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

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# Form 10-K

**(Mark One)**

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

**FOR THE FISCAL YEAR ENDED DECEMBER 31, 2017**

**or**

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

**Commission File Number 1-31719**

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

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| **Delaware** | **13-4204626** |
|---|---|
| **(State or other jurisdiction of incorporation or organization)** | **(I.R.S. Employer Identification No.)** |

**200 Oceangate, Suite 100, Long Beach, California 90802**
*(Address of principal executive offices)*
**(562) 435-3666**
*(Registrant's telephone number, including area code)*

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

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

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

**None**

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Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☒ Yes ☐ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
☐ Yes ☒ No

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

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

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

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

| | | | | |
|---|---|---|---|---|
| Large accelerated filer | ☒ | | Accelerated filer | ☐ |
| Non-accelerated filer | ☐ | (Do not check if a smaller reporting company) | Smaller reporting company | ☐ |
| Emerging growth company | ☐ | | | |

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. ☐

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

The aggregate market value of Common Stock held by non-affiliates of the registrant as of June 30, 2017, the last business day of our most recently completed second fiscal quarter, was approximately $2,952.7 million (based upon the closing price for shares of the registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 30, 2017).

As of February 23, 2018, approximately 59,727,000 shares of the registrant's Common Stock, $0.001 par value per share, were outstanding.

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**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the registrant's Proxy Statement for the 2018 Annual Meeting of Stockholders to be held on May 2, 2018, are incorporated by reference into Part III of this Form 10-K, to the extent described therein.

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(a) Incorporated by reference to “Executive Compensation” in the 2018 Proxy Statement.
(b) Incorporated by reference to “Security Ownership of Certain Beneficial Owners and Management” in the 2018 Proxy Statement.
(c) Incorporated by reference to “Related Party Transactions” and “Corporate Governance and Board of Directors Matters — Director Independence” in the 2018 Proxy Statement.
(d) Incorporated by reference to “Fees Paid to Independent Registered Public Accounting Firm” in the 2018 Proxy Statement.

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# FORWARD LOOKING STATEMENTS

*This Annual Report on Form 10-K (this "Form 10-K") contains forward-looking statements within the meaning of the Private Securities Litigation Reform Act of 1995 that involve risks and uncertainties. Many of the forward-looking statements are located under the heading "Management's Discussion and Analysis of Financial Condition and Results of Operations." Forward-looking statements provide current expectations of future events based on certain assumptions and include any statement that does not directly relate to any historical or current fact. Forward-looking statements can also be identified by words such as "future," "anticipates," "believes," "estimates," "expects," "intends," "plans," "predicts," "will," "would," "could," "can," "may," and similar terms. Forward-looking statements are not guarantees of future performance and the Company's actual results may differ significantly due to numerous known and unknown risks and uncertainties. Those known risks and uncertainties include, but are not limited to, the risk factors identified in the section of this Form 10-K titled "Risk Factors," as well as the following:*

- *the success of our profit improvement and maintenance initiatives, including the timing and amounts of the benefits realized, and administrative savings achieved;*
- *the numerous political and market-based uncertainties associated with the Affordable Care Act (the "ACA") or "Obamacare;"*
- *the market dynamics surrounding the ACA Marketplaces, including but not limited to uncertainties associated with risk transfer requirements, the potential for disproportionate enrollment of higher acuity members, the discontinuation of premium tax credits, the adequacy of agreed rates, and potential disruption associated with market withdrawal from Utah, Wisconsin, or other states;*
- *subsequent adjustments to reported premium revenue based upon subsequent developments or new information, including changes to estimated amounts payable or receivable related to Marketplace risk adjustment/risk transfer, risk corridors, and reinsurance;*
- *effective management of our medical costs;*
- *our ability to predict with a reasonable degree of accuracy utilization rates, including utilization rates associated with seasonal flu patterns or other newly emergent diseases;*
- *significant budget pressures on state governments and their potential inability to maintain current rates, to implement expected rate increases, or to maintain existing benefit packages or membership eligibility thresholds or criteria;*
- *the full reimbursement of the ACA health insurer fee, or HIF;*
- *the success of our efforts to retain existing government contracts, including those in Florida, New Mexico, Puerto Rico, Texas, and Washington, including the success of any protest filings;*
- *our ability to manage our operations, including maintaining and creating adequate internal systems and controls relating to authorizations, approvals, provider payments, and the overall success of our care management initiatives;*
- *our ability to consummate and realize benefits from acquisitions or divestitures;*
- *our receipt of adequate premium rates to support increasing pharmacy costs, including costs associated with specialty drugs and costs resulting from formulary changes that allow the option of higher-priced non-generic drugs;*
- *our ability to operate profitably in an environment where the trend in premium rate increases lags behind the trend in increasing medical costs;*
- *the interpretation and implementation of federal or state medical cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit sharing arrangements, and risk adjustment provisions and requirements;*
- *our estimates of amounts owed for such cost expenditure floors, administrative cost and profit ceilings, premium stabilization programs, profit-sharing arrangements, and risk adjustment provisions;*
- *the Medicaid expansion cost corridors in California, New Mexico, and Washington, and any other retroactive adjustment to revenue where methodologies and procedures are subject to interpretation or dependent upon information about the health status of participants other than Molina members;*
- *the interpretation and implementation of at-risk premium rules and state contract performance requirements regarding the achievement of certain quality measures, and our ability to recognize revenue amounts associated therewith;*
- *cyber-attacks or other privacy or data security incidents resulting in an inadvertent unauthorized disclosure of protected health information;*
- *the success of our health plan in Puerto Rico, including the resolution of the Puerto Rico debt crisis, payment of all amounts due under our Medicaid contract, the effect of the PROMESA law, the impact of Hurricane Maria and our efforts to better manage the health care costs of our Puerto Rico health plan;*

- *the success and renewal of our duals demonstration programs in California, Illinois, Michigan, Ohio, South Carolina, and Texas;*
- *the accurate estimation of incurred but not reported or paid medical costs across our health plans;*
- *efforts by states to recoup previously paid and recognized premium amounts;*
- *complications, member confusion, or enrollment backlogs related to the annual renewal of Medicaid coverage;*
- *government audits and reviews, or potential investigations, and any fine, sanction, enrollment freeze, monitoring program, or premium recovery that may result therefrom;*
- *changes with respect to our provider contracts and the loss of providers;*
- *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;*
- *the relatively small number of states in which we operate health plans, including the greater scale and revenues of our California, Ohio, Texas, and Washington health plans;*
- *the availability of adequate financing on acceptable terms to fund and capitalize our expansion and growth, repay our outstanding indebtedness at maturity and meet our liquidity needs, including the interest expense and other costs associated with such financing;*
- *our failure to comply with the financial or other covenants in our credit agreement, our bridge credit agreement or the indentures governing our outstanding notes;*
- *the sufficiency of our funds on hand to pay the amounts due upon conversion or maturity of our outstanding notes;*
- *the failure of a state in which we operate to renew its federal Medicaid waiver;*
- *changes generally affecting the managed care or Medicaid management information systems industries;*
- *increases in government surcharges, taxes, and assessments, including but not limited to the deductibility of certain compensation costs;*
- *newly emergent viruses or widespread epidemics, public catastrophes or terrorist attacks, and associated public alarm; and*
- *increasing competition and consolidation in the Medicaid industry.*

*Each of the terms "Molina Healthcare,Inc." "Molina Healthcare," "Company," "we," "our," and "us," as used herein, refers collectively to Molina Healthcare, Inc. and its wholly owned subsidiaries, unless otherwise stated. The Company assumes no obligation to revise or update any forward-looking statements for any reason, except as required by law.*

# ABOUT MOLINA HEALTHCARE

Molina Healthcare, Inc. provides managed health care services under the Medicaid and Medicare programs and through the state insurance marketplaces. Through our health plans operating across the nation and in the Commonwealth of Puerto Rico, we serve approximately 4.5 million members.

2017 was a year of great change for Molina Healthcare. On May 2, 2017, after several disappointing quarters in which we continued to underperform relative to our own internal financial metrics and to the managed care sector as a whole, the board terminated the employment of Dr. J. Mario Molina, our former president and chief executive officer, and John C. Molina, our former chief financial officer. Our former chief accounting officer, Joseph W. White, was promoted to chief financial officer and interim president and chief executive officer, while the board launched a search for a permanent president and chief executive officer. Effective as of November 6, 2017, Joseph M. Zubretsky was named as president and chief executive officer of Molina Healthcare. Over the past ten months, the executive management team has been largely restructured.

## 2017

**(Dollars in millions, except per-share amounts)**

| Total Revenue | Net Loss per Diluted Share | Adjusted Net Loss Per Share* |
|---|---|---|
| $19,883 | ($9.07) | ($8.72) |
| **Net Loss Margin** | **EBITDA*** | **Ending Membership** |
| (2.6)% | ($329) | 4,453,000 |

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Non-generally accepted accounting principles (Non-GAAP) financial measures referred to in this Form 10-K are designated with an asterisk (*). For more information, see “Management’s Discussion and Analysis of Financial Condition and Results of Operations (MD&A)—Non-GAAP Financial Measures,” and “MD&A—Supplemental Information.”

## OUR MISSION

Our mission is to provide quality healthcare to people receiving government assistance.

## OUR BUSINESS STRATEGY

### We are building a plan to improve and sustain profitability

Our margin recovery and sustainability plan is designed to:

- Restore margins through operational improvements and managed care fundamentals
- Optimize the revenue base for profitability and future revenue growth
- Enhance balance sheet and capital management discipline

### Restore margins through operational improvements and managed care fundamentals

In 2017, we changed leadership, restructured our workforce to better meet the needs of our business, and improved our cost structure. As described further below in “Consolidated Results–Fiscal Year 2017 Financial Summary,” and in the Notes to the Consolidated Financial Statements, Note 15, “Restructuring and Separation Costs,” in 2017 we implemented a comprehensive restructuring and profitability improvement plan that will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. As of December 31, 2017, we achieved $235 million of these run-rate reductions on an annualized basis.

*We have reconfigured our organization.* By reducing the workforce and number of management layers, and increasing management’s span of control, we have achieved significant savings.

*We are simplifying our provider networks.* We are terminating or renegotiating high-cost providers, narrowing networks in certain geographies, evaluating stop-loss thresholds and carve-outs, implementing value-based

contracting, evaluating ancillary services and pharmacy benefit management pricing and operations, and we have exited direct delivery operations.

*We are improving the effectiveness of utilization review and care management*. Areas of focus include specialist referrals, pre-authorization, concurrent review, high acuity populations and high utilizers of services, emergency room utilization and behavioral and medical integration.

*We are addressing at-risk revenues and risk adjustment.* We seek to more effectively engage in state rate setting, improve STAR ratings, increase retention of quality revenue withholds, and focus on coding and documentation to achieve risk scores commensurate with the acuity of our population.

*We are improving our claims payment function*. The key areas of improvement will include provider experience, payment accuracy and oversight of claims fraud, waste and abuse.

*We are evaluating information technology and management*. We seek to standardize the administrative platform, streamline operations and procedures, evaluate potential co-sourcing and/or outsource operational components, and consolidate data warehousing and data mining capabilities.

## Optimize revenue base for profitability and future revenue growth

*We will focus on defending existing revenue.*

- In early 2018, we received the disappointing news that we were unsuccessful in defending all of our New Mexico Medicaid business and most of our Florida Medicaid business during state re-procurements.
    - We will lodge the necessary protests and appeals to ensure that we have exhausted every avenue available to us for retaining the managed care contracts currently held by our Florida and New Mexico health plans.
    - In addition, we have taken significant steps to improve our RFP response process to better articulate and present the Molina value proposition. Steps we have taken include marshaling more internal and external resources to support the RFP process, engaging a broader and deeper array of subject matter experts, infusing more local market knowledge into the process, and retaining outside experts in Medicaid procurement to pre-score our proposals and conduct mock reviews.
- We have also experienced some success in the pursuit of new revenue and the defense of existing revenue:
    - In May 2017, our Washington health plan was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North-Central region of the state's Apple Health Integrated Managed Care Program. The new contract commenced January 1, 2018.
    - In June 2017, Molina Healthcare of Mississippi, Inc. was awarded a Medicaid Coordinated Care Contract for the statewide administration of the Mississippi Coordinated Access Network (MississippiCAN). The operational start date for the program is currently scheduled for October 1, 2018, pending the completion of a readiness review. The initial term of the contract is through June 2020, with options to renew annually for up to two additional years.
    - In August 2017, our Illinois health plan was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the state's three current managed care programs into one program. The contract began January 1, 2018, and will continue for four years with options to renew annually for up to four additional years.

*We will consider opportunistic revenue growth opportunities only if specific parameters are met.* Such parameters include a positive regulatory environment, manageable competitive forces, network viability, the ability to leverage scale and operations, and a scalable population.

*We will continue to identify opportunities for significant performance improvement.* The under-performing geographies and lines of business we have identified are under intense review for performance improvement to ensure that every product and geography contributes to the portfolio.

*We have taken decisive action with respect to our Affordable Care Act (ACA) Marketplace products*. Effective January 1, 2018, we have:

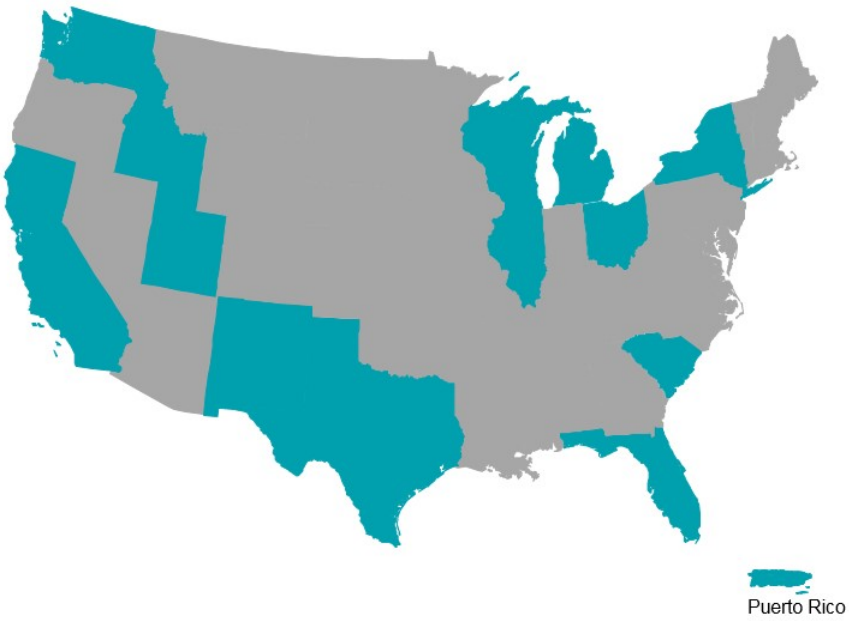
- Exited the Utah and Wisconsin Marketplaces;
- Reduced the scope of our Washington state Marketplace participation;
- Increased premiums averaging 58%; and
- Mitigated our exposure to uncertainties relating to cost sharing reduction (CSR) funding and reconciliation.

## Enhance balance sheet and capital management discipline

We are taking steps to improve reserving accuracy, increase tangible net equity, reduce the cost of borrowing, maximize the dividend capacity of our subsidiaries, maximize parent company liquidity and cash flow, deploy excess capital in a balanced manner, and reduce the optionality in our capital structure.

## OUR CORE BUSINESS FOOTPRINT TODAY

As of December 31, 2017, our health plan footprint included the five largest Medicaid markets.




## OUR SEGMENTS

We manage our operations through three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment. We regularly evaluate the appropriateness of our reportable segments, particularly in light of organizational changes, acquisition and divestiture activity, and changing laws and regulations. Therefore, these reportable segments may change in the future.

Business and financial overviews for our reportable segments are provided in “MD&A—Reportable Segments.”

Refer to Notes to Consolidated Financial Statements, Note 2, “Significant Accounting Policies” for revenue information by state health plan, and Note 20, “Segment Information,” for segment revenue, profit and total assets information.

## COMPETITIVE CONDITIONS AND ENVIRONMENT

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

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

For further competitor information specific to each of our reportable segments, refer to "MD&A—Reportable Segments."

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

## NON-GAAP FINANCIAL MEASURES

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

See further information regarding non-GAAP measures in the "Supplemental Information" section of this MD&A, including the reconciliations to U.S. GAAP. Non-GAAP financial measures referred to in this Form 10-K are designated with an asterisk (*).

## KEY PERFORMANCE INDICATORS

(Dollars in millions except per-share amounts, membership in millions)

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| Ending total membership | 4.5 | 4.2 | 3.5 |
| | | | |
| Premium revenue | $ 18,854 | $ 16,445 | $ 13,261 |
| Health Plans segment medical margin [1] | $ 1,781 | $ 1,671 | $ 1,467 |
| Operating (loss) income | $ (555) | $ 306 | $ 387 |
| | | | |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| Net (loss) income per diluted share | $ (9.07) | $ 0.92 | $ 2.58 |
| Diluted weighted average shares outstanding | 56.5 | 56.3 | 55.6 |
| | | | |
| Adjusted net (loss) income per diluted share* | $ (8.72) | $ 1.28 | $ 2.78 |
| EBITDA* | $ (329) | $ 467 | $ 508 |
| | | | |
| **Operating Statistics:** | | | |
| Medical care ratio [2] | 90.6 % | 89.8% | 88.9% |
| G&A ratio [3] | 8.0 % | 7.8% | 8.1% |
| Premium tax ratio [2] | 2.3 % | 2.8% | 2.9% |
| Effective income tax (benefit) expense rate | (16.4)% | 74.8% | 55.5% |
| Net (loss) profit margin [3] | (2.6)% | 0.3% | 1.0% |

(1) Medical margin is equal to premium revenue minus medical costs.
(2) Medical care ratio represents medical care costs as a percentage of premium revenue; premium tax ratio represents premium tax expenses as a percentage of premium revenue plus premium tax revenue.
(3) G&A ratio represents general and administrative expenses as a percentage of total revenue. Net (loss) profit margin represents net (loss) income as a percentage of total revenue.

See discussion of Key Performance Indicators in the “Consolidated Results” and “Reportable Segments” sections of this MD&A.

# CONSOLIDATED RESULTS

## FISCAL YEAR 2017 FINANCIAL SUMMARY

- Net loss per diluted share was $9.07 in 2017 compared with net income per diluted share of $0.92 in 2016.
- Adjusted net loss per diluted share* was $8.72 in 2017 compared with adjusted net income per diluted share* of $1.28 in 2016.
- The medical care ratio increased to 90.6% in 2017, from 89.8% in 2016.
- The general and administrative ratio increased to 8.0% in 2017, from 7.8% in 2016.
- We recorded a $73 million charge as a result of the federal government’s decision to stop paying cost sharing reduction rebates (CSRs) to health plans beginning in the fourth quarter of 2017. We believe we are legally entitled to those payments, and will pursue all available means to collect them.
- We recorded $47 million in charges for Marketplace changes in estimates, including risk adjustment and CSRs, related to 2016 dates of service that were estimated at December 31, 2016, and finalized during the second quarter of 2017.
- We recognized the $30 million release of the Marketplace-related premium deficiency reserve we had established as of December 31, 2016.

- We incurred non-cash impairment losses of $470 million in 2017. These losses included $269 million, primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management's determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago.

  Also during 2017, we recorded impairment losses of $28 million for our Molina Medicaid Solutions segment because management determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment than previously anticipated. In addition, we recorded impairment losses of $173 million for our Other segment, primarily relating to our Pathways business, because management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.
- We incurred restructuring and separation costs of $234 million in 2017 as a result of the implementation of our restructuring and profit improvement plan in 2017 (the 2017 Restructuring Plan). As previously disclosed, we estimate that our 2017 Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. As of December 31, 2017, we achieved $235 million of these run-rate reductions by the elimination of administrative costs (some of which are classified as medical care costs) on an annualized basis. As of December 31, 2017 we had also achieved an undetermined amount of medical care cost savings on an annualized basis through the re-negotiation of various medical provider contracts and the restructuring of our direct delivery operations. We expect to have more visibility into the actual value of these medical care cost savings later in 2018. We incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017.
- We incurred $14 million in expenses, including transaction fees, relating to our exchange of equity for $141 million face value of our 1.625% convertible senior notes.
- We recognized $75 million of other income for fees we received in connection with the termination of a proposed Medicare acquisition in early 2017.
- We recognized approximately $54 million in additional tax expense during the fourth quarter, due to the revaluation of our deferred tax assets as a result of the Tax Cuts and Jobs Act of 2017.

The following table summarizes significant items affecting 2017 financial results (in millions, except per diluted share amounts).

| | Year Ended December 31, 2017 | |
|---|---|---|
| | Amount | Per Diluted Share [1] |
| Termination of CSR subsidy payments for the fourth quarter of 2017 | $ 73 | $ 0.82 |
| Marketplace adjustments related to risk adjustment, CSR subsidies, and other items for 2016 dates of service | 47 | 0.52 |
| Change in Marketplace premium deficiency reserve for 2017 dates of service | (30) | (0.33) |
| Impairment losses | 470 | 6.01 |
| Restructuring and separation costs | 234 | 2.86 |
| Loss on debt extinguishment | 14 | 0.24 |
| Fee received for terminated Medicare acquisition | (75) | (0.84) |
| | $ 733 | $ 9.28 |

(1) Amounts shown are before considering revaluation of related deferred tax assets as a result of the *Tax Cuts and Jobs Act of 2017*, as applicable. Except for certain items that are not deductible for tax purposes, per diluted share amounts are generally calculated at a statutory income tax rate of 37%, which is in excess of the effective tax rate recorded in our consolidated statements of operations.

