MMS	Total
Premium Revenue	$5.9B	--	$5.9B
Service Revenue	--	$185M	$185M
Investment Income	$6M	--	$6M
Total Revenue	**$5.9B**	**$185M**	**$6.1B**
Medical Care Costs	$5.1B	--	$5.1B
Medical Care Ratio	**86%**	**--**	**86%**
Service Costs	--	$158M	$158M
Service Revenue Ratio	--	85%	85%
G&A Expense	$471M	$5M	$476M
G&A Ratio	**--**	**--**	**7.8%**
Premium Tax Expense	$169M	--	$169M
Depreciation	$35M	--	$35M
Amortization	$12M	$5M	$17M
Interest Expense	$17M	--	$17M
Income Before Tax	$120M	$17M	$137M
Net Income	**$74M**	**$11M**	**$85M**
Diluted EPS	**--**	**--**	**$1.80**
Weighted Average Diluted Shares Outstanding	--	--	47.3M
EBITDA	$184M	$36M	$220M
Effective Tax Rate	--	--	38%

Note: "G" denote guidance. Amounts are estimates and subject to change. Actual results may differ materially. See cautionary statement.

MOLINA HEALTHCARE

Rate change update

Please refer to the Company's cautionary statements.

	2011 CARRYOVER		2012	
Health Plan	**Effective Date**	**Revenue Change**	**Effective Date**	**Revenue Change**
California	7/1/2011	(≈3.5%)	1/1/2012	≈0.5%(1)
	10/1/2011	(≈0.5%)	10/1/2012	no change(2)
Florida	9/1/2011	≈7.5%	9/1/2012	no change(2)
Michigan	10/1/2011	≈1.0%	10/1/2012	no change(2)
Missouri	7/1/2011	≈5.0%	7/1/2012	(≈0.5%)(2)
New Mexico	7/1/2011	(≈2.5%)	7/1/2012	no change(2)
Ohio	10/1/2011	≈27.0% (Rx carve in)	1/1/2012	(≈2.0%) (1)
Texas	9/1/2011	(≈2.0%)	3/1/2012	n/a(3)
Utah	7/1/2011	(≈2.0%)	7/1/2012	(≈1.5%) (2)
Washington	10/1/2011	(≈0.5%)	1/1/2012	(≈0.2%) (1)
	n/a	n/a	7/1/2012	n/a(3)
Wisconsin	1/1/2011	(11.0%)	1/1/2012	(≈7.5%) (2)

Note:
(1) Denotes known rate changes
(2) Denotes estimated rate changes excluding new business
(3) Rate changes not meaningful due to benefit carve ins and/or geographic population expansion

MOLINA HEALTHCARE

Texas expansion

	2012 Guidance
Effective Date	3/12
MOH Expected Membership Prior to Expansion[1]	155K
MOH Expected Additional Membership	170K
Total Expected MOH Membership[2]	**325K**
MOH Expected Market Penetration[2]	10%
MOH Expected Incremental Revenue	**$900M**

Note: Denotes guidance. Amounts are estimates and subject to change. Actual results may differ materially. See cautionary statements.

1. Denotes estimated membership at 2/29/12.
2. Denotes estimated membership at 12/31/12 .

MOLINA HEALTHCARE

Texas March 2012 – estimated impact of re-procurement

Line of Business	Dec 2011 Members	Dec 2011 Rates	Mar 2012 Members	Mar 2012 Rates
TOTAL STAR	18,000	$220	123,000	$235
TOTAL CHIP	73,000	$85	80,000	$130
TOTAL STAR PLUS	64,000	$440	100,000	$780
TOTAL	155,000	$250	303,000	$390

*Guidance assumes MCR of 90% FY 2012

MOLINA HEALTHCARE

Washington July 2012 – estimated impact of re-procurement

Line of Business	June 2012 Members	June 2012 Rates	July 2012 Members	July 2012 Rates
TANF	327,000	$160	288,000	$155
ABD	5,000	$850	12,000	$865
CHIP	11,000	$100	9,000	$95
State Funded - BHP	8,000	$225	6,000	$240
TOTAL	**351,000**	**$170**	**315,000**	**$180**

- Premium revenue excluding Medicare, is expected to drop approximately 10% year-over-year
- Guidance assumes MCR of 86% FY 2012

MOLINA HEALTHCARE

What could affect our 2012 number?

Potential headwinds:

- Premium rate decreases greater than projected
- Texas cost and utilization issues
- Less than anticipated enrollment in Texas
- Greater loss of enrollment than projected in WA
- Higher than projected ABD utilization in WA
- MO RFP outcome
- Revenue and cost pressures in Idaho and Maine
- Potential equity dilution from convertible bond (strike price $31.29)

MOLINA HEALTHCARE

What could affect our 2012 number?