# TRENDS AND UNCERTAINTIES

## Medicaid Contract Re-Procurement

The following table illustrates Health Plans segment Medicaid contracts scheduled for re-procurement in the near term. While we have been notified of the Medicaid regulators' intention to re-procure the contracts, the anticipated award dates and effective dates are management's current best estimates; such dates are subject to change. Premium revenue is stated in millions.

| Health Plan | Medicaid Program(s) | Membership as of December 31, 2017 | Premium Revenue Year Ended December 31, 2017 | Anticipated Award Date | Anticipated Effective Date |
|---|---|---|---|---|---|
| Puerto Rico | All | 314,000 | $ 732 | Q2 2018 | 10/1/2018 |
| Texas | ABD, MMP | 100,000 | $ 1,814 | Q3 2018 | 1/1/2020 |
| Washington [1] | All in 7 of 9 regions | 574,000 | $ 1,861 | Q2 2018 | 1/1/2019 |

(1) The re-procurement information presented for the Washington health plan includes all Medicaid membership in the following regions: Northeast, Northwest, Central and Southeast, Pierce County, King County, Olympic Peninsula, and West-Central. Five of the seven largest regions' contracts that are awarded will be effective January 1, 2019. The remaining two will be effective on January 1, 2020.

*Florida Health Plan.* On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served approximately 360,000 Medicaid members in Florida, which represented approximately $1,486 million premium revenue for the year ended December 31, 2017. This decision does not affect the Florida health plan's current contracts with AHCA, which run through December 31, 2018. We recorded impairment losses in connection with this event. Refer to the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," for further information regarding all impairment losses recorded in 2017.

*New Mexico Health Plan.* In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico, which represented approximately $1,205 million premium revenue for the year ended December 31, 2017. This decision does not affect the New Mexico plan's current contract with HSD which runs through December 31, 2018. We recorded impairment losses in connection with this event.

*Illinois Health Plan.* In August 2017, our Illinois health plan was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the state's three current managed care programs into one program. The contract began January 1, 2018, and will continue for four years with options to renew annually for up to four additional years.

*Washington Health Plan.* In May 2017, our Washington health plan was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North-Central region of the state's Apple Health Integrated Managed Care Program. The new contract commenced January 1, 2018.

## Pressures on Medicaid Funding

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following:

- Ending the entitlement nature of Medicaid by capping future increases in federal health spending for these programs, and shifting more of the risk for health costs in the future to states and consumers;
- Reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults;
- Changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap");

- Requiring Medicaid beneficiaries to work;
- Limiting the amount of lifetime benefits for Medicaid beneficiaries; and
- Numerous other potential changes and reforms.

### ACA and the Marketplace

The future of the Affordable Care Act (ACA) and its underlying programs, including the Marketplace, is subject to substantial uncertainty. Effective January 1, 2018, we have:

- Exited the Utah and Wisconsin Marketplaces;
- Reduced the scope of our Washington state Marketplace participation;
- Increased premiums averaging 58%;
- Mitigated our exposure to uncertainties relating to cost sharing reduction (CSR) funding and reconciliation; and
- Adjusted broker commissions to market rates.

As a result of these actions, we estimate that our ACA Marketplace membership will decline to approximately 300,000 members by the end of 2018, from 815,000 members as of December 31, 2017.

# REPORTABLE SEGMENTS

## HOW WE ASSESS PERFORMANCE

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

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

Gross margin for our Health Plans segment is referred to as "Medical margin," and for our Molina Medicaid Solutions and Other segments, as "Service margin." The service margin is equal to service revenue minus cost of service revenue. Management's discussion and analysis of the changes in the individual components of medical margin and service margin follows.

## SEGMENT SUMMARY

| | 2017 | 2016 | 2015 |
|---|---|---|---|
| | | (In millions) | |
| Health Plans segment medical margin [1] | $ 1,781 | $ 1,671 | $ 1,467 |
| Molina Medicaid Solutions segment service margin [2] | 16 | 21 | 55 |
| Other segment service margin [2] | 13 | 33 | 5 |
| | $ 1,810 | $ 1,725 | $ 1,527 |
| | | | |
| Health Plans segment medical care ratio | 90.6% | 89.8% | 88.9% |

(1) Represents premium revenue minus medical care costs.
(2) Represents service revenue minus cost of service revenue.

# HEALTH PLANS

## BUSINESS OVERVIEW

- 97.3% of total revenue in 2017
- 96.9% of total revenue in 2016
- Employees: approximately 5,300

***Our Industry***

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

The federal government guarantees matching funds to states for qualifying Medicaid expenditures based on each state's federal medical assistance percentage (FMAP). A state's FMAP is calculated annually and varies inversely with average personal income in the state. The average FMAP across all jurisdictions is currently about 59%, and ranges from a federally established FMAP floor of 50% to as high as 75%.

We participate in the following Medicaid programs:

- Temporary Assistance for Needy Families, or TANF - The most common Medicaid program, covers primarily low-income families with children.
- Aged, Blind or Disabled, or ABD - Medicaid ABD programs cover low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries typically use more services than those served by other Medicaid programs because of their critical health issues.
- Children's Health Insurance Program, or CHIP - A joint federal and state matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage. States have the option of administering CHIP through their Medicaid programs.
- Medicaid Expansion - In states that have elected to participate, Medicaid Expansion provides eligibility to nearly all low-income individuals under age 65 with incomes at or below 138% of the federal poverty line.

*Marketplace.* The ACA authorized the creation of Marketplace insurance exchanges, allowing individuals and small groups to purchase health insurance that is federally subsidized, effective January 1, 2014. We participate in the Marketplace in California, Florida, Michigan, New Mexico, Ohio, Texas and Washington. As previously announced, we exited the Utah and Wisconsin ACA Marketplaces effective January 1, 2018.

*Medicare.* Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance, and prescription drug benefits. Medicare is funded by Congress, and administered by the Centers for Medicare and Medicaid Services (CMS). Medicare beneficiaries may enroll in a Medicare Advantage plan, under which managed care plans contract with CMS to provide benefits that are comparable to original Medicare. Such benefits are provided in exchange for a fixed per-member per-month (PMPM) premium payment that varies based on the county in which a member resides, the demographics of the member, and the member's health condition. Since 2006, Medicare beneficiaries have had the option of selecting a new prescription drug benefit from an existing Medicare Advantage plan. The drug benefit, available to beneficiaries for a monthly premium, is subject to certain cost sharing depending upon the specific benefit design of the selected plan.

*Medicare-Medicaid Plans, or MMPs*. Approximately nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs. These beneficiaries are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage. Medicaid supplements Medicare by paying for services not covered by Medicare, such as dental care and long-term care services and support, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligible"), and to

deliver services to these individuals in a more financially efficient manner, some states have undertaken demonstration programs to integrate Medicare and Medicaid services for dual eligible individuals. The health plans participating in such demonstrations are referred to as MMPs. We operate MMPs in six states.

***Significant Trends and Developments***

Refer to the discussion above, in the “Consolidated Results,” and also below, in “Financial Performance by Program” sections of this MD&A.

***Competition***

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

***Regulation***

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

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

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

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

*Regulatory Capital Requirements and Dividend Restrictions.* Our health plans are subject to stringent minimum capitalization requirements that limit their ability to pay dividends to us. For further information, refer to the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

***Quality***

Our long-term success depends, in large part, on the quality of the services we provide. As of December 31, 2017, 11 of our 13 health plans were accredited by the National Committee for Quality Assurance (NCQA), including the Multicultural Health Care Distinction, which is awarded to organizations that meet or exceed its rigorous requirements for multicultural health care.

The table below presents our health plans’ NCQA status, as well as their scores as part of the CMS 2017 Star Ratings, which measures the quality of Medicare plans across the country using a 5-star rating system.

We believe that these objective measures of quality are important to state Medicaid agencies, as a growing number of states link reimbursement and patient assignment to quality scores. Additionally, Medicare pays quality bonuses to health plans that achieve high quality.

| State | NCQA Health Plan Accreditation | NCQA Multicultural Healthcare Distinction | NCQA Health Insurance Plan Rating 2017-2018 (Medicaid) | Medicare Star Rating 2018 |
|---|---|---|---|---|
| California | Marketplace – Accredited<br>Medicaid – Commendable | Marketplace & Medicaid | 3.0 ★★★☆☆ | 3.0 ★★★☆☆ |
| Florida | Marketplace – Accredited<br>Medicaid – Commendable | Marketplace & Medicaid | 3.0 ★★★☆☆ | 3.0 ★★★☆☆ |
| Illinois | Medicaid – Accredited | Medicaid | 3.0 ★★★☆☆ | not applicable |
| Michigan | Marketplace – Accredited<br>Medicaid – Commendable | Marketplace & Medicaid | 3.5 ★★★½☆ | 3.0 ★★★☆☆ |
| New Mexico | Marketplace – Accredited<br>Medicaid – Commendable | Marketplace & Medicaid | 3.0 ★★★☆☆ | 3.0 ★★★☆☆ |
| Ohio | Marketplace – Accredited<br>Medicaid – Accredited | Marketplace & Medicaid | 3.5 ★★★½☆ | 2.5 ★★½☆☆ (Part D Only) |
| South Carolina | Medicaid – Commendable | Medicaid | 3.0 ★★★☆☆ | not applicable |
| Texas | Marketplace – Accredited<br>Medicaid – Commendable | Marketplace & Medicaid | 3.5 ★★★½☆ | 3.0 ★★★☆☆ |
| Utah | Medicaid – Commendable | Medicaid | 3.5 ★★★½☆ | 3.5 ★★★½☆ |
| Washington | Marketplace – Accredited<br>Medicaid – Commendable | Marketplace & Medicaid | 3.5 ★★★½☆ | 3.0 ★★★☆☆ |
| Wisconsin | Medicaid – Commendable | Medicaid | 3.5 ★★★½☆ | 3.5 ★★★½☆ |

***Programs and Services***

As of December 31, 2017, the Health Plans segment consisted of health plans operating in 12 states and the Commonwealth of Puerto Rico. These health plans served approximately 4.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

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

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

***Basis for our Premium Rates***

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

*Medicare.* Under Medicare Advantage, managed care plans contract with CMS to provide benefits in exchange for a fixed PMPM premium payment that varies based on the county in which a member resides, and adjusted for demographic and health risk factors. CMS also considers inflation, changes in utilization patterns and average per capita fee-for-service Medicare costs in the calculation of the fixed PMPM premium payment. Amounts payable to us under the Medicare Advantage contracts are subject to annual revision by CMS, and we elect to participate in each Medicare service area or region on an annual basis. Medicare Advantage premiums paid to us are subject to

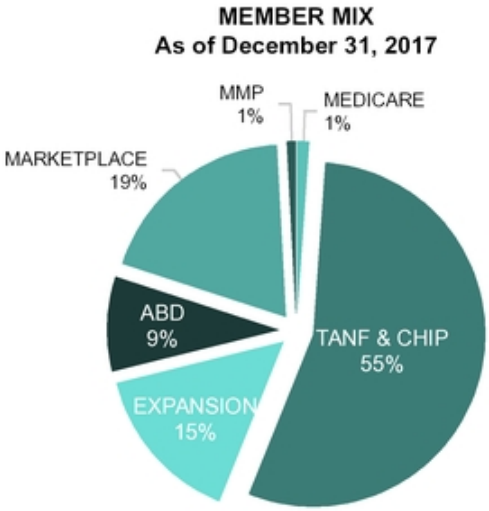
federal government reviews and audits which can result, and have resulted, in retroactive and prospective premium adjustments. Compared with our Medicaid plans, Medicare Advantage contracts generate higher average PMPM revenues and health care costs.

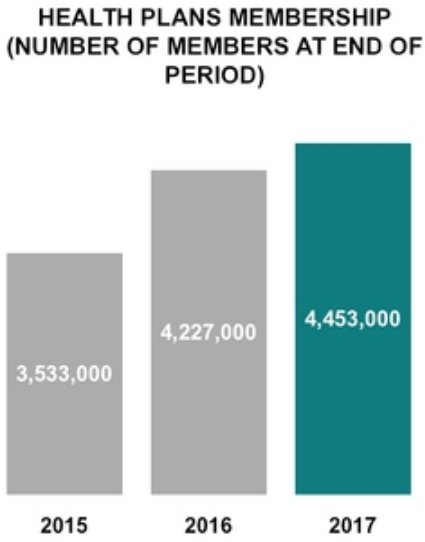
*Marketplace*. For our Marketplace plans, we develop premium rates during the spring of each year for policies effective in the following calendar year. Premium rates are based on our estimates of projected member utilization, medical unit costs, member risk acuity, member risk transfer, and administrative costs, with the intent of realizing a target pretax percentage profit margin. Our actuaries certify the actuarial soundness of Marketplace premiums in the rate filings submitted to the various state and federal authorities for approval.

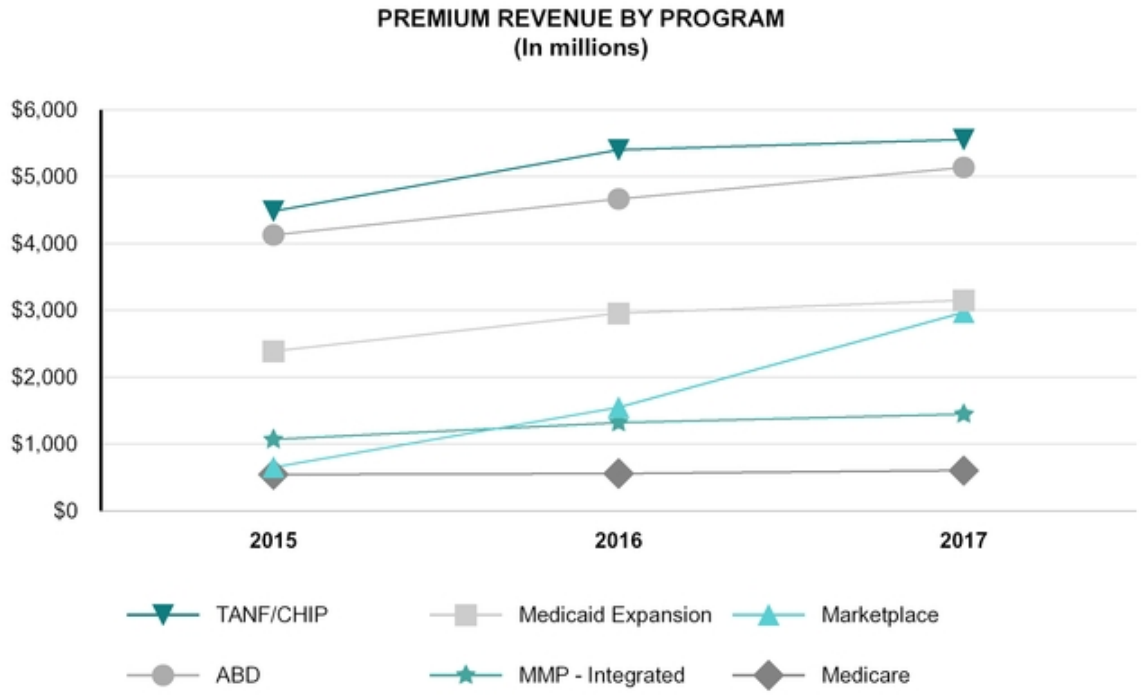
***Premiums by Program***

The amount of the premiums paid to our health plans may vary substantially between states and among various government programs. The following table sets forth the ranges of premiums paid to our state health plans by program on a PMPM basis, for the year ended December 31, 2017. The “Consolidated” column represents the weighted-average amounts for our total membership by program.

| | PMPM Premiums | | |
|---|---|---|---|
| | Low | High | Consolidated |
| TANF and CHIP | $ 110.00 | $ 290.00 | $ 180.00 |
| Marketplace | 180.00 | 480.00 | 270.00 |
| Medicaid Expansion | 320.00 | 510.00 | 390.00 |
| ABD | 380.00 | 1,460.00 | 1,050.00 |
| MMP – Integrated | 1,290.00 | 3,230.00 | 2,180.00 |
| Medicare | 940.00 | 1,250.00 | 1,140.00 |




PREMIUM REVENUE BY PROGRAM
(In millions)
$6,000
$5,000
$4,000
$3,000
$2,000
$1,000
$0
2015
2016
2017
TANF/CHIP
Medicaid Expansion
Marketplace
ABD
MMP - Integrated
Medicare

***Membership by Program and Health Plan***

The following tables set forth our health plans' membership as of the dates indicated:

| | As of December 31, | | |
|---|---|---|---|
| | **2017** | **2016** | **2015** |
| **Ending Membership by Program:** | | | |
| TANF and CHIP | 2,457,000 | 2,536,000 | 2,312,000 |
| Marketplace | 815,000 | 526,000 | 205,000 |
| Medicaid Expansion | 668,000 | 673,000 | 557,000 |
| ABD | 412,000 | 396,000 | 366,000 |
| MMP – Integrated | 57,000 | 51,000 | 51,000 |
| Medicare | 44,000 | 45,000 | 42,000 |
| | 4,453,000 | 4,227,000 | 3,533,000 |
| | | | |
| **Ending Membership by Health Plan:** | | | |
| California | 746,000 | 683,000 | 620,000 |
| Florida [(1)] | 625,000 | 553,000 | 440,000 |
| Illinois | 165,000 | 195,000 | 98,000 |
| Michigan | 398,000 | 391,000 | 328,000 |
| New Mexico [(2)] | 253,000 | 254,000 | 231,000 |
| New York [(3)] | 32,000 | 35,000 | — |
| Ohio | 327,000 | 332,000 | 327,000 |
| Puerto Rico | 314,000 | 330,000 | 348,000 |
| South Carolina | 116,000 | 109,000 | 99,000 |
| Texas | 430,000 | 337,000 | 260,000 |
| Utah | 152,000 | 146,000 | 102,000 |
| Washington | 777,000 | 736,000 | 582,000 |
| Wisconsin | 118,000 | 126,000 | 98,000 |
| | 4,453,000 | 4,227,000 | 3,533,000 |

(1) On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served a total of approximately 360,000 Medicaid members in Florida.

(2) In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico.

(3) The New York health plan was acquired on August 1, 2016.

# FINANCIAL OVERVIEW

2017 Compared with 2016

In 2017, a 10% increase in membership, and a 5% increase in revenue PMPM, resulted in increased premium revenue of 15%, or $2.4 billion, when compared with 2016.

The medical care ratio increased to 90.6% in 2017, from 89.8% in 2016. Medical margin (measured in absolute dollars) increased 7% in 2017 over 2016. Our 2017 medical care ratio of 90.6% was burdened by substantial unfavorable out-of-period items, including:

- Approximately $150 million of medical margin deterioration resulting from unfavorable prior period claims development, the related need to replenish margins for adverse development in our liability for medical claims and benefits payable, and increased reserves for premiums we expect to repay to state Medicaid agencies; and
- Approximately $90 million of unfavorable Marketplace items, most notably the lack of CSR reimbursement in the fourth quarter of 2017.

Absent these items, our medical care ratio for 2017 would have been approximately 89.3%.

2016 Compared with 2015

In 2016, a 27% increase in membership, partially offset by a 3% decrease in revenue PMPM, resulted in increased premium revenue of 24%, or $3.2 billion, when compared with 2015.

The medical care ratio increased to 89.8% in 2016, from 88.9% in 2015. The increase in our medical care ratio was driven primarily by Marketplace membership. Medical margin (measured in absolute dollars) increased 14% in 2016 over 2015. The medical care ratio of all of our programs excluding Marketplace decreased by 10 basis points between 2015 and 2016, as decreasing margins in Medicaid Expansion (where we saw a 300 basis point increase in our medical care ratio) were offset by improved margins in other programs. Consolidated medical care costs measured on a PMPM basis decreased approximately 3% in 2016 when compared with 2015.

## FINANCIAL PERFORMANCE BY PROGRAM

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

| | Year Ended December 31, 2017 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months [1] | Premium Revenue | | Medical Care Costs | | MCR [2] | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| TANF and CHIP | 30.2 | $ 5,554 | $ 183.75 | $ 5,111 | $ 169.09 | 92.0% | $ 443 |
| Medicaid Expansion | 8.1 | 3,150 | 388.42 | 2,674 | 329.73 | 84.9 | 476 |
| ABD | 4.9 | 5,135 | 1,050.41 | 4,863 | 994.80 | 94.7 | 272 |
| Total Medicaid | 43.2 | 13,839 | 320.16 | 12,648 | 292.61 | 91.4 | 1,191 |
| MMP | 0.7 | 1,446 | 2,177.72 | 1,317 | 1,982.36 | 91.0 | 129 |
| Medicare | 0.5 | 601 | 1,143.63 | 493 | 939.67 | 82.2 | 108 |
| Total Medicare | 1.2 | 2,047 | 1,722.47 | 1,810 | 1,523.15 | 88.4 | 237 |
| Core operations | 44.4 | 15,886 | 357.68 | 14,458 | 325.53 | 91.0 | 1,428 |
| Marketplace | 10.8 | 2,968 | 274.47 | 2,615 | 241.84 | 88.1 | 353 |
| | 55.2 | $ 18,854 | $ 341.39 | $ 17,073 | $ 309.14 | 90.6% | $ 1,781 |

| | Year Ended December 31, 2016 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months [1] | Premium Revenue | | Medical Care Costs | | MCR [2] | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| TANF and CHIP | 30.2 | $ 5,403 | $ 179.21 | $ 4,950 | $ 164.18 | 91.6% | $ 453 |
| Medicaid Expansion | 7.8 | 2,952 | 378.58 | 2,475 | 317.37 | 83.8 | 477 |
| ABD | 4.7 | 4,666 | 991.24 | 4,277 | 908.39 | 91.6 | 389 |
| Total Medicaid | 42.7 | 13,021 | 305.28 | 11,702 | 274.33 | 89.9 | 1,319 |
| MMP | 0.6 | 1,321 | 2,160.94 | 1,141 | 1,866.93 | 86.4 | 180 |
| Medicare | 0.5 | 558 | 1,063.44 | 515 | 981.36 | 92.3 | 43 |
| Total Medicare | 1.1 | 1,879 | 1,653.73 | 1,656 | 1,457.67 | 88.1 | 223 |
| Core operations | 43.8 | 14,900 | 340.28 | 13,358 | 305.03 | 89.6 | 1,542 |
| Marketplace | 6.7 | 1,545 | 231.38 | 1,416 | 212.17 | 91.7 | 129 |
| | 50.5 | $ 16,445 | $ 325.87 | $ 14,774 | $ 292.75 | 89.8% | $ 1,671 |

| | Year Ended December 31, 2015 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months [1] | Premium Revenue | | Medical Care Costs | | MCR [2] | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| TANF and CHIP | 25.5 | $ 4,483 | $ 175.64 | $ 4,122 | $ 161.50 | 92.0% | $ 361 |
| Medicaid Expansion | 5.9 | 2,389 | 408.51 | 1,931 | 330.18 | 80.8 | 458 |
| ABD | 4.3 | 4,124 | 966.83 | 3,784 | 887.27 | 91.8 | 340 |
| Total Medicaid | 35.7 | 10,996 | 308.54 | 9,837 | 276.05 | 89.5 | 1,159 |
| MMP | 0.5 | 1,066 | 2,040.08 | 974 | 1,863.93 | 91.4 | 92 |
| Medicare | 0.5 | 546 | 1,069.17 | 502 | 982.50 | 91.9 | 44 |
| Total Medicare | 1.0 | 1,612 | 1,560.08 | 1,476 | 1,428.18 | 91.5 | 136 |
| Core operations | 36.7 | 12,608 | 343.80 | 11,313 | 308.51 | 89.7 | 1,295 |
| Marketplace | 2.6 | 653 | 252.58 | 481 | 185.85 | 73.6 | 172 |
| | 39.3 | $ 13,261 | $ 337.79 | $ 11,794 | $ 300.43 | 88.9% | $ 1,467 |

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

## 2017 TRENDS

*Medicaid TANF, CHIP and ABD.* TANF represented approximately 40% of our total Medicaid revenue in 2017, with a medical care ratio of 92.0%. Keys to the cost-effective delivery of care to TANF members include:

- Effective utilization controls and care management, particularly with respect to high-risk pregnancies; and
- Reducing unit costs of high-cost providers.

Our ABD program represented approximately 37% of our total Medicaid revenue in 2017, with a medical care ratio of 94.7%. Keys to the cost-effective delivery of care to ABD members include:

- Improved care management and coordination of services for high acuity populations, focusing on the integration of behavioral and physical health services;
- Targeting high risk members for care management intervention and more comprehensive documentation of medical conditions; and
- Improved management of community and other long-term care services for members in this program.

*Medicaid Expansion.* Medicaid Expansion represented approximately 23% of our total Medicaid revenue in 2017, with a medical care ratio of 84.9%. This program continues to contribute favorably to our overall profitability and was responsible for approximately 40% of our total Medicaid medical margin for 2017. While premiums and margins for Medicaid Expansion have been declining in recent years, the rating environment appears to have stabilized.

*Marketplace.* The Marketplace 2017 medical care ratio was 88.1%. As noted above, the Marketplace program was burdened in 2017 by a net $90 million unfavorable impact from various Marketplace CSR, risk adjustment and premium deficiency reserve items. In response to profitability challenges, effective January 1, 2018, we exited the Marketplaces entirely in Utah and Wisconsin while also limiting our presence in Washington. Also effective January 1, 2018, we increased Marketplace premium rates by an average of 58%.

2017 Compared with 2016

*Medicaid TANF and CHIP.* The performance of TANF and CHIP was very consistent between 2017 and 2016, with flat enrollment, a premium revenue increase of approximately 3%; and an increase in the medical care ratio to 92.0% in 2017, from 91.6% in 2016.

*Medicaid ABD.* ABD enrollment grew approximately 4% in 2017 compared with 2016, while premium revenue grew by approximately 10%. The medical care ratio for our ABD membership deteriorated to 94.7% in 2017, from 91.6% in 2016. The deterioration in medical cost performance was most notable in Michigan, New Mexico and Texas.

*Medicaid Expansion.* Medicaid Expansion enrollment grew approximately 4% in 2017 compared with 2016, while premium revenue grew by approximately 7%. The medical care ratio for our Medicaid Expansion membership deteriorated to 84.9% in 2017 from 83.8% in 2016. Reduced premium rates in California were the primary driver of declining performance in 2017.

*MMP and Medicare.* MMP and Medicare enrollment and premium combined grew by approximately 9% in 2017 compared with 2016. The medical care ratio for this membership increased 30 basis points from 2016 to 2017.

*Marketplace.* Marketplace enrollment increased over 60% in 2017 compared with 2016, while premium revenue increased over 90%. Despite a decrease in the medical care ratio of 360 basis points in 2017 compared with 2016, our Marketplace program still failed to meet expectations in 2017.

2016 Compared with 2015

*Medicaid TANF, CHIP and ABD.* TANF, CHIP and ABD revenue increased in 2016 when compared with 2015, due to health plan acquisitions in late 2015 and 2016, as well as inclusion of a full year of Puerto Rico operations in 2016 (Puerto Rico began operations effective April 1, 2015). The slight decline in the medical care ratio for these programs on a consolidated basis when comparing 2016 with 2015 is not significant given normal margin fluctuations observed when performance is reviewed at this level of detail.

*Medicaid Expansion.* Member months increased 33% in 2016, when compared with 2015, as a result of membership growth in all states. Lower premium revenue PMPM more than offset lower medical costs PMPM, leading to an increase in the consolidated medical care ratio for the Medicaid Expansion program. Medicaid Expansion medical care ratios increased in Illinois, Michigan, New Mexico and Ohio.

*MMP and Medicare.* Membership and revenue increased on a consolidated basis for the MMP and Medicare programs when comparing 2016 with 2015. The medical care ratio for these programs, in the aggregate, decreased due to higher margins for the MMP program.

*Marketplace. O*ur Marketplace program performed poorly in 2016. The medical care ratio of our Marketplace membership increased to 91.7% in 2016, from 73.6% in 2015. This decline in profitability was the result of lower premium revenue PMPM, the recording of a $30 million premium deficiency reserve at December 31, 2016, and higher medical costs PMPM.

The poor performance of our Marketplace program in 2016 was exacerbated by the federal government's failure to pay amounts owed to our health plans under the Marketplace risk corridor program. We believe our health plans are owed approximately $76 million in Marketplace risk corridor payments for 2016 dates of service, but have not recorded any amounts associated with this claim.

# FINANCIAL PERFORMANCE BY STATE HEALTH PLAN

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

***Health Plans Segment Financial Data — Core Operations (Medicaid and Medicare Combined)***

| | Year Ended December 31, 2017 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 7.4 | $ 2,392 | $ 321.46 | $ 2,117 | $ 284.53 | 88.5% | $ 275 |
| Florida | 4.3 | 1,522 | 350.15 | 1,461 | 335.97 | 96.0 | 61 |
| Illinois | 2.1 | 593 | 286.69 | 638 | 308.41 | 107.6 | (45) |
| Michigan | 4.6 | 1,545 | 334.22 | 1,360 | 294.15 | 88.0 | 185 |
| New Mexico | 2.9 | 1,258 | 439.95 | 1,166 | 407.94 | 92.7 | 92 |
| New York [1] | 0.4 | 181 | 449.85 | 170 | 424.17 | 94.3 | 11 |
| Ohio | 3.9 | 2,130 | 544.98 | 1,894 | 484.66 | 88.9 | 236 |
| Puerto Rico [1] | 3.8 | 732 | 190.13 | 691 | 179.65 | 94.5 | 41 |
| South Carolina | 1.4 | 445 | 328.41 | 412 | 304.04 | 92.6 | 33 |
| Texas | 2.8 | 2,150 | 769.82 | 1,978 | 708.20 | 92.0 | 172 |
| Utah | 1.1 | 355 | 316.44 | 290 | 258.96 | 81.8 | 65 |
| Washington | 8.9 | 2,445 | 275.64 | 2,143 | 241.55 | 87.6 | 302 |
| Wisconsin | 0.8 | 131 | 168.64 | 107 | 136.84 | 81.1 | 24 |
| Other [2] | — | 7 | — | 31 | — | — | (24) |
| | 44.4 | $ 15,886 | $ 357.68 | $ 14,458 | $ 325.53 | 91.0% | $ 1,428 |

| | Year Ended December 31, 2016 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 7.4 | $ 2,247 | $ 304.83 | $ 1,900 | $ 257.72 | 84.5% | $ 347 |
| Florida | 4.1 | 1,348 | 329.58 | 1,227 | 299.94 | 91.0 | 121 |
| Illinois | 2.3 | 603 | 258.72 | 568 | 243.71 | 94.2 | 35 |
| Michigan | 4.7 | 1,517 | 324.18 | 1,339 | 286.00 | 88.2 | 178 |
| New Mexico | 2.8 | 1,245 | 440.63 | 1,162 | 411.30 | 93.3 | 83 |
| New York [1] | 0.2 | 82 | 446.72 | 79 | 431.73 | 96.6 | 3 |
| Ohio | 3.9 | 1,927 | 490.71 | 1,718 | 437.56 | 89.2 | 209 |
| Puerto Rico [1] | 4.0 | 726 | 180.65 | 694 | 172.57 | 95.5 | 32 |
| South Carolina | 1.3 | 378 | 296.58 | 320 | 250.97 | 84.6 | 58 |
| Texas | 2.9 | 2,182 | 744.65 | 1,926 | 657.38 | 88.3 | 256 |
| Utah | 1.1 | 344 | 297.68 | 296 | 256.31 | 86.1 | 48 |
| Washington | 8.1 | 2,146 | 263.50 | 1,936 | 237.66 | 90.2 | 210 |
| Wisconsin | 1.0 | 142 | 165.95 | 106 | 123.44 | 74.4 | 36 |
| Other [2] | — | 13 | — | 87 | — | — | (74) |
| | 43.8 | $ 14,900 | $ 340.28 | $ 13,358 | $ 305.03 | 89.6% | $ 1,542 |

| | Year Ended December 31, 2015 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 6.9 | 2,163 | $ 314.73 | $ 1,901 | $ 276.57 | 87.9% | $ 262 |
| Florida | 2.4 | 802 | 333.18 | 801 | 333.02 | 100.0 | 1 |
| Illinois | 1.2 | 398 | 329.48 | 367 | 303.72 | 92.2 | 31 |
| Michigan | 3.4 | 1,068 | 318.95 | 901 | 268.91 | 84.3 | 167 |
| New Mexico | 2.7 | 1,226 | 450.16 | 1,097 | 402.85 | 89.5 | 129 |
| New York [1] | — | — | — | — | — | — | — |
| Ohio | 4.0 | 2,025 | 500.15 | 1,710 | 422.43 | 84.5 | 315 |
| Puerto Rico [1] | 3.2 | 567 | 178.31 | 505 | 158.80 | 89.1 | 62 |
| South Carolina | 1.3 | 348 | 267.25 | 278 | 213.30 | 79.8 | 70 |
| Texas | 3.0 | 1,918 | 639.47 | 1,778 | 592.95 | 92.7 | 140 |
| Utah | 1.1 | 318 | 293.42 | 285 | 263.18 | 89.7 | 33 |
| Washington | 6.6 | 1,586 | 241.84 | 1,454 | 221.75 | 91.7 | 132 |
| Wisconsin | 0.9 | 148 | 157.14 | 113 | 120.06 | 76.4 | 35 |
| Other [2] | — | 41 | — | 123 | — | — | (82) |
| | 36.7 | $ 12,608 | $ 343.80 | $ 11,313 | $ 308.51 | 89.7% | $ 1,295 |

***Health Plans Segment Financial Data — Marketplace***

| | Year Ended December 31, 2017 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 1.7 | $ 309 | $ 185.88 | $ 231 | $ 138.61 | 74.6% | $ 78 |
| Florida | 3.6 | 1,046 | 293.35 | 1,009 | 283.17 | 96.5 | 37 |
| Michigan | 0.3 | 51 | 180.26 | 38 | 135.64 | 75.2 | 13 |
| New Mexico | 0.3 | 110 | 349.50 | 84 | 264.14 | 75.6 | 26 |
| Ohio | 0.2 | 86 | 363.24 | 81 | 340.44 | 93.7 | 5 |
| Texas | 2.6 | 663 | 250.08 | 517 | 195.20 | 78.1 | 146 |
| Utah | 0.9 | 180 | 215.93 | 178 | 213.33 | 98.8 | 2 |
| Washington | 0.5 | 163 | 317.39 | 156 | 304.74 | 96.0 | 7 |
| Wisconsin | 0.7 | 360 | 477.53 | 327 | 433.98 | 90.9 | 33 |
| Other [2] | — | — | — | (6) | — | — | 6 |
| | 10.8 | $ 2,968 | $ 274.47 | $ 2,615 | $ 241.84 | 88.1% | $ 353 |

| | Year Ended December 31, 2016 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 0.8 | $ 131 | $ 166.01 | $ 129 | $ 164.35 | 99.0% | $ 2 |
| Florida | 2.6 | 590 | 228.65 | 538 | 208.53 | 91.2 | 52 |
| Michigan | — | 10 | 232.88 | 6 | 154.32 | 66.3 | 4 |
| New Mexico | 0.2 | 60 | 287.37 | 47 | 223.85 | 77.9 | 13 |
| Ohio | 0.1 | 40 | 348.06 | 29 | 254.78 | 73.2 | 11 |
| Texas | 1.4 | 279 | 208.48 | 184 | 137.13 | 65.8 | 95 |
| Utah | 0.7 | 103 | 166.21 | 127 | 204.14 | 122.8 | (24) |
| Washington | 0.3 | 76 | 272.48 | 79 | 284.87 | 104.5 | (3) |
| Wisconsin | 0.6 | 256 | 363.54 | 282 | 399.51 | 109.9 | (26) |
| Other [2] | — | — | — | (5) | — | — | 5 |
| | 6.7 | $ 1,545 | $ 231.38 | $ 1,416 | $ 212.17 | 91.7% | $ 129 |

| | Year Ended December 31, 2015 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 0.2 | $ 37 | $ 179.77 | $ 25 | $ 124.68 | 69.4% | $ 12 |
| Florida | 1.7 | 397 | 229.85 | 280 | 162.04 | 70.5 | 117 |
| Michigan | — | 4 | 212.70 | 2 | 124.35 | 58.5 | 2 |
| New Mexico | 0.1 | 11 | 242.42 | 9 | 185.13 | 76.4 | 2 |
| Ohio | 0.1 | 10 | 399.81 | 8 | 290.81 | 72.7 | 2 |
| Texas | 0.1 | 45 | 286.78 | 31 | 197.41 | 68.8 | 14 |
| Utah | 0.1 | 16 | 221.00 | 15 | 202.41 | 91.6 | 1 |
| Washington | — | 19 | 369.59 | 16 | 301.94 | 81.7 | 3 |
| Wisconsin | 0.3 | 114 | 403.08 | 102 | 362.28 | 89.9 | 12 |
| Other [2] | — | — | — | (7) | — | — | 7 |
| | 2.6 | $ 653 | $ 252.58 | $ 481 | $ 185.85 | 73.6% | $ 172 |

***Health Plans Segment Financial Data — Total***

| | Year Ended December 31, 2017 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 9.1 | $ 2,701 | $ 296.68 | $ 2,348 | $ 257.86 | 86.9% | $ 353 |
| Florida | 7.9 | 2,568 | 324.56 | 2,470 | 312.18 | 96.2 | 98 |
| Illinois | 2.1 | 593 | 286.69 | 638 | 308.41 | 107.6 | (45) |
| Michigan | 4.9 | 1,596 | 325.43 | 1,398 | 285.11 | 87.6 | 198 |
| New Mexico | 3.2 | 1,368 | 430.97 | 1,250 | 393.67 | 91.3 | 118 |
| New York [1] | 0.4 | 181 | 449.85 | 170 | 424.17 | 94.3 | 11 |
| Ohio | 4.1 | 2,216 | 534.56 | 1,975 | 476.39 | 89.1 | 241 |
| Puerto Rico [1] | 3.8 | 732 | 190.13 | 691 | 179.65 | 94.5 | 41 |
| South Carolina | 1.4 | 445 | 328.41 | 412 | 304.04 | 92.6 | 33 |
| Texas | 5.4 | 2,813 | 516.84 | 2,495 | 458.50 | 88.7 | 318 |
| Utah | 2.0 | 535 | 273.55 | 468 | 239.49 | 87.5 | 67 |
| Washington | 9.4 | 2,608 | 277.93 | 2,299 | 245.01 | 88.2 | 309 |
| Wisconsin | 1.5 | 491 | 320.71 | 434 | 283.14 | 88.3 | 57 |
| Other [2] | — | 7 | — | 25 | — | — | (18) |
| | 55.2 | $ 18,854 | $ 341.39 | $ 17,073 | $ 309.14 | 90.6% | $ 1,781 |

| | Year Ended December 31, 2016 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | MCR | Medical Margin |
| | | Total | PMPM | Total | PMPM | | |
| California | 8.2 | $ 2,378 | $ 291.41 | $ 2,029 | $ 248.70 | 85.3% | $ 349 |
| Florida | 6.7 | 1,938 | 290.56 | 1,765 | 264.60 | 91.1 | 173 |
| Illinois | 2.3 | 603 | 258.72 | 568 | 243.71 | 94.2 | 35 |
| Michigan | 4.7 | 1,527 | 323.36 | 1,345 | 284.82 | 88.1 | 182 |
| New Mexico | 3.0 | 1,305 | 430.15 | 1,209 | 398.49 | 92.6 | 96 |
| New York [1] | 0.2 | 82 | 446.72 | 79 | 431.73 | 96.6 | 3 |
| Ohio | 4.0 | 1,967 | 486.66 | 1,747 | 432.36 | 88.8 | 220 |
| Puerto Rico [1] | 4.0 | 726 | 180.65 | 694 | 172.57 | 95.5 | 32 |
| South Carolina | 1.3 | 378 | 296.58 | 320 | 250.97 | 84.6 | 58 |
| Texas | 4.3 | 2,461 | 576.69 | 2,110 | 494.41 | 85.7 | 351 |
| Utah | 1.8 | 447 | 251.63 | 423 | 238.03 | 94.6 | 24 |
| Washington | 8.4 | 2,222 | 263.80 | 2,015 | 239.21 | 90.7 | 207 |
| Wisconsin | 1.6 | 398 | 255.30 | 388 | 248.28 | 97.2 | 10 |
| Other [2] | — | 13 | — | 82 | — | — | (69) |
| | 50.5 | $ 16,445 | $ 325.87 | $ 14,774 | $ 292.75 | 89.8% | $ 1,671 |

| | Year Ended December 31, 2015 | | | | | | |
|---|---|---|---|---|---|---|---|
| | Member Months | Premium Revenue | | Medical Care Costs | | | |
| | | Total | PMPM | Total | PMPM | MCR | Medical Margin |
| California | 7.1 | $ 2,200 | $ 310.86 | $ 1,926 | $ 272.22 | 87.6% | $ 274 |
| Florida | 4.1 | 1,199 | 289.95 | 1,081 | 261.49 | 90.2 | 118 |
| Illinois | 1.2 | 398 | 329.48 | 367 | 303.72 | 92.2 | 31 |
| Michigan | 3.4 | 1,072 | 318.47 | 903 | 268.27 | 84.2 | 169 |
| New Mexico | 2.8 | 1,237 | 446.47 | 1,106 | 398.98 | 89.4 | 131 |
| New York [1] | — | — | — | — | — | — | — |
| Ohio | 4.1 | 2,035 | 499.52 | 1,718 | 421.61 | 84.4 | 317 |
| Puerto Rico [1] | 3.2 | 567 | 178.31 | 505 | 158.80 | 89.1 | 62 |
| South Carolina | 1.3 | 348 | 267.25 | 278 | 213.30 | 79.8 | 70 |
| Texas | 3.1 | 1,963 | 621.97 | 1,809 | 573.32 | 92.2 | 154 |
| Utah | 1.2 | 334 | 288.83 | 300 | 259.32 | 89.8 | 34 |
| Washington | 6.6 | 1,605 | 242.82 | 1,470 | 222.36 | 91.6 | 135 |
| Wisconsin | 1.2 | 262 | 213.95 | 215 | 176.01 | 82.3 | 47 |
| Other [2] | — | 41 | — | 116 | — | — | (75) |
| | 39.3 | $ 13,261 | $ 337.79 | $ 11,794 | $ 300.43 | 88.9% | $ 1,467 |

(1) The New York health plan was acquired on August 1, 2016. Our Puerto Rico health plan began serving members on April 1, 2015.
(2) "Other" medical care costs include primarily medically related administrative costs of the parent company, and direct delivery costs.

## MEDICAL CARE COSTS BY TYPE

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. The following table provides the details of consolidated medical care costs by type for the periods indicated (dollars in millions except PMPM amounts):

| | Year Ended December 31, | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2017 | | | 2016 | | | 2015 | | |
| | Amount | PMPM | % of Total | Amount | PMPM | % of Total | Amount | PMPM | % of Total |
| Fee for service | $ 12,682 | $ 229.63 | 74.3% | $ 10,993 | $ 217.84 | 74.4% | $ 8,572 | $ 218.35 | 72.7% |
| Pharmacy | 2,563 | 46.40 | 15.0 | 2,213 | 43.84 | 15.0 | 1,610 | 41.01 | 13.7 |
| Capitation | 1,360 | 24.63 | 8.0 | 1,218 | 24.13 | 8.2 | 982 | 25.02 | 8.3 |
| Direct delivery | 73 | 1.33 | 0.4 | 78 | 1.55 | 0.5 | 128 | 3.26 | 1.1 |
| Other | 395 | 7.15 | 2.3 | 272 | 5.39 | 1.9 | 502 | 12.79 | 4.2 |
| | $ 17,073 | $ 309.14 | 100.0% | $ 14,774 | $ 292.75 | 100.0% | $ 11,794 | $ 300.43 | 100.0% |

## PREMIUM TAXES

The premium tax ratio (premium tax expense as a percentage of premium revenue plus premium tax revenue) was 2.3% in 2017, 2.8% in 2016, and 2.9% in 2015. The decreases in the premium tax ratio were primarily due to the significant revenue growth at our Florida health plan in 2017 and 2016, which operates in a state with no premium tax, and growth in MMP revenue. The Medicare portion of MMP revenue is not subject to premium tax.

## HEALTH INSURER FEES (HIF)

The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there were no health insurer fees reimbursed, nor health insurer fees incurred, in 2017.

HIF reimbursed, as a percentage of premium revenue, was consistent at 1.8% in 2016 and 2015.

## IMPAIRMENT LOSSES

In 2017, we incurred $269 million of impairment losses related to our Health Plans segment, primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management's determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago.