Please refer to the Company's cautionary statements.

Potential tailwinds:

- Rate increases in markets where we are expecting none
- Cost and utilization improvement Texas
- Higher than projected enrollment in CA (ABD), TX and WA

MOLINA HEALTHCARE

Where is 2013 guidance?

Moving parts for 2013

- 2012 Supreme Court Decision on individual mandate and Medicaid expansion
- 2012 Presidential election
- Ohio RFP (goes into effect 1/2013)
- Florida expansion
- Georgia RFP
- Texas and Washington enrollment
- Dual eligible transitions
  - CA, OH, MI, WA

Sources: 1. http://www.kff.org/medicaid/upload/8215.pdf

MOLINA HEALTHCARE

Dual eligibles in Molina states

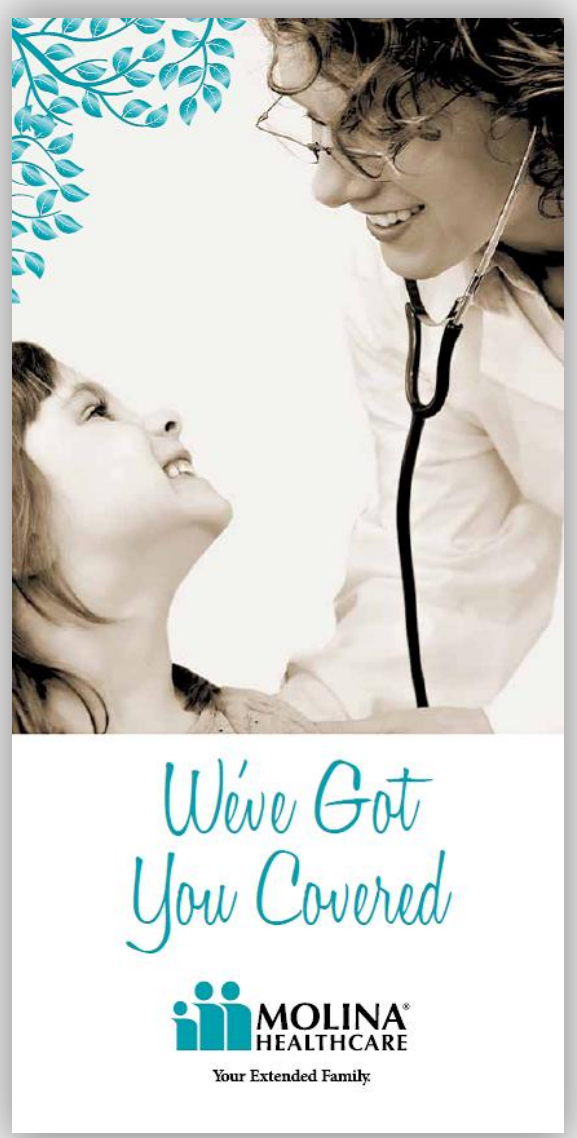
Approximately 40% of all duals in the United States reside in Molina states.

State	Total Dual Enrollment	As % of Total Medicaid Enrollment	Total Medicaid Expenditures for Duals (millions)	As % of Total Medicaid Spending	Per Person Spending for Duals	Per Person Medicaid Spending for Non-Disabled Adults
U.S.	8,896,020	15%	$120,520	39%	$15,459	$2,541
California	1,167,865	11%	$13,952	40%	$13,304	$969
Florida	560,967	20%	$5,253	38%	$10,935	$2,854
Michigan	257,837	14%	$3,285	37%	$14,826	$3,036
Missouri	169,391	17%	$2,253	37%	$15,864	$3,370
New Mexico	53,342	11%	$682	26%	$14,537	$3,356
Ohio	290,634	14%	$4,873	40%	$19,677	$2,844
Texas	609,468	15%	$6,014	30%	$10,797	$3,185
Utah	30,280	10%	$361	26%	$14,129	$2,940
Washington	144,224	12%	$1,920	34%	$15,722	$2,741
Wisconsin	215,227	22%	$2,748	55%	$14,542	$2,123

Source: CMS Fact Sheet, "People Enrolled in Medicare and Medicaid," May 2011.

Established programs position Molina to serve duals

Investment highlights



- Attractive sector growth prospects driven by government policies and economic conditions
- Proven flexible health care services portfolio (risk-based, fee-based and direct delivery)
- Diversified geographic exposure with significant presence in high growth regions
- Focus on government-sponsored health care programs
- Seasoned management team with strong track record of delivering earnings growth
- Over 30 years of experience

MOLINA HEALTHCARE

Q&A