# MOLINA MEDICAID SOLUTIONS

## BUSINESS OVERVIEW

- 1.0% of total revenue in 2017
- 1.1% of total revenue in 2016
- Employees: approximately 1,200

***Programs and Services***

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with Medicaid agencies in six states, and the U.S. Virgin Islands. Our existing state Medicaid management information system (MMIS) contracts have terms that currently extend to 2018 through 2025, before renewal options.

***Competition and Regulation***

Molina Medicaid Solutions competes with large MMIS vendors, such as DXC Technology Company, Conduent, Inc. and CNSI. Molina Medicaid Solutions' contracts with state government customers may include unique and specialized performance requirements. In particular, contracts with state government customers are subject to various procurement regulations, contract provisions, and other requirements relating to their formation, administration, and performance.

## FINANCIAL OVERVIEW

2017 Compared with 2016

The year over year change in service margin was insignificant to our consolidated results of operations.

As discussed further in the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," in 2017 we recorded goodwill impairment losses of $28 million.

2016 Compared with 2015

Service margin declined $34 million in 2016 compared with 2015, primarily due to increased service costs associated with legacy state contracts that were re-procured.

# OTHER

## BUSINESS OVERVIEW

- 1.7% of total revenue in 2017
- 2.0% of total revenue in 2016
- Employees: Corporate – approximately 7,100; Pathways – approximately 6,000

***Programs and Services***

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

We acquired the outstanding ownership interests in Pathways Health and Community Support, LLC (Pathways), formerly known as Providence Human Services, LLC, in late 2015. Substantially all of Pathways' revenue is derived from contracts with state or local government agencies and government intermediaries, the majority of which are negotiated fee-for-service arrangements.

## FINANCIAL OVERVIEW

2017 Compared with 2016

Service margin declined $20 million in 2017 compared with 2016, due primarily to reduced revenues as a result of the termination of operations in selected markets, and increased professional labor benefit expenses.

As discussed further in the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," in 2017 we recorded impairment losses primarily relating to our Pathways subsidiary, of $162 million for goodwill and $11 million for intangible assets.

2016 Compared with 2015

Service margin was $33 million in 2016 and insignificant in 2015. The service margin in 2015 was insignificant because our acquisition of Pathways was not completed until the fourth quarter of 2015.

# OTHER CONSOLIDATED INFORMATION

## GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses as a percentage of total revenue (the "general and administrative expense ratio") was 8.0% in 2017, 7.8% in 2016, and 8.1% in 2015. Our general and administrative ratio has been relatively constant since the phase-in of the ACA Medicaid Expansion and Marketplace programs beginning in 2014.

## DEPRECIATION AND AMORTIZATION

Depreciation and amortization amounted to 0.9%, 1.0% and 0.8% of total revenue for the years ended December 31, 2017, 2016 and 2015, respectively.

## RESTRUCTURING AND SEPARATION COSTS

For a comprehensive discussion of our 2017 Restructuring Plan, refer to "Liquidity and Financial Condition—Future Sources and Uses of Liquidity," in this MD&A, and Notes to Consolidated Financial Statements, Note 15, "Restructuring and Separation Costs."

## INTEREST EXPENSE

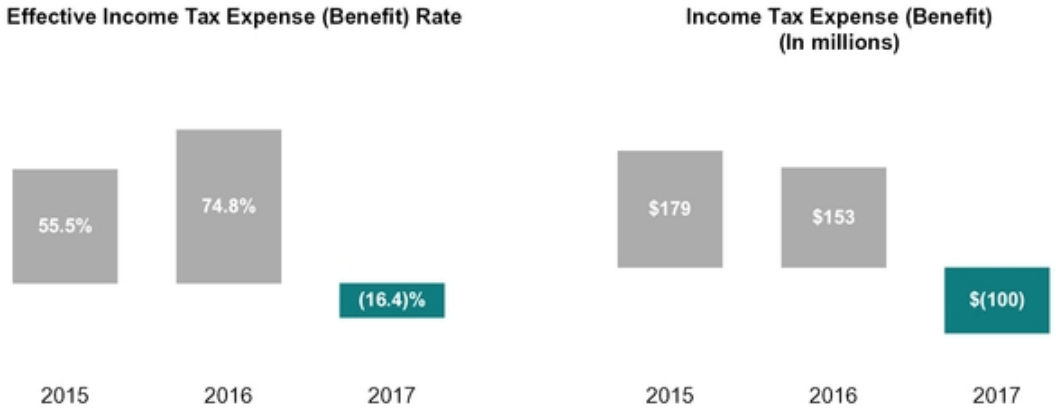
Interest expense increased to $118 million for the year ended December 31, 2017, compared with $101 million for the year ended December 31, 2016. The increase was due primarily to our issuance of $330 million aggregate principal amount of senior notes (the 4.875% Notes) due June 15, 2025, and $300 million borrowed under our

Credit Facility in the third quarter of 2017. For further details regarding debt financing transactions, please refer to the Notes to Consolidated Financial Statements, Note 11, “Debt.”

Interest expense increased to $101 million for the year ended December 31, 2016, compared with $66 million for the year ended December 31, 2015. The increase was due primarily to our issuance of $700 million aggregate principal amount of senior notes (the 5.375% Notes) due November 15, 2022, in the fourth quarter of 2015.

Interest expense includes non-cash interest expense relating to the amortization of the discount on our long-term debt obligations, which amounted to $32 million, $31 million and $30 million for the years ended December 31, 2017, 2016, and 2015, respectively.

### INCOME TAXES




The revaluation of deferred tax assets in connection with the *Tax Cuts and Jobs Act of 2017* resulted in $54 million additional income tax expense in the year ended December 31, 2017 ($0.95 per diluted share). In addition, the effective tax benefit for 2017 is less than the statutory tax benefit due to the relatively large amount of reported expenses that are not deductible for tax purposes, primarily relating to goodwill impairment losses and separation costs.

The decrease in income before taxes in 2016 compared with 2015, combined with the relatively large amount of reported expenses that are not deductible for tax purposes, resulted in an effective tax rate in excess of 70% for the full year 2016, compared with 55.5% for 2015.

## LIQUIDITY AND FINANCIAL CONDITION

### INTRODUCTION

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

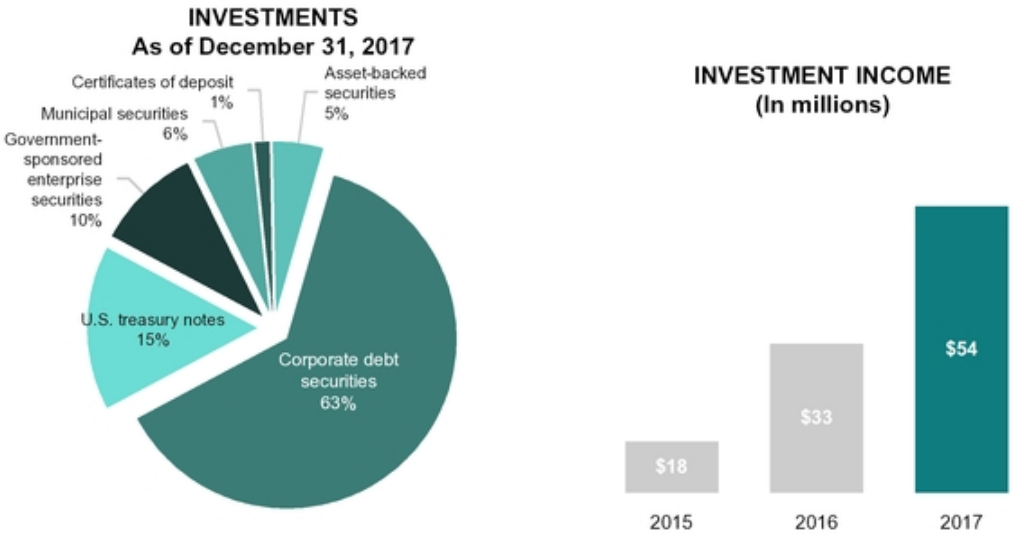
Our regulated subsidiaries generate significant cash flows from premium revenue. Such cash flows are our primary source of liquidity. Thus, any future decline in our profitability may have a negative impact on our liquidity. We generally receive premium revenue a short time before we pay for the related health care services. A majority of the assets held by our regulated subsidiaries are in the form of cash, cash equivalents, and investments. After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short-term obligations in longer term, investment-grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board approved investment policies which conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of 10 years or

less (excluding variable rate securities, for which interest rates are periodically reset) and that the average maturity be three years or less. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels.

Our non-current restricted investments are invested principally in certificates of deposit and U.S. treasury securities; we have the ability to hold our non-current restricted investments until maturity. We also maintain certain funds from the issuance of our 4.875% Notes in a segregated deposit account, a current asset reported as “Restricted investments” in the accompanying consolidated balance sheets. Such investments, while restricted as to their use and held in a segregated deposit account, are classified as available-for-sale based upon our contractual liquidity requirements.

All of our unrestricted investments are classified as current assets and are presented in the table below.




Investment income increased in 2017 compared with 2016, and in 2016 compared with 2015, primarily due to the increase in invested assets in each of 2017 and 2016. See further discussion below in “Liquidity.”

## MARKET RISK

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

Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2017, the fair value of our fixed income investments would decrease by approximately $24 million. Declines in interest rates over time will reduce our investment income.

For further information on fair value measurements and our investment portfolio, please refer to the Notes to Consolidated Financial Statements, Note 4, “Fair Value Measurements,” Note 5, “Investments,” and Note 9, “Restricted Investments, Non-current.”

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. As of December 31, 2017, $300 million was outstanding under the Credit Facility.

In January 2018, we entered into a bridge credit agreement (Bridge Credit Agreement) with several banks. Under the Bridge Credit Agreement, the banks agreed to lend us up to $550 million to be used to: (i) satisfy conversions of

our 1.125% Convertible Notes; (ii) satisfy and/or refinance indebtedness incurred to satisfy conversion of the 1.125% Convertible Notes; (iii) repay or refinance our Credit Facility; (iv) pay fees and expenses in connection with the foregoing; and, subject to the satisfaction of specified conditions, for general corporate purposes. Borrowings under the Bridge Credit Agreement will bear interest based, at our election, at a base rate or an adjusted LIBOR rate, plus in each case the applicable margin. No amounts are currently outstanding under the Bridge Credit Agreement.

## LIQUIDITY

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

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2017 | 2016 | 2015 | 2016 to 2017 Change | 2015 to 2016 Change |
| | (In millions) | | | | |
| Net cash provided by operating activities | $ 804 | $ 673 | $ 1,125 | $ 131 | $ (452) |
| Net cash used in investing activities | (1,073) | (202) | (1,420) | (871) | 1,218 |
| Net cash provided by financing activities | 636 | 19 | 1,085 | 617 | (1,066) |
| Net increase in cash and cash equivalents | $ 367 | $ 490 | $ 790 | $ (123) | $ (300) |

***Operating Activities***

2017 Compared with 2016

Net cash provided by operating activities was $804 million in 2017 compared with $673 million in 2016, an increase of $131 million, due to the following factors:

The combined effect of our 2017 net loss and adjustments to cash provided by operating activities, which included non-cash impairment losses of $470 million and non-cash restructuring charges of $60 million, resulted in a $114 million use of cash.

*Receivables and deferred revenue*. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the net effect of the timing of premiums received at our California, Florida, Illinois, and Washington health plans positively impacted our cash flows from operating activities in the amount of $325 million.

*Amounts due government agencies*. While amounts due government agencies increased $340 million in 2017, this increase was less than the increase experienced in 2016, resulting in a decrease to cash flows from operations of $132 million. This decrease was due primarily to a decline in the amounts accrued for Health Plans segment programs that mandate medical cost floors or medical cost corridors, under which a portion of certain Medicaid, Medicare, and Marketplace premiums received by our health plans may be returned if certain minimum amounts are not spent on defined medical care costs. This decrease was partially offset by increased Marketplace risk adjustment accruals.

2016 Compared with 2015

Net cash provided by operating activities was $673 million in 2016, compared with $1,125 million in 2015, a decrease of $452 million. This decrease was due primarily to a $91 million decrease in net income, and the following factors:

*Receivables and deferred revenue*. Cash flows from operations in each year were impacted by the timing of payments we receive from our states. In general, states may delay our premium payments, which we record as a receivable, or they may prepay the following month's premium payment, which we record as deferred revenue. We typically receive capitation payments monthly; however, the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period. In the current year, the net effect of the timing of premiums received at our California and Illinois health plans negatively impacted our cash flows from operating activities.

*Medical claims and benefits payable*. In 2016, the change in medical claims and benefits payable reduced cash flows from operations by $256 million, primarily because membership and related medical costs grew at a higher rate in 2015 than in 2016, resulting in a lower year-over-year change in 2016.

*Amounts due government agencies*. In 2016, the change in amounts due government agencies, when compared with the change in 2015, increased cash flows from operations by $271 million, due primarily to increased accruals for Marketplace risk adjustments.

***Investing Activities***

2017 Compared with 2016

Net cash used in investing activities was $1,073 million in 2017, compared with $202 million in 2016, an increase of $871 million. More cash was used in investing activities in 2017 primarily due to $789 million of increased purchases of investments as a result of the 2017 financing transactions described below, and $195 million decreased proceeds from sales and maturities of investments.

2016 Compared with 2015

Net cash used in investing activities was $202 million in 2016, compared with $1,420 million in 2015, a decrease of $1,218 million. Less cash was used in investing activities in 2016 primarily due to $840 million increased proceeds from sales and maturities of investments, and a reduction in cash paid in business combinations of $402 million in 2016, compared with 2015.

***Financing Activities***

2017 Compared with 2016

Cash provided by financing activities was $636 million in 2017, compared with $19 million in 2016. In 2017, cash inflows included $325 million for the net proceeds from our issuance of 4.875% Notes, and borrowings of $300 million under our Credit Facility, with no comparable activity in 2016.

2016 Compared with 2015

Cash provided by financing activities was $19 million in 2016, compared with $1,085 million in 2015. In 2015, we received net proceeds from our fiscal 2015 offerings of the 5.375% Notes amounting to $689 million, and common stock amounting to $373 million, with no comparable activity in 2016.

## FINANCIAL CONDITION

We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

On a consolidated basis, at December 31, 2017, our working capital was $1,954 million compared with $1,418 million at December 31, 2016. At December 31, 2017, our cash and investments amounted to $6,000 million, compared with $4,689 million of cash and investments at December 31, 2016.

*Debt Ratings*. Our 5.375% Notes and 4.875% Notes are rated “BB-” by Standard & Poor’s, and “B3” by Moody’s Investor Service, Inc. A significant downgrade in our ratings could adversely affect our borrowing capacity and costs.

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

| Credit Facility Financial Covenants | Required Per Agreement | As of December 31, 2017 |
|---|---|---|
| Net leverage ratio | <4.0x | 3.1x |
| Interest coverage ratio | >3.5x | 6.7x |

In addition, the terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures. As of December 31, 2017, we were in compliance with all covenants under the Credit Facility.

# FUTURE SOURCES AND USES OF LIQUIDITY

***Sources***

*Parent Cash and Cash Equivalents.* Cash, cash equivalents and investments held by the parent company—Molina Healthcare, Inc.—amounted to $696 million as of December 31, 2017.

*Dividends from Subsidiaries.* When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. We received $245 million, $100 million, and $125 million in dividends from our regulated health plan subsidiaries in 2017, 2016, and 2015, respectively. We received $41 million, $1 million and $17 million in dividends from our unregulated subsidiaries during 2017, 2016 and 2015, respectively. See further discussion in the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions,” and Note 22, “Condensed Financial Information of Registrant—Note C - Dividends and Capital Contributions.”

*Borrowing Capacity and Debt Financing.* We have available borrowing capacity of $550 million under our Bridge Credit Agreement (which amount is subject to the use of proceeds restrictions set forth in its terms), and $194 million under our Credit Facility. On June 6, 2017, we completed the private offering of $330 million aggregate principal amount of the 4.875% Notes. As a result of the proceeds from this transaction, we have adequate cash held in a restricted account available to repay the $161 million principal balance outstanding under our 1.625% Convertible Notes, if noteholders exercise their conversion or put rights in 2018. See further discussion in the Notes to Consolidated Financial Statements, Note 11, “Debt,” for further information.

*2017 Restructuring Plan.* As previously disclosed, we estimate that our 2017 Restructuring Plan will reduce annualized run-rate expenses by approximately $300 million to $400 million when completed by the end of 2018. As of December 31, 2017, we achieved $235 million of these run-rate reductions by the elimination of administrative costs (some of which are classified as medical care costs) on an annualized basis. As of December 31, 2017 we had also achieved an undetermined amount of medical care cost savings on an annualized basis through the re-negotiation of various medical provider contracts and the restructuring of our direct delivery operations. We expect to have more visibility into the actual value of these medical care cost savings later in 2018. We incurred substantially all of the costs associated with the 2017 Restructuring Plan in 2017. The following table illustrates our current estimates of run-rate savings associated with the 2017 Restructuring Plan:

| Estimated Savings Expected to be Realized by Reportable Segment | Health Plans | Other | Total |
|---|---|---|---|
| | | (In millions) | |
| General and administrative expenses | $65 | $92 to $152 | $157 to $217 |
| Medical care costs | $126 to $166 | $17 | $143 to $183 |
| | $191 to $231 | $109 to $169 | $300 to $400 |

*Shelf Registration Statement.* We have a shelf registration statement on file with the Securities and Exchange Commission to register an unlimited amount of any combination of debt or equity securities in one or more offerings. Specific information regarding the terms and securities being offered will be provided at the time of an offering. Proceeds from future offerings are expected to be used for general corporate purposes, including, but not limited to, the repayment of debt, investments in or extensions of credit to our subsidiaries and the financing of possible acquisitions or business expansion.

***Uses***

*Regulatory Capital Requirements.* In 2017, 2016, and 2015, we contributed capital of $370 million, $338 million, and $320 million, respectively, to our health plans subsidiaries to satisfy statutory net worth requirements. For a comprehensive discussion of this topic, refer to the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

*Convertible Senior Notes.* Refer to the Notes to Consolidated Financial Statements, Note 11, “Debt,” for a detailed discussion of our Convertible Senior Notes. Both our 1.625% Convertible Notes and our 1.125% Convertible Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger.

The stock price trigger for the 1.625% Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this trigger in the quarter ended December 31, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of December 31, 2017. As described above, we have adequate cash held in a restricted account available to repay the 1.625% Convertible Notes, if noteholders exercise their conversion or put rights in 2018.

The stock price trigger for the 1.125% Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended December 31, 2017, and are convertible to cash through at least March 31, 2018. Because the 1.125% Convertible Notes may be converted into cash within 12 months, the $550 million carrying amount is reported in current portion of long-term debt as of December 31, 2017. For economic reasons related to the trading market for our 1.125% Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Convertible Notes may elect to convert the notes to cash. If conversion requests are received, the settlement of the notes must be paid in cash pursuant to the terms of the relevant indentures. We have sufficient available cash, combined with borrowing capacity available under our Credit Facility and Bridge Credit Agreement, to fund conversions should they occur.

*Exchange Offers.* We may from time to time seek to retire or purchase material amounts of our outstanding debt through cash purchases and/or exchanges for equity securities, in open market purchases, privately negotiated transactions or otherwise. For example, on December 7, 2017, we announced that on December 6, 2017 we priced a synthetic exchange transaction with a limited number of holders of our 1.625% Convertible Notes pursuant to which we agreed to repurchase from such noteholders an aggregate of $141 million principal amount of our 1.625% Convertible Notes and simultaneously issue to such noteholders an aggregate of 2.6 million shares of our common stock registered under the shelf registration statement described above. Future repurchases or exchanges, if any, will depend on prevailing market conditions, our liquidity requirements, contractual restrictions and other factors.

## CONTRACTUAL OBLIGATIONS

In the table below, we present our contractual obligations as of December 31, 2017. Some of the amounts included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table.

Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material non-cancelable commitments.

| | Total [1] | 2018 | 2019-2020 | 2021-2022 | 2023 and after |
|---|---|---|---|---|---|
| | | | (In millions) | | |
| Medical claims and benefits payable | $ 2,192 | $ 2,192 | $ — | $ — | $ — |
| Principal amount of debt [2] | 2,041 | — | 550 | 1,000 | 491 |
| Amounts due government agencies | 1,542 | 1,542 | — | — | — |
| Lease financing obligations | 410 | 17 | 37 | 39 | 317 |
| Interest on long-term debt | 428 | 73 | 140 | 119 | 96 |
| Operating leases | 262 | 67 | 109 | 52 | 34 |
| Purchase commitments | 11 | 6 | 5 | — | — |
| | $ 6,886 | $ 3,897 | $ 841 | $ 1,210 | $ 938 |

(1) As of December 31, 2017, we have recorded approximately $13 million of unrecognized tax benefits. The table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. For further information, refer to Notes to Consolidated Financial Statements, Note 13, "Income Taxes."

(2) Represents the principal amounts due on our 5.375% Notes due 2022, 1.125% Convertible Notes due 2020, 4.875% Notes due 2025, Credit Facility due 2022, and our 1.625% Convertible Notes due 2044. The amounts in the table reflect the 1.625% Convertible Notes' contractual maturity date in 2044; however, on specified dates beginning in 2018, holders of the 1.625% Convertible Notes may convert, or may require us to repurchase some or all of the 1.625% Convertible Notes, as described in the Notes to Consolidated Financial Statements, Note 11, "Debt."

*Commitments and Contingencies.* We are not a party to off-balance sheet financing arrangements, except for operating leases which are disclosed in the Notes to Consolidated Financial Statements, Note 19, "Commitments and Contingencies."

# INFLATION

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

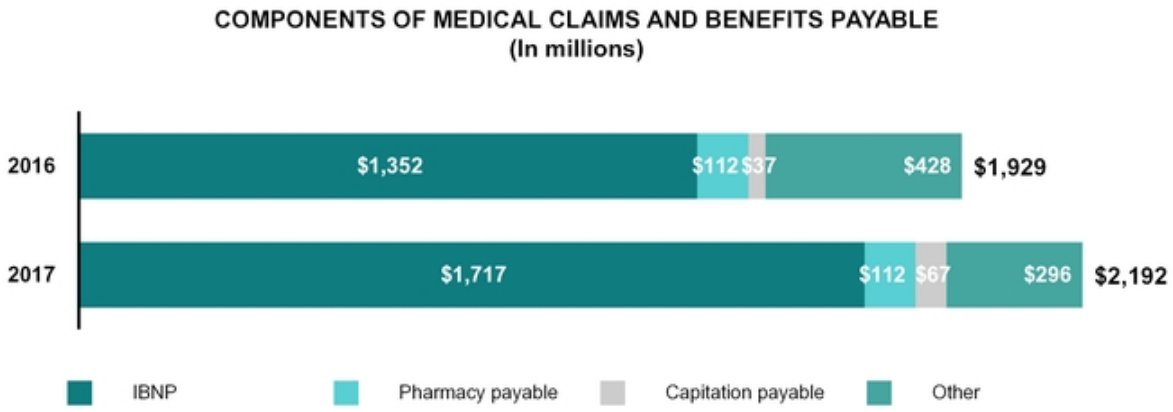
# COMPLIANCE COSTS

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

# CRITICAL ACCOUNTING ESTIMATES

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

- *Health Plans segment medical claims and benefits payable.* See discussion below, and refer to the Notes to Consolidated Financial Statements, Note 10, "Medical Claims and Benefits Payable."
- *Health Plans segment contractual provisions that may adjust or limit revenue or profit.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Health Plans segment quality incentives.* For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, "Significant Accounting Policies."
- *Goodwill and intangible assets, net.* See discussion below, and refer to the Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net."




“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various state agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. As of December 31, 2017 and 2016, we recorded non-risk provider payables relating to such intermediary arrangements of approximately $122 million and $225 million, respectively.

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

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

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not yet paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP, as reported on our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. As indicated in the graph above, our estimated IBNP liability represented $1,717 million of our total medical claims and benefits payable of $2,192 million as of December 31, 2017.

The factors we consider when estimating our IBNP include, without limitation:

- claims receipt and payment experience (and variations in that experience),
- changes in membership,
- provider billing practices,
- health care service utilization trends,
- cost trends,
- product mix,
- seasonality,
- prior authorization of medical services,

- benefit changes,
- known outbreaks of disease or increased incidence of illness such as influenza,
- provider contract changes,
- changes to Medicaid fee schedules, and
- the incidence of high dollar or catastrophic claims.

Our assessment of these factors is then translated into an estimate of our IBNP liability at the relevant measuring point through the calculation of a base estimate of IBNP, a further provision for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNP is derived through application of claims payment completion factors and trended PMPM cost estimates.

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

The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2017 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2017, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions.

| Increase (Decrease) in Estimated Completion Factors | Increase (Decrease) in Medical Claims and Benefits Payable |
|---|---|
| (6)% | $ 527 |
| (4)% | 351 |
| (2)% | 176 |
| 2% | (176) |
| 4% | (351) |
| 6% | (527) |

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2017 that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in millions.

| (Decrease) Increase in Trended Per Member Per Month Cost Estimates | (Decrease) Increase in Medical Claims and Benefits Payable |
|---|---|
| (6)% | $ (263) |
| (4)% | (176) |
| (2)% | (88) |
| 2% | 88 |
| 4% | 176 |
| 6% | 263 |

The following per-share amounts are based on a combined federal and state statutory tax rate of 37%, and 56 million diluted shares outstanding for the year ended December 31, 2017. Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNP at December 31, 2017, net income for the year ended December 31, 2017 would increase or decrease by approximately $55 million, or $0.98 per diluted share. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNP at December 31, 2017, net income for the year ended December 31, 2017 would increase or decrease by approximately $28 million, or $0.49 per diluted share. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $276 million, or $4.90 per diluted share, and $138 million, or $2.45 per diluted share, respectively.

It is important to note that any change in the estimate of either completion factors or trended PMPM costs would usually be accompanied by a change in the estimate of the other component, and that a change in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, changes in estimates involving both completion factors and trended PMPM costs will usually act to drive estimates of claims liabilities and medical care costs in the same direction. If completion factors were overestimated by 1%, resulting in an overstatement of net income by approximately $55 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

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

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

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

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

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

Refer to the Notes to Consolidated Financial Statements, Note 10, “Medical Claims and Benefits Payable,” for additional information regarding the specific factors used to determine our changes in estimates of IBNP, as well as a table presenting the components of the change in our medical claims and benefits payable, for all periods presented in the accompanying consolidated financial statements.

## GOODWILL AND INTANGIBLE ASSETS, NET

At December 31, 2017, goodwill and intangible assets, net, represented approximately 3% of total assets and 19% of total stockholders’ equity, compared with 10% and 46%, respectively, at December 31, 2016.

In the year ended December 31, 2017, we recorded impairment losses relating to goodwill and intangible assets, net, of $470 million. These losses included $269 million primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management’s determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan’s future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago. Also during 2017, we recorded impairment losses of $28 million for our Molina Medicaid Solutions segment because management determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment. In addition, we recorded impairment losses of $173 million for our Other segment, primarily relating to our Pathways business, because management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.

***Goodwill***

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Such events or circumstances may include experienced or expected operating cash-flow deterioration or losses, significant loss of membership, loss of state funding, loss of state contracts, and other factors.

We conduct our required annual impairment testing of goodwill during the fourth quarter of each year for each of our reporting units that have recorded goodwill. Our reporting units comprise our health plan subsidiaries, and our Molina Medicaid Solutions and Pathways subsidiaries. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment. We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment. We believe that the dynamic economic and political environments in which we operate often necessitate the performance of the quantitative test to prove that goodwill is not impaired on an annual basis. As of December 31, 2017, we performed qualitative impairment tests for our Michigan, Washington and Wisconsin health plans; based on these tests, we do not believe that it is more likely than not that the carrying value of these reporting units would exceed their estimated fair values.

As of December 31, 2017, we performed quantitative impairment tests for our Florida, Illinois, New Mexico, New York and South Carolina health plans, and our Molina Medicaid Solutions subsidiary.

We estimated the fair values of our reporting units using the higher of the income approach using discounted cash flows, or the asset liquidation method. For the annual impairment test, the base year in the reporting units’ discounted cash flows is derived from the most recent annual financial budgeting cycle, for which the planning process commences in the fourth quarter of the year. When computing discounted cash flows, we make assumptions about a wide variety of internal and external factors, and consider what the reporting unit’s selling price would be in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations, capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. When determining the discount rate, we consider the overall level of inherent risk of the reporting unit, and the expected rate an outside investor would expect to earn. The asset liquidation method is computed as total assets minus total liabilities, excluding intangible assets and liabilities.

Key assumptions in our cash flow projections, including changes in membership, premium rates, health care and operating cost trends, and contract renewals and the procurement of new contracts, are consistent with those used in our long-range business plan and annual planning process. If these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss, and adjusted if necessary for the impact of tax deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

For our South Carolina health plan and our Molina Medicaid Solutions subsidiary, whose goodwill was not impaired as of December 31, 2017, their estimated fair values exceeded their carrying amounts by 46% and 9%, respectively. The Molina Medicaid Solutions' reporting unit recorded a goodwill impairment loss as of September 30, 2017; therefore its estimated fair value did not substantially exceed its carrying amount as of December 31, 2017.

Refer to Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," for further details on the goodwill impairment losses recorded in 2017.

No goodwill impairment charges were recorded in the years ended December 31, 2016, or 2015.

***Intangible Assets***

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite-lived intangible asset's (or asset group's) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including the ability of our health plan subsidiaries to obtain the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed.

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

Refer to Notes to Consolidated Financial Statements, Note 8, "Goodwill and Intangible Assets, Net," for further details on the intangible impairment losses recorded in 2017.

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2016, or 2015.

# SUPPLEMENTAL INFORMATION

## FINANCIAL MEASURES THAT SUPPLEMENT U.S. GAAP (NON-GAAP FINANCIAL MEASURES)

We use these non-GAAP financial measures as supplemental metrics in evaluating our financial performance, making financing and business decisions, and forecasting and planning for future periods. For these reasons, management believes such measures are useful supplemental measures to investors in comparing our performance to the performance of other public companies in the health care industry.

**EBITDA***

We believe that EBITDA* is particularly helpful in assessing our ability to meet the cash demands of our operating units. The following table reconciles net (loss) income, which we believe to be the most comparable GAAP measure, to EBITDA*.

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| Adjustments: | | | |
| Depreciation, and amortization of intangible assets and capitalized software | 165 | 161 | 120 |
| Interest expense | 118 | 101 | 66 |
| Income tax (benefit) expense | (100) | 153 | 179 |
| EBITDA* | $ (329) | $ 467 | $ 508 |

**ADJUSTED NET (LOSS) INCOME* AND ADJUSTED NET (LOSS) INCOME PER SHARE***

We believe that adjusted net (loss) income* and adjusted net (loss) income per diluted share* are very helpful in assessing our financial performance exclusive of the non-cash impact of the amortization of purchased intangibles. The following table reconciles net (loss) income, which we believe to be the most comparable GAAP measure, to adjusted net (loss) income*.

| | Year Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2017 | | 2016 | | 2015 | |
| | (In millions, except diluted per-share amounts) | | | | | |
| | Amount | Per share | Amount | Per share | Amount | Per share |
| Net (loss) income | $ (512) | $ (9.07) | $ 52 | $ 0.92 | $ 143 | $ 2.58 |
| Adjustment: | | | | | | |
| Amortization of intangible assets | 30 | 0.55 | 32 | 0.57 | 18 | 0.32 |
| Income tax effect [(1)] | (11) | (0.20) | (12) | (0.21) | (7) | (0.12) |
| Amortization of intangible assets, net of tax effect | 19 | 0.35 | 20 | 0.36 | 11 | 0.20 |
| Adjusted net (loss) income* | $ (493) | $ (8.72) | $ 72 | $ 1.28 | $ 154 | $ 2.78 |

(1) Income tax effect of adjustments calculated at the blended federal and state statutory tax rate of 37%.

# OTHER FINANCIAL DATA

## SELECTED FINANCIAL DATA

(In millions, except per-share amounts)

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | 2017 | 2016 | 2015 | 2014 | 2013 |
| **Statements of Operations Data:** | | | | | |
| Revenue: | | | | | |
| Premium revenue [1] | $ 18,854 | $ 16,445 | $ 13,261 | $ 9,035 | $ 6,179 |
| Service revenue [2] | 521 | 539 | 253 | 210 | 205 |
| Premium tax revenue | 438 | 468 | 397 | 294 | 172 |
| Health insurer fees reimbursed [1] | — | 292 | 244 | 108 | — |
| Investment income and other revenue | 70 | 38 | 23 | 20 | 33 |
| Total revenue | 19,883 | 17,782 | 14,178 | 9,667 | 6,589 |
| Operating expenses: | | | | | |
| Medical care costs | 17,073 | 14,774 | 11,794 | 8,076 | 5,380 |
| Cost of service revenue [2] | 492 | 485 | 193 | 157 | 161 |
| General and administrative expenses | 1,594 | 1,393 | 1,146 | 765 | 666 |
| Premium tax expenses | 438 | 468 | 397 | 294 | 172 |
| Health insurer fee | — | 217 | 157 | 89 | — |
| Depreciation and amortization | 137 | 139 | 104 | 93 | 73 |
| Impairment losses | 470 | — | — | — | — |
| Restructuring and separation costs | 234 | — | — | — | — |
| Total operating expenses | 20,438 | 17,476 | 13,791 | 9,474 | 6,452 |
| Operating (loss) income | (555) | 306 | 387 | 193 | 137 |
| Other expenses, net: | | | | | |
| Interest expense | 118 | 101 | 66 | 57 | 52 |
| Other (income) expense, net | (61) | — | (1) | 1 | 4 |
| Total other expenses, net | 57 | 101 | 65 | 58 | 56 |
| (Loss) income from continuing operations before income taxes | (612) | 205 | 322 | 135 | 81 |
| Income tax (benefit) expense | (100) | 153 | 179 | 73 | 36 |
| (Loss) income from continuing operations | (512) | 52 | 143 | 62 | 45 |
| Income from discontinued operations, net of tax benefit [3] | — | — | — | — | 8 |
| Net (loss) income | $ (512) | $ 52 | $ 143 | $ 62 | $ 53 |
| Basic net (loss) income per share: [4] | | | | | |
| (Loss) income from continuing operations | $ (9.07) | $ 0.93 | $ 2.75 | $ 1.34 | $ 0.98 |
| (Loss) income from discontinued operations | — | — | — | (0.01) | 0.18 |
| Basic net (loss) income per share | $ (9.07) | $ 0.93 | $ 2.75 | $ 1.33 | $ 1.16 |
| Diluted net (loss) income per share: [4] | | | | | |
| (Loss) income from continuing operations | $ (9.07) | $ 0.92 | $ 2.58 | $ 1.30 | $ 0.96 |
| (Loss) income from discontinued operations | — | — | — | (0.01) | 0.17 |
| Diluted net (loss) income per share | $ (9.07) | $ 0.92 | $ 2.58 | $ 1.29 | $ 1.13 |
| Weighted average shares outstanding: | | | | | |
| Basic | 56 | 55 | 52 | 47 | 46 |
| Diluted | 56 | 56 | 56 | 48 | 47 |

(1) The Centers for Medicare and Medicaid Services (CMS) incorporates the Health Insurer Fee (HIF) in our Medicare and

Marketplace premium rates. We have therefore reclassified such amounts in our consolidated statements of operations to premium revenue, from health insurer fees reimbursed, for all applicable periods presented. The amounts reclassified from health insurer fees reimbursed to premium revenue for years ended December 31, 2016, 2015, and 2014, amounted to $53 million, $20 million and $12 million, respectively.

(2) Service revenue and cost of service revenue include revenue and costs generated by our Pathways subsidiary, which was acquired on November 1, 2015.

(3) Income from discontinued operations is presented net of income tax benefit, which was insignificant in 2017, 2016, 2015 and 2014 and $10, in 2013, respectively.

(4) Source data for calculations in thousands.

| | December 31, | | | | |
|---|---|---|---|---|---|
| | 2017 | 2016 | 2015 | 2014 | 2013 |
| **Balance Sheet Data:** | | | | | |
| Cash and cash equivalents | $ 3,186 | $ 2,819 | $ 2,329 | $ 1,539 | $ 936 |
| Total assets | 8,471 | 7,449 | 6,576 | 4,435 | 2,988 |
| Long-term debt, including current portion [1] | 2,169 | 1,645 | 1,609 | 887 | 770 |
| Total liabilities | 7,134 | 5,800 | 5,019 | 3,425 | 2,095 |
| Stockholders' equity | 1,337 | 1,649 | 1,557 | 1,010 | 893 |

(1) Includes long-term debt and lease financing obligations.

## STOCK REPURCHASE PROGRAMS

Purchases of common stock made by us, or on our behalf during the quarter ended December 31, 2017, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below:

| | Total Number of Shares Purchased [1] | Average Price Paid per Share [1] | Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs | Approximate Dollar Value of Shares Authorized to Be Purchased Under the Plans or Programs |
|---|---|---|---|---|
| October 1 — October 31 | 163 | $ 68.76 | — | $ — |
| November 1 — November 30 | — | $ — | — | $ — |
| December 1 — December 31 | 12,699 | $ 73.83 | — | $ — |
| | 12,862 | $ 73.77 | — | |

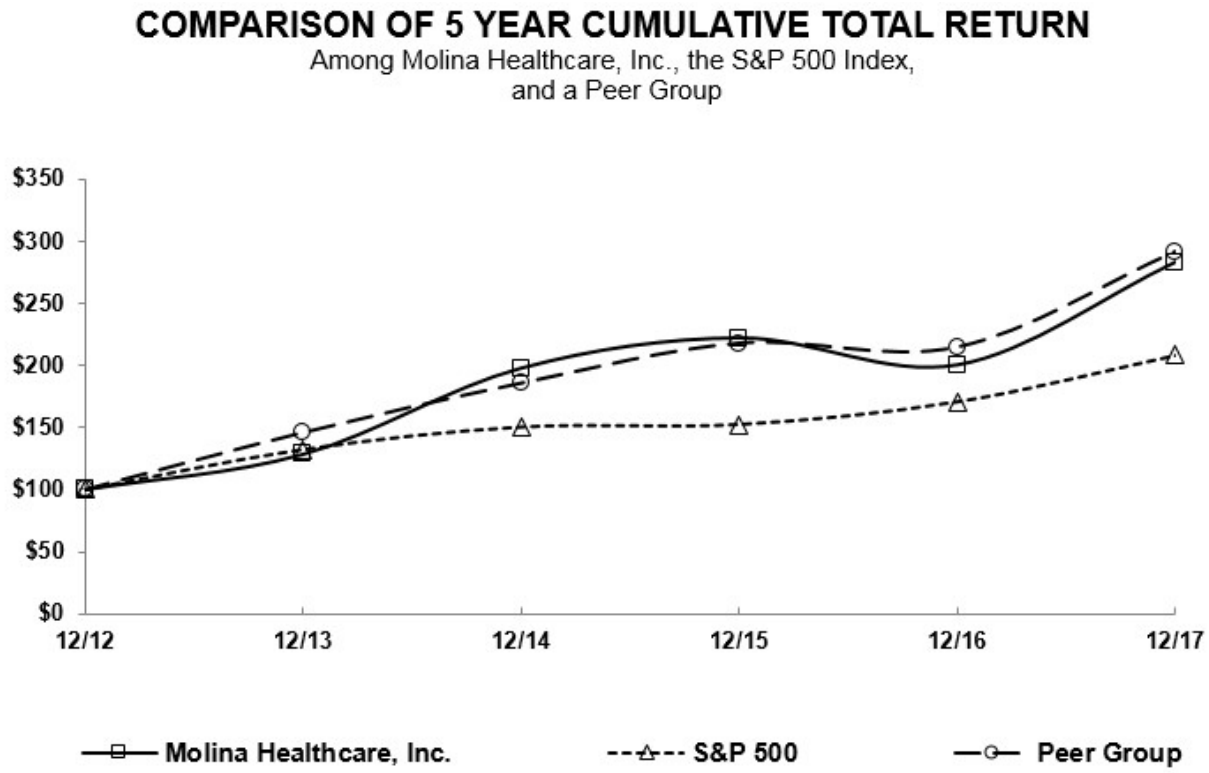
(1) During the quarter ended December 31, 2017, we withheld 12,862 shares of common stock under our 2011 Equity Incentive Plan to settle our employees' income tax obligations.

## STOCK PERFORMANCE GRAPH

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

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor's Corporation Composite 500 Index (S&P 500) and a peer group index for the five-year period from December 31, 2012 to December 31, 2017. The comparison assumes $100 was invested on December 31, 2012, in our common stock and in each of the foregoing indices and

assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock performance and is not necessarily indicative of future stock price performance.




The peer group index consists of Centene Corporation (CNC), Cigna Corporation (CI), DaVita HealthCare Partners, Inc. (DVA), Humana Inc. (HUM), Magellan Health, Inc. (MGLN), Team Health Holdings, Inc. (TMH), Tenet Healthcare Corporation (THC), Triple-S Management Corporation (GTS), Universal American Corporation (UAM), Universal Health Services, Inc. (UHS) and WellCare Health Plans, Inc. (WCG).

## STOCK PRICE RANGE AND DIVIDENDS


Our common stock is listed on the New York Stock Exchange under the trading symbol “MOH.” As of February 23, 2018, there were 34 holders of record of our common stock.

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

Our ability to pay dividends is partially dependent on, among other things, our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate, as well as requirements of the government-sponsored health programs in which we participate. Additionally, the indentures governing our outstanding senior notes and the credit agreement governing the revolving credit facility contain various covenants that limit our ability to pay dividends on our common stock.

Any future determination to pay dividends will be at the discretion of our board of directors and will depend upon, among other factors, our results of operations, financial condition, capital requirements and contractual and regulatory restrictions. For more information regarding restrictions on the ability of our regulated subsidiaries to pay dividends to us, please see the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Regulatory Capital Requirements and Dividend Restrictions.”

## PROPERTIES

As of December 31, 2017, the Health Plans segment leased a total of 71 facilities, the Molina Medicaid Solutions segment leased a total of 13 facilities and the Other segment leased a total of 260 facilities. We own a 186,000 square-foot office building in Troy, Michigan and a 24,000 square-foot mixed use (office and clinic) facility in Pomona, California under our Health Plans segment. We own a 26,700 square foot data center in Albuquerque, New Mexico and 42 properties in Pennsylvania, which are primarily residential housing facilities, under our Other segment. While we believe our current and anticipated facilities will be adequate to meet our operational needs for the foreseeable future, we are continuing to periodically evaluate our employee and operational growth prospects to determine if additional space is required, and where it would be best located.

## EMPLOYEES

As of December 31, 2017, we had approximately 20,000 employees. Our employee base is multicultural and reflects the diverse membership we serve.

## AVAILABLE INFORMATION

Dr. C. David Molina founded our Company in 1980 as a provider organization serving low-income families in Southern California. We were originally organized in California as a holding company for our initial health plan and reincorporated in Delaware in 2002. Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666.

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

# RISK FACTORS

*You should carefully consider the risks described below and all of the other information set forth in this Form 10-K, including our consolidated financial statements and accompanying notes. These risks and other factors may affect our forward-looking statements, including those we make in this annual report or elsewhere, such as in press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. The risks described below are not the only risks facing our Company. Additional risks that we are unaware of, or that we currently believe are not material, may also become important factors that adversely affect our business. If any of the following risks actually occurs, our business, financial condition, results of operations, and future prospects could be materially and adversely affected. In that event, among other effects, the trading price of our common stock could decline, and you could lose part or all of your investment.*

## Risks Related to Our Business

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

We currently derive our premium revenues from 13 state health plans and our health plan in the Commonwealth of Puerto Rico. Measured by ending membership by health plan as of December 31, 2017, our top four health plans were in Washington, California, Florida, and Texas, with an aggregate of 2,578,000 members, or approximately 58% of total membership. If we are unable to continue to operate in any of our existing jurisdictions, or if our current operations in any portion of those jurisdictions are significantly curtailed or terminated entirely, our revenues could decrease materially.

Many of our government contracts for the provision of managed care programs to people receiving government assistance are effective only for a fixed period of time and may be extended for an additional period of time if the contracting entity or its agent elects to do so. When such contracts expire, they may be opened for bidding by competing healthcare providers, and there is no guarantee that the contracts will be renewed or extended. For example, our current Medicaid contract with the Florida Agency for Health Care Administration (“AHCA”) expires on December 31, 2018. As of December 31, 2017, our Florida health plan served approximately 360,000 Medicaid members. On February 1, 2018, AHCA notified our Florida health plan that it was only granted the opportunity to bid on a post-December 31, 2018 managed care contract for a single region in Florida (which consisted of approximately 59,000 Medicaid members as of December 31, 2017), as opposed to the eight regions covered by our existing contract. As yet another example, our New Mexico health plan’s current Medicaid contract with the New Mexico Human Services Department (“HSD”) will also expire on December 31, 2018. On January 8, 2018, HSD notified our New Mexico health plan that it had not been selected to bid on a post December 31, 2018 managed care contract. Our New Mexico health plan served approximately 224,000 Medicaid members as of December 31, 2017. We have filed a protest with regard to HSD’s decision, and as appropriate we will pursue all protest rights and rights of appeal with regard to AHCA’s decision. However, there can be no assurances that any

protest filing in either New Mexico or Florida will be successful, and as a result we may lose the applicable Medicaid membership as of the end of 2018.

In any bidding process, our health plans may face competition from numerous other health plans, many with greater financial resources and greater name recognition than we have. For example, the following three health plans have upcoming requests for proposal, or RFPs:

- The Texas Health and Human Service Commission (HHSC) currently contracts with five STAR+PLUS (ABD) plans: Anthem, Cigna, Centene, United Healthcare and Molina. Our Texas health plan served a total of approximately 430,000 members as of December 31, 2017. The Texas STAR+PLUS RFP was issued on December 4, 2017, proposals are due March 6, 2018, and the new contracts that are awarded will be effective January 1, 2020 through August 31, 2022. If the RFP responsive bid of our Texas health plan is not successful, or if our Texas health plan's contract with HHSC is not renewed, or if it is renewed but coverage is reduced, our revenues would be materially and adversely impacted.
- The Washington State Health Care Authority (HCA) currently contracts with five Apple Health plans: Anthem, Community Health Plan of Washington, Centene, United Healthcare and Molina. Our Washington health plan served a total of approximately 777,000 members as of December 31, 2017. The Washington Fully Integrated Managed Care RFP issued on February 16, 2018, is the third of three re-procurement RFPs for all Medicaid lives in Washington state. Proposals for the third and final RFP are due April 12, 2018, and five of the seven largest regions contracts that are awarded will be effective January 1, 2019. The remaining two will be effective on January 1, 2020. The HCA has indicated that fewer than five MCOs will be awarded re-procurement contracts in three of the seven remaining regions. If the RFP responsive bid of our Washington health plan is not successful, or if our Washington health plan's contract with HCA is not renewed, or if it is renewed but coverage is reduced, our revenues would be materially and adversely impacted.
- The Puerto Rico Health Insurance Administration (ASES) currently contracts with five Government Health plans: First Medical, MMM and its subsidiary PMC, Triple-S, and Molina. Our Puerto Rico health plan had approximately 314,000 members as of December 31, 2017. The Puerto Rico Government Health Plan RFP was issued on February 9, 2018, proposals are due May 25, 2018, and the new contracts that are awarded will be effective October 1, 2018 through June 30, 2021, with a one-year option to June 30, 2022. If the RFP responsive bid of our Puerto Rico health plan is not successful, or if our Puerto Rico health plan's contract with ASES is not renewed, or if it is renewed but coverage is reduced, our revenues would be materially and adversely impacted.

Even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the Medicaid contract being less profitable than we had expected or, in extreme cases, could result in a net loss. Furthermore, our government contracts contain certain provisions regarding, among other things, eligibility, enrollment and dis-enrollment processes for covered services, eligible providers, periodic financial and information reporting, quality assurance and timeliness of claims payment, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies.

If any of our governmental contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business and reputation may be adversely impacted, and our financial position, results of operations or cash flows could be materially and adversely affected. In addition, we may be unable to support the carrying amount of goodwill we have recorded for the applicable business, because its fair value estimated future cash flows.

***If our attempts to retain our contracts in Florida and/or New Mexico are not successful, of if we lose other contracts that constitute a significant amount of our revenue, we will lose the administrative cost efficiencies that are inherent in a large revenue base. In such circumstances, we may not be able to reduce fixed costs proportionally with our lower revenue, and the financial impact of lost contracts may exceed the net income ascribed to those contracts.***

We are currently able to spread the cost of centralized services over a large revenue base. Many of our administrative costs are fixed in nature, and will be incurred at the same level regardless of the size of our revenue base. If our attempts to retain our contracts in Florida and /or New Mexico are not successful, or if we lose other contracts that constitute a significant amount of our revenue, we may not be able to reduce the expense of centralized services in a manner that is proportional to that loss of revenue. In such circumstances, not only will our total dollar margins decline, but our percentage margins, measured as a percentage of revenue, will also decline. This loss of cost efficiency, and the resulting stranded administrative costs, could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

***If, in the interests of maintaining or improving longer term profitability, we decide to exit voluntarily certain state contractual arrangements, make changes to our provider networks, or make changes to our administrative infrastructure, we may incur short- to medium-term disruptions to our business that could materially reduce our premium revenues and our net income.***

Decisions that we make with regard to retaining or exiting our portfolio of state and Federal contracts, and changes to the manner in which we serve the members attached to those contracts, could generate substantial expenses associated with the run out of existing operations and the restructuring of those of operations that remain. Such expense could include, but would not be limited to, goodwill and intangible asset impairment charges, restructuring costs, additional medical costs incurred due to the inability to leverage long-term relationships with medical providers, and costs incurred to finish the run out of businesses that have ceased to generate revenue.

***If we are unable to successfully execute our profit maintenance and improvement initiatives and our restructuring plans, or if we fail to realize the anticipated benefits of those initiatives and plans, our business, cash flows, financial position, or results of operations could be materially and adversely affected.***

In August 2017, we announced the implementation of a comprehensive restructuring and profitability improvement plan. The restructuring plan includes the streamlining of our organizational structure, the re-design of certain core operating processes, the remediation of high cost provider contracts, the restructuring of our direct delivery operations, and the review of our vendor base in an attempt to insure that we are partnering with the lowest cost, most effective, vendors. As part of the restructuring plan, we reduced our corporate and health plans workforce by approximately 16%. For the year ended December 31, 2017, we reported restructuring and separation costs of $234 million.

In addition, in the second half of 2017, we launched several profit maintenance and improvement initiatives. We anticipate pursuing additional profit maintenance and improvement initiatives throughout 2018.

Our restructuring plan and profit improvement initiatives create numerous uncertainties, including the effect of the initiatives and plan on our business, operations, revenues, and profitability, potential disruptions to our business as a result of management's attention to the initiatives and plan, uncertainty regarding the potential amount and timing of future cost savings associated with the initiatives and plan, and the potential negative impact of the initiatives and plan on employee morale. The success of the initiatives and plan will depend, in part, on factors that are beyond our control. Accordingly, we can provide no assurance that the goals of the initiatives and plan will be fully achieved. Failure in this regard could have a material and adverse impact on our business, cash flows, financial position, or results of operations.

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

Because of the time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such IBNP medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations, is negatively impacted by the more limited experience we have had with those populations.

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

If our actual liability for claims payments is higher than estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

***We are subject to retroactive adjustment to our Medicaid premium revenue as a result of retroactive risk adjustment; retroactive changes to contract terms and the resolution of differing interpretations of those terms; the difficulty of estimating performance-based premium; and retroactive adjustments to "blended" premium rates to reflect the actual mix of members captured in those blended rates.***

The complexity of some of our Medicaid contract provisions; imprecise language in those contracts, the desire of state Medicaid agencies in some circumstances to retroactively adjust for the acuity of the medical needs of our members; and state delays in processing rate changes can create uncertainty around the amount of revenue we should recognize.

For example, in February 2017, the New Mexico Human Services Department (HSD) notified us that it had disallowed certain medically related administrative expenses and other items in the computation of its Medicaid Expansion risk corridor; this corridor was effective January 1, 2014, through December 31, 2016. As a result of this action, income before taxes at the New Mexico health plan was reduced by $45 million for the year ended December 31, 2016. Of this amount, $29 million related to dates of service prior to 2016.

A current example of exposure to this risk is in California, where the state Medicaid agency is several years behind in its reconciliation and settlement with us of the difference between expenses that it has paid on our behalf to providers of long term services and supports, and the amounts that it has withheld from our premium for those expenses; and has yet to share with us certain premium rates related to July 2017 through December 2017.

Any circumstance such as those described above could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***If we fail to accurately predict and effectively manage our medical care costs, our operating results could be materially and adversely affected.***

Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue net of premium tax, has fluctuated substantially, and has varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio of 90.6%, for the year ended December 31, 2017 had been one percentage point higher, or 91.6%, our net loss per diluted share for the year ended December 31, 2017 would have been approximately $11.17 rather than our actual net loss per diluted share of $9.07, a difference of $2.10.

Many factors may affect our medical care costs, including:

- the level of utilization of health care services,
- unexpected patterns in the annual flu season,
- increases in hospital costs,
- increased incidences or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage,
- increased maternity costs,
- payment rates that are not actuarially sound,
- changes in state eligibility certification methodologies,
- relatively low levels of hospital and specialty provider competition in certain geographic areas,
- increases in the cost of pharmaceutical products and services,
- changes in health care regulations and practices,
- epidemics,
- new medical technologies, and
- other various external factors.

Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***If we are unable to collect health insurer fee (HIF) reimbursement from our state partners, our business, cash flows, financial position, or results of operations could be materially and adversely affected.***

Because Medicaid is a government funded program, Medicaid health plans must request reimbursement for the HIF from respective state partners to offset the impact of this tax. When states reimburse us for the amount of the HIF,

that reimbursement is itself subject to income tax, the HIF, and applicable state premium taxes. Because the HIF is not deductible for income tax purposes, our net income is reduced by the full amount of the assessment. Based on our previous years' experience, we expect to ultimately recognize revenue sufficient to reimburse us for the full amount of the HIF we will pay (along with related tax effects) in September of 2018. However, we are uncertain as to the timing of such reimbursements. We expect this HIF assessment, related to our Medicaid business, to be approximately $232 million, with an expected tax effect from the reimbursement of the assessment of approximately $63 million. Therefore, the total reimbursement needed as a result of the Medicaid-related HIF is approximately $295 million. The delay or failure of our state partners to reimburse us in full for the HIF and its related tax effects could have a material adverse effect on our business, financial condition, cash flows or results of operations.

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

As of December 31, 2017, the carrying amounts of goodwill and intangible assets, net, amounted to $186 million, and $69 million, respectively.

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss, and adjusted if necessary for the impact of tax deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

Finite-lived, separately-identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite-lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment.

Key assumptions in our cash flow projections, including changes in membership, premium rates, health care and operating cost trends, and contract renewals and the procurement of new contracts, are consistent with those used in our long-range business plan and annual planning process. If these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected.

An event or events could occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose our Medicaid contract in the applicable state or states. If such state health plans have recorded goodwill and intangible assets, net, the contract loss would result in a non-cash impairment charge. Additionally, if we are unable to procure new state MMIS contracts, the outcome of our goodwill impairment tests could be adversely affected and result in a non-cash impairment charge. Such a non-cash impairment charge could have a material adverse impact on our financial results.

We incurred non-cash impairment losses of $470 million in 2017. These losses included $269 million, primarily in connection with our Florida, New Mexico, and Illinois health plans. The impairments at Florida and New Mexico were the result of our recent Medicaid contract losses. The Illinois impairment was the result of management's determination, in the course of its annual impairment assessment of the goodwill of the Illinois health plan, that the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. While we are confident that we can improve profitability in Illinois so that it is a meaningful contributor to our company, the current profit profile of the health plan does not support the purchase prices paid for certain membership years ago.

Also during 2017, we recorded impairment losses of $28 million for our Molina Medicaid Solutions segment because management determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment than previously anticipated. In addition, we recorded impairment losses of $173 million for our Other segment, primarily relating to our Pathways business, because management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected.

***We operate in an unstable political environment which creates uncertainties with regard to the sources and amounts of our revenues, volatility with regard to the amount of our medical costs, and vulnerability to unforeseen programmatic or regulatory changes.***

As a result of the election of President Trump and the GOP control of both houses of Congress, the future of the ACA and its underlying programs are subject to substantial uncertainty, making long-term business planning exceedingly difficult. We are unable to predict with any degree of certainty whether the ACA will be modified or repealed in its entirety, and if it is repealed, what it will be replaced with; nor are we able to predict when any such changes, if enacted, would become effective.

Currently, there are a number of different legislative proposals being considered, some of which would involve significantly reduced federal spending on the Medicaid program, and constitute a fundamental change in the federal role in health care. These proposals include elements such as the following: ending the entitlement nature of Medicaid (and perhaps Medicare as well) by capping future increases in federal health spending for these programs, and shifting much more of the risk for health costs in the future to states and consumers; reversing the ACA's expansion of Medicaid that enables states to cover low-income childless adults; changing Medicaid to a state block grant program, including potentially capping spending on a per-enrollee basis (a "per capita cap"); requiring Medicaid beneficiaries to work; limiting the amount of lifetime benefits for Medicaid beneficiaries; prohibiting the federal government from operating Marketplaces; eliminating the advanced premium tax credits, and cost sharing reductions for low income individuals who purchase their health insurance through the Marketplaces; expanding and encouraging the use of private health savings accounts; providing for insurance plans that offer fewer and less extensive health insurance benefits than under the ACA's essential health benefits package, including broader use of catastrophic coverage plans; establishing and funding high risk pools or reinsurance programs for individuals with chronic or high cost conditions; allowing insurers to sell insurance across state lines; and numerous other potential changes and reforms. Changes to or the repeal of the ACA, or the adoption of new health care regulatory laws, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***A reversal of the Medicaid Expansion would have a negative impact on our revenues.***

In the states that have elected to participate, the ACA provided for the expansion of the Medicaid program to offer eligibility to nearly all individuals under age 65 with incomes at or below 138% of the federal poverty line. Since January 1, 2014, our health plans in California, Illinois, Michigan, New Mexico, Ohio, and Washington have participated in the Medicaid Expansion program under the ACA. At December 31, 2017, our membership included approximately 668,000 Medicaid Expansion members, or 15% of our total membership. If the Medicaid Expansion is reversed by repeal of the ACA or otherwise, we could lose this membership, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***Our participation in the Marketplace creates certain risks which could adversely impact our business, financial position, and results of operations.***

The ACA authorized the creation of marketplace insurance exchanges (the "Marketplace"), allowing individuals and small groups to purchase federally subsidized health insurance. As of December 31, 2017, we participated in the individual Marketplace in nine states and our Marketplace membership represented 19% of our total membership, or approximately 815,000 members. In an effort to reduce our exposure to the risks related to the Marketplace, we implemented premium increases averaging 58% effective January 1, 2018 and we exited the Marketplace in Utah and Wisconsin. These market exits and price increases have resulted in substantially lower Marketplace membership.

A number of larger commercial insurance plans, including Humana Inc., have discontinued their participation in the Marketplace. The perceived instability and impending changes in the Marketplace could further promote reduced participation among the uninsured. Further, the withdrawal of cost sharing subsidies and/or premium tax credits, the elimination of the individual mandate to purchase health insurance in December 2017, the use of special enrollment periods, or any announcement that some or all of our health plans will be leaving the Marketplace for 2018, could additionally impact Marketplace enrollment. These market and political dynamics may increase the risk that our Marketplace products will be selected by individuals who have a higher risk profile or utilization rate than we anticipated when we established the pricing for our Marketplace products, leading to financial losses.

***The Medicare-Medicaid Duals Demonstration Pilot Programs could be discontinued or altered, resulting in a loss of premium revenue.***

To coordinate care for those who qualify to receive both Medicare and Medicaid services (the "dual eligibles"), and to deliver services to these individuals in a more financially efficient manner, under the direction of CMS some states implemented demonstration pilot programs to integrate Medicare and Medicaid services for dual eligibles.

The health plans participating in such demonstrations are referred to as Medicare-Medicaid Plans (MMPs). We operate MMPs in six states: California, Illinois, Michigan, Ohio, South Carolina, and Texas. At December 31, 2017, our membership included approximately 57,000 integrated MMP members, representing just over 1% of our total membership. However, the capitation payments paid to us for dual eligibles are significantly higher than the capitation payments for other members, representing 8% of our total premium revenues in 2017. If the states running the MMP pilot programs conclude that the demonstration pilot programs are not delivering better coordinated care and reduced costs, they could decide to discontinue or substantially alter such programs, resulting in a reduction to our premium revenues.

***Continuing changes in health care laws, and in the health care industry, make it difficult to develop actuarially sound rates.***

Comprehensive changes to the U.S. health care system make it more difficult for us to manage our business, and increase the likelihood that the assumptions we make with respect to our future operations and results will prove to be inaccurate. The continuing pace of change has made it difficult for us to develop actuarially sound rates because we have limited historical information on which to develop these rates. In the absence of significant historical information to develop actuarial rates, we must make certain assumptions. These assumptions may subsequently prove to be inaccurate. For example, rates of utilization could be significantly higher than we projected, or the assumptions of policymakers about the amount of savings that could be achieved through the use of utilization management in managed care could be flawed. Moreover, our lack of actuarial experience for a particular program, region, or population, could cause us to set our reserves at an inadequate level.

***Our health plans segment operates with very low profit margins, and small changes in operating performance or slight changes to our accounting estimates will have a disproportionate impact on our reported net income.***

A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost-plus and performance-based reimbursement programs. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are potentially subject to differing interpretations by ourselves and the relevant government agency with whom we contract. If the applicable government agency disagrees with our interpretation or implementation of a particular contract provisions at issue, we could be required to adjust the amount of our obligations under these provisions and/or make a payment or payments to such government agency. Any interpretation of these contract provisions by the applicable governmental agency that varies from our interpretation and implementation of the provision, or that is inconsistent with our revenue recognition accounting treatment, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, many of our contracts also contain provisions pertaining to at-risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. If we are unsuccessful in achieving the stated performance measure, we will be unable to recognize the revenue associated with that measure. Any failure of our health plans to satisfy one of these performance measure provisions could have a material adverse effect on our business, financial condition, cash flows or results of operations.

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

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

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

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

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

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

Introduction of new high cost specialty drugs and sudden costs spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism has an adverse impact on our financial condition and results of operations. For example, Gilead priced a new hepatitis C drug, Sovaldi, at $84,000 per standard course of therapy in 2014. With the advent of Sovaldi in early 2014, the cost of the drug was generally not factored into our 2014 capitation rates which undermined the actuarial soundness of those rates. Further, the relatively high incidence of hepatitis C in Medicaid populations coupled with the exorbitant cost of Sovaldi created a public health and public financing problem across the country. More recently, the FDA approved the first drug to treat patients with spinal muscular atrophy, Spinraza, in December 2016. After this approval, the distributor of Spinraza announced that one dose will have a list price of $125,000, which means the drug will cost between $650,000 and $750,000 to cover the five or six doses required in the first year, and approximately $375,000 annually thereafter, presumably for the life of the patient. The inordinate cost of Spinraza was not contemplated in the development of our 2017 capitation rates. In addition, evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will always be successful.

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

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

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

Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Due to insolvency or other circumstances, such providers may be unable to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures may force us to pay such claims even when we have no legal obligation to do so; or we have already paid claims to a delegated provider and such payments cannot be recouped when the

delegated provider becomes insolvent. Liabilities incurred or losses suffered as a result of provider insolvency could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***State and federal budget deficits may result in Medicaid, CHIP, or Medicare funding cuts which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.***

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. As discussed below, such budgetary pressures are particularly intense in the Commonwealth of Puerto Rico. State budgetary pressures may result in unexpected Medicaid, CHIP, or Medicare rate cuts which could reduce our revenues and profit margins. Moreover, some federal deficit reduction or entitlement reform proposals would fundamentally change the structure and financing of the Medicaid program. A number of these proposals include both tax increases and spending reductions in discretionary programs and mandatory programs, such as Social Security, Medicare, and Medicaid.

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

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

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

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

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

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

***The Commonwealth of Puerto Rico may fail to pay the premiums of our Puerto Rico health plan, which could negatively impact our business, financial condition, cash flows, or results of operations.***

The government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it very difficult for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2017, our Puerto Rico health plan served approximately 314,000 members, and had recognized premium revenue of approximately $179 million in the fourth quarter of 2017, or approximately $60 million per month. A default by ASES on its payment obligations under our Medicaid contract, or a determination by ASES to terminate our contract based on insufficient funds available, could result in our having paid, or in our having to pay, provider claims in amounts for which we are not paid reimbursement, and could make it unfeasible for the Puerto Rico health plan to continue to operate. A default by ASES or termination of our Puerto Rico Medicaid contract could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In February 2018, ASES issued an RFP in connection with a new island-wide re-procurement for Medicaid. In the event we do not participate in the re-procurement, or if the responsive bid of our Puerto Rico health plan is unsuccessful, our current contract with ASES will expire without renewal as of December 31, 2018. Our exit from the Commonwealth may result in disruptions to our business, and cause us to incur stranded overhead costs.

***Large-scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.***

Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions. For example, natural disasters, such as a major earthquake in Los Angeles or Cascadia, or a major hurricane in Florida or South Carolina, could have a significant impact on the health of a large number of our covered members. Other conditions that could impact our members include a virulent influenza season or epidemic, or newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikungunya virus, conditions for which vaccines may not exist, are not effective, or have not been widely administered.

In addition, federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction. All of these conditions, and others, could have a significant impact on the health of the population of wide-spread areas. We seek to set our IBNP reserves appropriately to account for anticipatable spikes in utilization, such as for the flu season. However, if one of our health plan states were to experience a large-scale natural disaster, a viral epidemic or pandemic, a significant terrorism attack, or some other large-scale event affecting the health of a large number of our members, our covered medical expenses in that state would rise, which could have a material adverse effect on our business, cash flows, financial condition, or results of operations.

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

We are a corporate parent holding company and hold most of our assets in, and conduct most of our operations through, our direct subsidiaries. As a holding company, our results of operations depend on the results of operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. Our other health plans must give thirty days' advance notice and the opportunity to disapprove "extraordinary" dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. We received $245 million, $100 million, and $125 million in dividends from our regulated health plan subsidiaries during 2017, 2016 and 2015, respectively. The aggregate additional amounts our health plan subsidiaries could have paid us at December 31, 2017 and 2016, without approval of the regulatory authorities, were approximately $85 million and $201 million, respectively. If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments under our senior notes or revolving credit facility (Credit Facility).

***Our use and disclosure of personally identifiable information and other non-public information, including protected health information, is subject to federal and state privacy and security regulations, and our failure to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.***

State and federal laws and regulations including, but not limited to, HIPAA and the Gramm-Leach-Bliley Act, govern the collection, dissemination, use, privacy, confidentiality, security, availability, and integrity of personally identifiable information (PII), including protected health information, or PHI. HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities and business associates, including health plans such as ours. HIPAA requires covered entities like us to develop and maintain policies and procedures for PHI that is used or disclosed, and to adopt administrative, physical, and technical safeguards to protect PHI. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when

submitting or receiving certain electronic health care transactions, including activities associated with the billing and collection of health care claims.

Mandatory penalties for HIPAA violations range from $100 to $50,000 per violation, and up to $1.5 million per violation of the same standard per calendar year. A single breach incident can result in violations of multiple standards, resulting in possible penalties potentially in excess of $1.5 million. If a person knowingly or intentionally obtains or discloses PHI in violation of HIPAA requirements, criminal penalties may also be imposed. HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. We have experienced HIPAA breaches in the past, including breaches affecting over 500 individuals.

New health information standards, whether implemented pursuant to HIPAA, congressional action, or otherwise, could have a significant effect on the manner in which we must handle health care related data, and the cost of complying with standards could be significant. If we do not comply with existing or new laws and regulations related to PHI, PII, or non-public information, we could be subject to criminal or civil sanctions. Any security breach involving the misappropriation, loss, or other unauthorized disclosure or use of confidential member information, whether by us or a third party, such as our vendors, could subject us to civil and criminal penalties, divert management's time and energy, and have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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

Because we receive payments from federal and state governmental agencies, we are subject to various laws commonly referred to as "fraud and abuse" laws, including federal and state anti-kickback statutes, prohibited referrals, and the federal False Claims Act, which permit agencies and enforcement authorities to institute a suit against us for violations and, in some cases, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, or the institution of corporate integrity agreements. Liability under such federal and state statutes and regulations may arise if we know, or it is found that we should have known, that information we provide to form the basis for a claim for government payment is false or fraudulent, and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements. Fraud, waste and abuse prohibitions encompass a wide range of operating activities, including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a provider, upcoding, payments made to excluded providers, improper marketing, and the violation of patient privacy rights. In particular, there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices, particularly in the Medicare program. Companies involved in public health care programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud, waste and abuse, and are often the subject of fraud, waste and abuse investigations and audits. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. The federal government has taken the position that claims presented in violation of the federal anti-kickback statute may be considered a violation of the federal False Claims Act. In addition, under the federal civil monetary penalty statute, the U.S. Department of Health and Human Services (HHS), Office of Inspector General has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. *Qui tam* actions under federal and state law can be brought by any individual on behalf of the government. *Qui tam* actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay fines, or be excluded from the Medicare, Medicaid, or other state or federal health care programs as a result of an investigation arising out of such action. We have been the subject of *qui tam* actions in the past and other *qui tam* actions may be filed against us in the future. If we are subject to liability under a *qui tam* or other actions, our business, financial condition, cash flows, or results of operations could be adversely affected.

***Failure to attain profitability in any new start-up operations could negatively affect our results of operations.***

Start-up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process

claims. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, the new business would fail. We also could be required by the state or commonwealth to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our start-up costs.

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

***Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, stock price, and result in our inability to maintain compliance with applicable stock exchange listing requirements.***

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses.

We have identified material weaknesses in our internal control over financial reporting in the past, which have subsequently been remediated. If additional material weaknesses in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results.

Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are unable to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identify deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the New York Stock Exchange, SEC, or other regulatory authorities which would require additional financial and management resources.

This Form 10-K reflects management's conclusion regarding the effectiveness of our disclosure controls and procedures and internal control over financial reporting as of December 31, 2017. See “Management and Auditor’s Reports - Management’s Evaluation of Disclosure Controls and Procedures and Management’s Report on Internal Control Over Financial Reporting.”

***We are dependent on the leadership of our new chief executive officer and other executive officers and key employees.***

In May 2017, our board of directors terminated both our former chief executive officer and our former chief financial officer. On November 6, 2017, following an intensive six month executive search effort, the board hired Mr. Joseph Zubretsky as our new chief executive officer. Mr. Zubretsky, in turn, has hired other senior level executives. Under the leadership and direction of Mr. Zubretsky, our executive team has launched a vigorous turnaround plan, including many profit improvement initiatives. Our turnaround plan and operational improvements are highly dependent on the efforts of Mr. Zubretsky and our other key executive officers and employees. The loss of their leadership, expertise, and experience could negatively impact our operations. Our ability to replace them or any other key employee may be difficult and may take an extended period of time because of the limited number of individuals in the health care industry who have the breadth and depth of skills and experience necessary to operate and lead a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain, or motivate these personnel. If we are unsuccessful in recruiting, retaining, managing, and motivating such personnel, our business, financial condition, cash flows, or results of operations may be adversely affected.

***We face various risks inherent in the government contracting process that could materially and adversely affect our business and profitability, including periodic routine and non-routine reviews, audits, and investigations by government agencies.***

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

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

As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. To ensure information security, we have implemented controls to protect the confidentiality, integrity and availability of this data and the systems that store and transmit such data. However, our information technology systems and safety control systems are subject to a growing number of threats from computer programmers, hackers, and other adversaries that may be able to penetrate our network security and misappropriate our confidential information or that of third parties, create system disruptions, or cause damage, security issues, or shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit security vulnerabilities. Because the techniques used to circumvent, gain access to, or sabotage security systems can be highly sophisticated and change frequently, they often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world. We may be unable to anticipate these techniques or implement adequate preventive measures, resulting in potential data loss and damage to our systems. Our systems are also subject to compromise from internal threats such as improper action by employees including malicious insiders, vendors, counterparties, and other third parties with otherwise legitimate access to our systems. Our policies, employee training (including phishing prevention training), procedures and technical safeguards may not prevent all improper access to our network or proprietary or confidential information by employees, vendors, counterparties, or other third parties. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, or other similar events that could negatively affect our systems and our and our members' data.

Moreover, we face the ongoing challenge of managing access controls in a complex environment. The process of enhancing our protective measures can itself create a risk of systems disruptions and security issues. Given the breadth of our operations and increasing sophistication of cyberattacks, a particular incident could occur and persist for an extended period of time before being detected. The extent of a particular cyberattack and the steps that we may need to take to investigate the attack may take a significant amount of time before such an investigation could be completed and full and reliable information about the incident is known. During such time, the extent of any harm or how best to remediate it might not be known, which could further increase the risks, costs, and consequences of a data security incident. In addition, our systems must be routinely updated, patched, and upgraded to protect against known vulnerabilities. The volume of new software vulnerabilities has increased substantially, as has the importance of patches and other remedial measures. In addition to remediating newly identified vulnerabilities, previously identified vulnerabilities must also be updated. We are at risk that cyber attackers exploit these known vulnerabilities before they have been addressed. The complexity of our systems and platforms that we operate, the increased frequency at which vendors are issuing security patches to their products, our need to test patches, and in some instances, coordinate with third-parties before they can be deployed, all could further increase our risks. The increased use of mobile devices and other technologies can heighten these and other risks. Furthermore, certain aspects of the security of various technologies are unpredictable or beyond our control.

The cost to eliminate or address the foregoing security threats and vulnerabilities before or after a cyber-incident could be significant. We may need to expend significant additional resources in the future to continue to protect

against potential security breaches or to address problems caused by such attacks or any breach of our systems. Our remediation efforts may not be successful and could result in interruptions, delays, or cessation of service, and loss of members, vendors, and state contracts. In addition, breaches of our security measures and the unauthorized dissemination of sensitive personal information or proprietary information or confidential information about our members could expose our members to the risk of financial or medical identity theft, or expose us or other third parties to a risk of loss or misuse of this information, result in litigation and potential liability for us (including but not limited to material fines, damages, consent orders, penalties and/or remediation costs, mandatory disclosure to the media and regulators, or enforcement proceedings), damage our reputation, or otherwise have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying them. These laws and regulations, along with the terms of our government contracts, regulate how we do business, what services we offer, and how we interact with members and the public. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations, could reduce our profitability by imposing additional capital requirements, increasing our liability, increasing our administrative and other costs, increasing mandated benefits, forcing us to restructure our relationships with providers, requiring us to implement additional or different programs and systems, or making it more difficult to predict future results. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

***Potential divestitures of businesses or product lines may materially adversely affect our business, financial condition, cash flows, or results of operations.***

As a part of our business strategy, we continually review our products and business lines across all geographies to identify opportunities for performance improvement. Depending on the particular circumstances, we may determine that a divestiture of one or more businesses or product lines would be the best means to further our plan to improve and sustain profitability and enhance our focus on the execution of our business plan. Divestitures involve risks, including: difficulties in the separation of operations, services, products and personnel; the diversion of management's attention from other business concerns; the disruption of our business; the potential loss of key employees; the retention of uncertain contingent liabilities related to the divested business or product line; and the failure of our efforts to divest any such business or product line on the terms and time frames desired by management, or at all. Furthermore, we may be unsuccessful in finding a replacement for any lost revenue or income previously derived from the divested business or product line. In addition, divestitures may result in significant impairment charges, including those related to goodwill and other intangible assets, all of which could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***Our encounter data may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs.***

Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and to set premium rates. We have expended and may continue to expend additional effort and incur significant additional costs to collect or correct inaccurate or incomplete encounter data and have been, and continue to be exposed to, operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data.

We have experienced challenges in obtaining complete and accurate encounter data, due to difficulties with providers and third-party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could

adversely affect the premium rates we receive and how membership is assigned to us and subject us to financial penalties, which could have a material adverse effect on our results of operations, financial condition, cash flows and our ability to bid for, and continue to participate in, certain programs.

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

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

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. On an ongoing basis, we evaluate the ability of our existing operations to support our current and future business needs and to maintain our compliance requirements. As a result, we periodically consolidate, integrate, upgrade and expand our information systems capabilities as a result of technology initiatives, industry trends and recently enacted regulations, and changes in our system platforms. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in information processing technology, evolving systems and regulatory standards and changing customer preferences.

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

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

Our corporate headquarters is located in Long Beach, California. In addition, some of our health plans' claims are processed in Long Beach. Southern California is exposed to a statistically greater risk of a major earthquake than most other parts of the United States. If a major earthquake were to strike the Los Angeles area, our corporate functions and claims processing could be significantly impaired for a substantial period of time. If there is a major Southern California earthquake, there can be no assurances that our disaster recovery plan will be successful or that the business operations of all our health plans and our Molina Medicaid Solutions segment, including those that are remote from any such event, would not be substantially impacted.

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

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, health care regulatory law-based litigation, breach of contract actions, intellectual property infringement actions, and securities class actions. If we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. As an employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our plans are subject to liability for negligent acts, omissions, or injuries occurring at one of our clinics or caused by one of our employees. Given the significant amount of some medical malpractice awards and settlements, the medical malpractice insurance that we maintain may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management's attention.

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

We cannot predict the outcome of any lawsuit. Some of the liabilities related to litigation that we may incur may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us. The litigation to which we are subject could have a material adverse effect on our business, financial condition, results of operations, and cash flows.

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

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

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

We contract with third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Some of these third-parties also have direct access to our systems. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data or the information and data relating to our members or customers. We are also at risk of a data security incident involving a vendor or third party, which could result in a breakdown of such third party's data protection processes or cyber-attackers gaining access to our infrastructure through the third party. To the extent that a vendor or third party suffers a data security incident that compromises its operations, we could incur significant costs and possible service interruption, which could have an adverse effect on our business and operations. In addition, we may have disagreements with third party vendors and service providers regarding relative responsibilities for any such failures or incidents under applicable business associate agreements or other applicable outsourcing agreements. Any contractual remedies and/or indemnification obligations we may have for vendor or service provider failures or incidents may not be adequate to fully compensate us for any losses suffered as a result of any vendor's failure to satisfy its obligations to us or under applicable law. Further, we may not be adequately indemnified against all possible losses through the terms and conditions of our contracts with third party vendors and service providers. Our outsourcing arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition or other matters outside of our control. If we fail to adequately monitor and regulate the performance of our third party vendors and service providers, we could be subject to additional risk, including significant cybersecurity risk. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs and/or disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, or results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third party vendors and service providers, as a result of regulatory restrictions on outsourcing, unanticipated delays in transitioning our operations to the third party, vendor or service provider noncompliance with contract terms or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***Our substantial indebtedness could adversely affect our ability to raise additional capital to fund our operations, limit our ability to react to changes in the economy or our industry, expose us to interest rate risk to the extent of any variable rate debt, and prevent us from meeting our obligations under our outstanding indebtedness.***

We have a significant amount of indebtedness. As of December 31, 2017, our total indebtedness was approximately $2,169 million, including lease financing obligations. As of December 31, 2017, we also had $194 million available for borrowing under our Credit Facility. In addition, as of January 2, 2018, we had $550 million available under our Bridge Credit Agreement, subject to the use of proceeds conditions set forth therein.

Our substantial indebtedness could have significant consequences, including:

- increasing our vulnerability to adverse economic, industry, or competitive developments;
- requiring a substantial portion of our cash flows from operations to be dedicated to the payment of principal and interest on our indebtedness, therefore reducing our ability to use our cash flows to fund operations, make capital expenditures, and pursue future business opportunities;
- exposing us to the risk of increased interest rates to the extent of any future borrowings, including borrowings under our Credit Facility, at variable rates of interest;
- making it more difficult for us to satisfy our obligations with respect to our indebtedness, including our Credit Facility and our outstanding senior notes, and any failure to comply with the obligations of any of our debt instruments, including restrictive covenants and borrowing conditions, could result in an event of default under the indenture governing our outstanding senior notes and the agreements governing such other indebtedness;
- restricting us from making strategic acquisitions or causing us to make non-strategic divestitures;
- limiting our ability to obtain additional financing for working capital, capital expenditures, product and service development, debt service requirements, acquisitions, and general corporate or other purposes; and
- limiting our flexibility in planning for, or reacting to, changes in our business or market conditions and placing us at a competitive disadvantage compared to our competitors who are less highly leveraged and who, therefore, may be able to take advantage of opportunities that our substantial indebtedness may prevent us from exploiting.

***The terms of our debt impose, and will impose, restrictions on us that may affect our ability to successfully operate our business and our ability to make payments on our outstanding senior notes.***

The indentures governing our outstanding senior notes and the credit agreement governing our Credit Facility contain various covenants that could materially and adversely affect our ability to finance our future operations or capital needs and to engage in other business activities that may be in our best interest. These covenants limit our ability to, among other things:

- incur additional indebtedness or issue certain preferred equity;
- pay dividends on, repurchase, or make distributions in respect of our capital stock, prepay, redeem, or repurchase certain debt or make other restricted payments;
- make certain investments;
- create certain liens;
- sell assets, including capital stock of restricted subsidiaries;
- enter into agreements restricting our restricted subsidiaries' ability to pay dividends to us;
- consolidate, merge, sell, or otherwise dispose of all or substantially all of our assets;
- enter into certain transactions with our affiliates; and
- designate our restricted subsidiaries as unrestricted subsidiaries.

All of these covenants may restrict our ability to pursue our business strategies. Our ability to comply with these covenants may be affected by events beyond our control, such as prevailing economic conditions and changes in regulations, and if such events occur, we cannot be sure that we will be able to comply. A breach of these covenants could result in a default under the indentures for our outstanding senior notes and/or the credit agreement

governing our Credit Facility and the Bridge Credit Agreement including, as a result of cross default provisions and, in the case of our Credit Facility and our Bridge Credit Agreement, permit the lenders to cease making loans to us. If there were an event of default under the indentures governing our outstanding senior notes and/or the credit agreement governing our Credit Facility, holders of such defaulted debt could cause all amounts borrowed under these instruments to be due and payable immediately. Our assets or cash flow may not be sufficient to repay borrowings under our outstanding debt instruments in the event of a default thereunder.

In addition, the restrictive covenants in the credit agreement governing our Credit Facility require us to maintain specified financial ratios and satisfy other financial condition tests. Our ability to meet those financial ratios and tests will depend on our ongoing financial and operating performance, which, in turn, will be subject to economic conditions and to financial, market, and competitive factors, many of which are beyond our control.

If our operating performance declines, we may be required to obtain waivers from the lenders under our Credit Facility, from the holders of our outstanding senior notes or from the holders of other obligations, to avoid defaults thereunder. For example, in February 2017, to avoid default under our Credit Facility as a result of our failure to comply with certain financial covenants therein applicable to the three months ended December 31, 2016, we sought, and obtained, a waiver of such defaults by the required lenders under our Credit Facility.

If we are not able to obtain such waivers, our creditors could exercise their rights upon default, and we could be forced into bankruptcy or liquidation.

***We may not have the funds necessary to pay the amounts due upon conversion or required repurchase of our outstanding notes, and our indebtedness may contain limitations on our ability to pay the amounts due upon conversion or required repurchase.***

As of December 31, 2017, the aggregate outstanding principal amount of our 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes), and our 1.625% convertible senior notes due 2044 (1.625% Convertible Notes) was $550 million and $161 million, respectively. Both our 1.125% Convertible Notes and our 1.625% Convertible Notes are convertible into cash prior to their respective maturity dates under certain circumstances, one of which relates to the closing price of our common stock over a specified period. We refer to this conversion trigger as the stock price trigger. The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended December 31, 2017, and are convertible to cash through at least March 31, 2018. Because the 1.125% Convertible Notes may be converted into cash within 12 months, their carrying amount is reported in current portion of long-term debt as of December 31, 2017. For economic reasons related to the trading market for our 1.125% Convertible Notes, we believe that the amount of the notes that may be converted over the next twelve months, if any, will not be significant. However, if the trading market for our 1.125% Convertible Notes becomes closed or restricted due to market turmoil or other reasons such that the notes cannot be traded, or if the trading price of our 1.125% Convertible Notes, which normally trade at a marginal premium to the underlying composite stock-and-interest economic value, no longer includes that marginal premium, holders of our 1.125% Convertible Notes may elect to convert the notes to cash.

The stock price trigger for the 1.625% Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended December 31, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of December 31, 2017.

If conversion requests are received, the settlement of the notes must be paid primarily in cash pursuant to the terms of the relevant indentures.

In addition, in the event of a change in control or the termination in trading of our stock, each holder of our 1.125% Convertible Notes and our 1.625% Convertible Notes would have the right to require us to purchase some or all of their notes at a purchase price in cash equal to 100% of the principal amount of the notes, plus any accrued and unpaid interest.

Our ability to comply with the conversion or repurchase obligations under our 1.125% Convertible Notes and our 1.625% Convertible Notes will depend on the extent to which we have cash or financing available to satisfy such obligations and may also be limited by law, by regulatory authority, or by agreements governing our future indebtedness. The indentures for the 1.125% Convertible Notes and the 1.625% Convertible Notes provide that it would be an event of default if we do not make the cash payments due upon conversion or required repurchase of the notes. The occurrence of an event of default under one or both of these indentures may also constitute an event of default under our Credit Facility, our Bridge Credit Agreement and under our other indebtedness we may have

outstanding at such time. Any such default could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

***We may not be able to generate sufficient cash to service all of our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.***

Our ability to make scheduled payments on or to refinance our debt obligations depends on our financial condition and operating performance, which is subject to prevailing economic and competitive conditions and to certain financial, business, and other factors beyond our control. We may not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, and interest on our indebtedness.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay investments and capital expenditures, or to sell assets, seek additional capital, or restructure or refinance our indebtedness. Our ability to restructure or refinance our debt will depend on the condition of the capital markets and our financial condition at such time. Any refinancing of our debt could be at higher interest rates and may require us to comply with onerous covenants, which could further restrict our business operations. The terms of existing or future debt instruments, including our Credit Facility and Bridge Credit Agreement, and the indentures governing our outstanding senior notes, may restrict us from adopting some of these alternatives. In addition, any failure to make payments of interest and principal on our outstanding indebtedness on a timely basis would likely result in a reduction of our credit rating, which would harm our ability to incur additional indebtedness. These alternative measures may not be successful and may not permit us to meet our scheduled debt service obligations.

***A lowering or withdrawal of the ratings assigned to our debt securities by rating agencies may increase our future borrowing costs and reduce our access to capital.***

There can be no assurance that any rating assigned by the rating agencies to our debt or our corporate rating will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, future circumstances relating to the basis of the rating, such as adverse changes, so warrant. During 2017, both Moody's and Standard and Poor's downgraded our debt ratings. In February 2018, both Moody's and S&P downgraded our corporate and debt ratings further to BB- and B3, respectively, with modest negative impact on future borrowing cost. A further lowering or withdrawal of the ratings assigned to our debt securities by rating agencies would likely increase our future borrowing costs and reduce our access to capital, which could have a materially adverse impact on our business, financial condition, cash flows, or results of operations.

***If federal spending on the Medicaid program is reduced, populations served by Molina Medicaid Solutions could decline and our revenues could be materially reduced.***

As noted above, some of the ACA modifications considered involve significantly reduced federal spending on the Medicaid program. Among the proposals being considered include reversing the ACA's expansion of Medicaid, and changing Medicaid to a state block grant program, possibly including a per capita cap. An end to Medicaid Expansion could lower the populations served by Molina Medicaid Solutions. Changing Medicaid to a state block grant program would turn control of the program to states and cap what the federal government spends on Medicaid each year. Fixed state block grants could mean states will cut benefits or force beneficiaries to take on more cost-sharing. If Medicaid Expansion were reversed and the funding of Medicaid capped, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

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

Molina Medicaid Solutions currently provides business processing and information technology development and administrative services to Medicaid agencies in Idaho, Louisiana, Maine, New Jersey, West Virginia, and the U.S. Virgin Islands, and drug rebate administration services in Florida. If we are unable to continue to operate in any of those six jurisdictions, or if our current operations in any of those jurisdictions are significantly curtailed, the revenues and cash flows of Molina Medicaid Solutions could decrease materially, and as a result our profitability would be negatively impacted.

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

The government contracts of Molina Medicaid Solutions may be subject to periodic competitive bidding. In such process, Molina Medicaid Solutions may face competition as other service providers, some with much greater

financial resources and greater name recognition, attempt to enter our markets through the competitive bidding process. Molina Medicaid Solutions also anticipates bidding in other states which have issued RFPs for procurement of a new MMIS. If our responsive bids in other states are not successful, we will be unable to grow in a manner consistent with our projections. In addition, we may be unable to support the carrying amount of goodwill we have recorded for this business, because its fair value estimated future cash flows. Even if our responsive bids are successful, the bids may be based upon assumptions or other factors which could result in the contract being less profitable than we had expected or had been the case prior to competitive re-bidding.

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

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

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

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

***Our business may be adversely affected by the transition from traditional fee-for-service to Medicaid managed care.***

To reduce expenses, a number of state Medicaid programs are expected to pursue the transition from a fee-for-service focus of their Medicaid programs to a Medicaid managed care focus. A shift in Medicaid payment models from fee-for-service to managed care will require a concomitant shift in the focus of MMIS. In connection with such a transition, MMIS must also make a transition from a system built around claims adjudication to one that performs analytics and can be used to manage Medicaid population health outcomes. If our Molina Medicaid Solutions segment is unable to accomplish this transition, our business, financial condition, cash flows, or results of operations may be adversely affected.

## Risks Related to Our Common Stock

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

We may issue equity securities in the future, or securities that are convertible into or exchangeable for, or that represent the right to receive, shares of our common stock. Sales of a substantial number of shares of our common stock or other equity securities, including sales of shares in connection with any future acquisitions, could be substantially dilutive to our stockholders. These sales may have a harmful effect on prevailing market prices for our common stock and our ability to raise additional capital in the financial markets at a time and price favorable to us. Moreover, to the extent that we issue restricted stock units, stock appreciation rights, options, or warrants to purchase our common stock in the future and those stock appreciation rights, options, or warrants are exercised or as the restricted stock units vest, our stockholders may experience further dilution. Holders of our shares of

common stock have no preemptive rights that entitle holders to purchase a pro rata share of any offering of shares of any class or series and, therefore, such sales or offerings could result in increased dilution to our stockholders. Our certificate of incorporation provides that we have authority to issue 150 million shares of common stock and 20 million shares of preferred stock. As of December 31, 2017, approximately 60 million shares of common stock and no shares of preferred or other capital stock were issued and outstanding.

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

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

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

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

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

Further, our board of directors or a committee thereof has the power, without stockholder approval, to designate the terms of one or more series of preferred stock and issue shares of preferred stock. The ability of our board of directors or a committee thereof to create and issue a new series of preferred stock could impede a merger, takeover or other business combination involving us or discourage a potential acquirer from making a tender offer for our common stock, which, under certain circumstances, could reduce the market price of our common stock.

# LEGAL PROCEEDINGS

Refer to the Notes to Consolidated Financial Statements, Note 19, “Commitments and Contingencies—Legal Proceedings,” for a discussion of legal proceedings.

# MANAGEMENT AND AUDITOR’S REPORTS

## MANAGEMENT’S EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES

We maintain disclosure controls and procedures, as defined in Rule 13a-15(e) and Rule 15d-15(e) under the Securities Exchange Act of 1934, as amended (the Exchange Act), that are designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is accumulated and communicated to our management, including our principal executive officer and principal financial officer or persons performing similar functions, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost-benefit relationship of any possible controls and procedures.

Under the supervision and with the participation of our management, including our chief executive officer and our chief financial officer, we carried out an evaluation of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this Form 10-K pursuant to Rule 13a-15(b) and Rule 15d-15(b) of the Exchange Act. Based on this evaluation and after consideration of the remediation of the two material weaknesses in our internal control over financial reporting described below, our chief executive officer and our chief financial officer concluded that, our disclosure controls and procedures were effective as of December 31, 2017, at the reasonable assurance level. In addition, management concluded that our consolidated financial statements included in this Annual Report on Form 10-K are fairly stated in all material respects in accordance with U.S. generally accepted accounting principles (GAAP) for each of the periods presented herein.

## MANAGEMENT'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING

Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Exchange Act. Our internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors, and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on our financial statements.

Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with GAAP. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of the effectiveness of our internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

After consideration of the remediation of the two material weaknesses described below, management concluded that we maintained effective internal control over financial reporting as of December 31, 2017, based on criteria described in *Internal Control-Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

Ernst & Young, LLP, the independent registered public accounting firm who audited our Consolidated Financial Statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis. The Company determined that a material weakness in its internal control over financial reporting existed at December 31, 2016, and an additional material weakness existed at September 30, 2017. The following describes those material weaknesses and their remediation.

***Material Weakness as of December 31, 2016***

As disclosed in our Annual Report on Form 10-K for the year ended December 31, 2016, our management determined that as of December 31, 2016 a material weakness existed in our internal control over financial reporting relating to the operation of an element of its process for calculating the amount owed to California by its California health plan. More specifically, a Medicaid Expansion contract amendment executed in the fourth quarter of 2016 changed the medical loss ratio corridor formula and such amendment was not initially considered in determining the liability. As a result, we understated net income by $44 million for the year ended December 31, 2016, which is material to our consolidated results for the year ended December 31, 2016. This amount was corrected prior to the issuance of our consolidated financial statements as of and for the year ended December 31, 2016.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of December 31, 2016, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

We have executed a remediation plan to address this material weakness. The remediation efforts we have implemented included the development of robust protocols to ensure that the control relating to the review of a

contractual amendment affecting the computation of the Medicaid Expansion medical loss ratio corridor for our California health plan will operate as designed.

We have tested the operating effectiveness of the historical control, and new controls subsequent to implementation and, as a result, believe these measures have remediated the material weakness as of December 31, 2016 identified above and strengthened our internal control over financial reporting for the computation of our California Medicaid Expansion medical loss ratio corridor.

***Material Weakness as of September 30, 2017***

As disclosed in our Quarterly Report on Form 10-Q for the three months ended September 30, 2017, our management determined that as of September 30, 2017, a material weakness existed in our internal control over financial reporting relating to the design and operating effectiveness of our internal control for our interim goodwill impairment tests for our Pathways subsidiary and Molina Medicaid Solutions segment. Specifically, spreadsheet formula errors in our valuation model, and errors made in the calculation of impairment losses recorded, were not detected in our review procedures. As a result, we initially miscalculated the goodwill impairment in the three months ended September 30, 2017. The impairment calculation was corrected prior to the filing of our unaudited consolidated financial statements as of and for the three and nine months ended September 30, 2017.

Because of this material weakness, management concluded that we did not maintain effective internal control over financial reporting as of September 30, 2017, based on criteria described in *Internal Control - Integrated Framework* (2013) issued by COSO.

We have implemented a remediation plan to address this material weakness. The remediation efforts included: enhancement of the design of the controls relating to the computation and rigor of review of the goodwill impairment tests; engagement of additional subject matter experts to support the valuation calculations, key assumptions and review process; and development of new review controls that operate at an appropriate level of precision to prevent or detect potential material errors within the valuation calculations.

We have tested the operating effectiveness of the new controls subsequent to implementation and, as a result, believe these measures have remediated the material weakness as of September 30, 2017, identified above and strengthened our internal control over financial reporting for our interim goodwill impairment tests for our Pathways subsidiary and Molina Medicaid Solutions segment.

***Changes in Internal Control over Financial Reporting***

Except as described above, management did not identify any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) during the quarter ended December 31, 2017, that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

# REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

**To the Stockholders and the Board of Directors of Molina Healthcare, Inc.**

**Opinion on Internal Control over Financial Reporting**

We have audited Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Molina Healthcare, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2017, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2017 and 2016, the related consolidated statements of operations, comprehensive (loss) income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2017, and the related notes and our report dated March 1, 2018, expressed an unqualified opinion thereon.

**Basis for Opinion**

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

**Definition and Limitations of Internal Control Over Financial Reporting**

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2018

# REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

**To the Stockholders and the Board of Directors of Molina Healthcare, Inc.**

**Opinion on the Financial Statements**

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2017 and 2016, and the related consolidated statements of operations, comprehensive (loss) income, stockholders' equity and cash flows, for each of the three years in the period ended December 31, 2017, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the consolidated financial position of the Company as of December 31, 2017 and 2016, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2017, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2017, based on criteria established in *Internal Control — Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated March 1, 2018, expressed an unqualified opinion thereon.

**Basis for Opinion**

These financial statements are the responsibility of the Company‘s management. Our responsibility is to express an opinion on the Company‘s financial statements based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (“PCAOB“) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ ERNST & YOUNG LLP

We have served as the Company’s auditor since 2000.

Los Angeles, California

March 1, 2018

# AUDITED FINANCIAL STATEMENTS AND NOTES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# MOLINA HEALTHCARE, INC.
# CONSOLIDATED STATEMENTS OF OPERATIONS

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions, except per-share data) | | |
| Revenue: | | | |
| Premium revenue | $ 18,854 | $ 16,445 | $ 13,261 |
| Service revenue | 521 | 539 | 253 |
| Premium tax revenue | 438 | 468 | 397 |
| Health insurer fees reimbursed | — | 292 | 244 |
| Investment income and other revenue | 70 | 38 | 23 |
| Total revenue | 19,883 | 17,782 | 14,178 |
| Operating expenses: | | | |
| Medical care costs | 17,073 | 14,774 | 11,794 |
| Cost of service revenue | 492 | 485 | 193 |
| General and administrative expenses | 1,594 | 1,393 | 1,146 |
| Premium tax expenses | 438 | 468 | 397 |
| Health insurer fees | — | 217 | 157 |
| Depreciation and amortization | 137 | 139 | 104 |
| Impairment losses | 470 | — | — |
| Restructuring and separation costs | 234 | — | — |
| Total operating expenses | 20,438 | 17,476 | 13,791 |
| Operating (loss) income | (555) | 306 | 387 |
| Other expenses, net: | | | |
| Interest expense | 118 | 101 | 66 |
| Other income, net | (61) | — | (1) |
| Total other expenses, net | 57 | 101 | 65 |
| (Loss) income before income tax (benefit) expense | (612) | 205 | 322 |
| Income tax (benefit) expense | (100) | 153 | 179 |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| | | | |
| Net (loss) income per share: | | | |
| Basic | $ (9.07) | $ 0.93 | $ 2.75 |
| Diluted | $ (9.07) | $ 0.92 | $ 2.58 |
| | | | |
| Weighted average shares outstanding: | | | |
| Basic | 56 | 55 | 52 |
| Diluted | 56 | 56 | 56 |

See accompanying notes.

# MOLINA HEALTHCARE, INC.
# CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| Other comprehensive (loss) income: | | | |
| Unrealized investment (loss) gain | (5) | 3 | (5) |
| Less: effect of income taxes | (2) | 1 | (2) |
| Other comprehensive (loss) income, net of tax | (3) | 2 | (3) |
| Comprehensive (loss) income | $ (515) | $ 54 | $ 140 |

See accompanying notes.

# MOLINA HEALTHCARE, INC.
# CONSOLIDATED BALANCE SHEETS

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| | (In millions, except per-share data) | |
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 3,186 | $ 2,819 |
| Investments | 2,524 | 1,758 |
| Restricted investments | 169 | — |
| Receivables | 871 | 974 |
| Income taxes refundable | 54 | 39 |
| Prepaid expenses and other current assets | 185 | 131 |
| Derivative asset | 522 | 267 |
| Total current assets | 7,511 | 5,988 |
| Property, equipment, and capitalized software, net | 342 | 454 |
| Deferred contract costs | 101 | 86 |
| Intangible assets, net | 69 | 140 |
| Goodwill | 186 | 620 |
| Restricted investments | 119 | 110 |
| Deferred income taxes | 103 | 10 |
| Other assets | 40 | 41 |
| | $ 8,471 | $ 7,449 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| Current liabilities: | | |
| Medical claims and benefits payable | $ 2,192 | $ 1,929 |
| Amounts due government agencies | 1,542 | 1,202 |
| Accounts payable and accrued liabilities | 366 | 385 |
| Deferred revenue | 282 | 315 |
| Current portion of long-term debt | 653 | 472 |
| Derivative liability | 522 | 267 |
| Total current liabilities | 5,557 | 4,570 |
| Long-term debt | 1,318 | 975 |
| Lease financing obligations | 198 | 198 |
| Deferred income taxes | — | 15 |
| Other long-term liabilities | 61 | 42 |
| Total liabilities | 7,134 | 5,800 |
| Stockholders' equity: | | |
| Common stock, $0.001 par value; 150 shares authorized; outstanding: 60 shares at December 31, 2017 and 57 shares at December 31, 2016 | — | — |
| Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding | — | — |
| Additional paid-in capital | 1,044 | 841 |
| Accumulated other comprehensive loss | (5) | (2) |
| Retained earnings | 298 | 810 |
| Total stockholders' equity | 1,337 | 1,649 |
| | $ 8,471 | $ 7,449 |

See accompanying notes.

# MOLINA HEALTHCARE, INC.
# CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

| | Common Stock | | Additional Paid-in Capital | Accumulated Other Comprehensive Loss | Retained Earnings | Total |
|---|---|---|---|---|---|---|
| | Outstanding | Amount | | | | |
| | | | (In millions) | | | |
| Balance at January 1, 2015 | 50 | $ — | $ 396 | $ (1) | $ 615 | $ 1,010 |
| Net income | — | — | — | — | 143 | 143 |
| Other comprehensive loss, net | — | — | — | (3) | — | (3) |
| Common stock offering, including issuance costs | 6 | — | 373 | — | — | 373 |
| Share-based compensation | — | — | 26 | — | — | 26 |
| Tax benefit from share-based compensation | — | — | 8 | — | — | 8 |
| Balance at December 31, 2015 | 56 | — | 803 | (4) | 758 | 1,557 |
| Net income | — | — | — | — | 52 | 52 |
| Other comprehensive income, net | — | — | — | 2 | — | 2 |
| Share-based compensation | 1 | — | 36 | — | — | 36 |
| Tax benefit from share-based compensation | — | — | 2 | — | — | 2 |
| Balance at December 31, 2016 | 57 | — | 841 | (2) | 810 | 1,649 |
| Net loss | — | — | — | — | (512) | (512) |
| Other comprehensive loss, net | — | — | — | (3) | — | (3) |
| 1.625% Convertible Notes exchange transaction | 3 | — | 161 | — | — | 161 |
| Share-based compensation | — | — | 42 | — | — | 42 |
| Balance at December 31, 2017 | 60 | $ — | $ 1,044 | $ (5) | $ 298 | $ 1,337 |

See accompanying notes.

# MOLINA HEALTHCARE, INC.
# CONSOLIDATED STATEMENTS OF CASH FLOWS

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Operating activities: | | | |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| Adjustments to reconcile net (loss) income to net cash provided by operating activities: | | | |
| Depreciation and amortization | 178 | 182 | 126 |
| Impairment losses | 470 | — | — |
| Deferred income taxes | (94) | 22 | (7) |
| Share-based compensation | 46 | 26 | 23 |
| Non-cash restructuring charges | 60 | — | — |
| Amortization of convertible senior notes and lease financing obligations | 32 | 31 | 30 |
| Loss on debt extinguishment | 14 | — | — |
| Other, net | 21 | 16 | 19 |
| Changes in operating assets and liabilities: | | | |
| Receivables | 103 | (348) | 56 |
| Prepaid expenses and other current assets | (56) | (69) | (35) |
| Medical claims and benefits payable | 263 | 226 | 482 |
| Amounts due government agencies | 341 | 473 | 202 |
| Accounts payable and accrued liabilities | (12) | (4) | 84 |
| Deferred revenue | (34) | 92 | 24 |
| Income taxes | (16) | (26) | (22) |
| Net cash provided by operating activities | 804 | 673 | 1,125 |
| Investing activities: | | | |
| Purchases of investments | (2,718) | (1,929) | (1,923) |
| Proceeds from sales and maturities of investments | 1,771 | 1,966 | 1,126 |
| Purchases of property, equipment and capitalized software | (86) | (176) | (132) |
| (Increase) decrease in restricted investments held-to-maturity | (12) | 4 | (6) |
| Net cash paid in business combinations | — | (48) | (450) |
| Other, net | (28) | (19) | (35) |
| Net cash used in investing activities | (1,073) | (202) | (1,420) |
| Financing activities: | | | |
| Proceeds from senior notes offerings, net of issuance costs | 325 | — | 689 |
| Proceeds from borrowings under credit facility | 300 | — | — |
| Proceeds from common stock offering, net of issuance costs | — | — | 373 |
| Proceeds from employee stock plans | 19 | 18 | 18 |
| Cash paid for financing transaction fees | (7) | — | — |
| Other, net | (1) | 1 | 5 |
| Net cash provided by financing activities | 636 | 19 | 1,085 |
| Net increase in cash and cash equivalents | 367 | 490 | 790 |
| Cash and cash equivalents at beginning of period | 2,819 | 2,329 | 1,539 |
| Cash and cash equivalents at end of period | $ 3,186 | $ 2,819 | $ 2,329 |

See accompanying notes.

**MOLINA HEALTHCARE, INC.**

**CONSOLIDATED STATEMENTS OF CASH FLOWS**

**(continued)**

| | Year Ended December 31, | | |
|---|---|---|---|
| | **2017** | **2016** | **2015** |
| | **(In millions)** | | |
| Supplemental cash flow information: | | | |
| Cash paid during the period for: | | | |
| Income taxes | $ 7 | $ 153 | $ 197 |
| Interest | $ 78 | $ 66 | $ 38 |
| Schedule of non-cash investing and financing activities: | | | |
| 1.625% convertible notes exchange transaction: | | | |
| Issuance of common stock in exchange for 1.625% Convertible Notes | $ 193 | $ — | $ — |
| Component of 1.625% Convertible Notes allocated to additional paid-in capital, net of income taxes | (32) | — | — |
| Net increase to additional paid-in capital | $ 161 | $ — | $ — |
| Common stock used for stock-based compensation | $ (22) | $ (8) | $ (15) |
| Details of business combinations: | | | |
| Fair value of assets acquired | $ — | $ (186) | $ (389) |
| Fair value of liabilities assumed | — | 28 | 41 |
| Payable to seller | — | 8 | — |
| Amounts advanced for acquisitions | — | 102 | (102) |
| Net cash paid in business combinations | $ — | $ (48) | $ (450) |
| Details of change in fair value of derivatives, net: | | | |
| Gain (loss) on 1.125% Call Option | $ 255 | $ (107) | $ 45 |
| (Loss) gain on 1.125% Conversion Option | (255) | 107 | (45) |
| Change in fair value of derivatives, net | $ — | $ — | $ — |

See accompanying notes.

# NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

## 1. Basis of Presentation

***Organization and Operations***

Molina Healthcare, Inc. provides quality managed healthcare to people receiving government assistance. We offer cost-effective Medicaid-related solutions to meet the health care needs of low-income families and individuals, and to assist government agencies in their administration of the Medicaid program. We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

As of December 31, 2017, the Health Plans segment consisted of health plans operating in 12 states and the Commonwealth of Puerto Rico. These health plans served approximately 4.5 million members eligible for Medicaid, Medicare, and other government-sponsored health care programs for low-income families and individuals. This membership includes Affordable Care Act Marketplace (Marketplace) members, most of whom receive government premium subsidies. The health plans are operated by our respective wholly owned subsidiaries in those states, each of which is licensed as a health maintenance organization (HMO).

Our health plans' state Medicaid contracts generally have terms of three to four years. These contracts typically contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. The contracts are subject to risk of loss when a state issues a new request for proposal (RFP) open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may be subject to non-renewal. See below for further information regarding our Florida and New Mexico Medicaid contracts.

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

The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. Molina Medicaid Solutions is under contract with Medicaid agencies in six states, and the U.S. Virgin Islands.

The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

***2017 and Recent Developments – Health Plans Segment***

*Florida Health Plan.* On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served approximately 360,000 Medicaid members in Florida, which represented approximately $1,486 million premium revenue for the year ended December 31, 2017. This decision does not affect the Florida health plan's current contracts with AHCA, which run through December 31, 2018. We recorded impairment charges in connection with this event. Refer to Note 8, "Goodwill and Intangible Assets, Net," for further information.

*New Mexico Health Plan.* In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico, which represented approximately $1,205 million premium revenue for the year ended December 31, 2017. This decision does not affect the New Mexico plan's current contract with HSD which runs through December 31, 2018. We recorded impairment charges in connection with this event. Refer to Note 8, "Goodwill and Intangible Assets, Net," for further information.

*Illinois Health Plan.* In August 2017, our Illinois health plan was awarded a statewide Medicaid managed care contract by the Illinois Department of Healthcare and Family Services. This Medicaid contract further integrates behavioral health and physical health by combining the state's three current managed care programs into one

program. The contract began January 1, 2018, and will continue for four years with options to renew annually for up to four additional years.

*Mississippi Health Plan.* In June 2017, Molina Healthcare of Mississippi, Inc. was awarded a Medicaid Coordinated Care Contract for the statewide administration of the Mississippi Coordinated Access Network (MississippiCAN). The operational start date for the program is currently scheduled for October 1, 2018, pending the completion of a readiness review. The initial term of the contract is through June 2020, with options to renew annually for up to two additional years.

*Washington Health Plan.* In May 2017, our Washington health plan was selected by the Washington State Health Care Authority to negotiate and enter into managed care contracts for the North-Central region of the state's Apple Health Integrated Managed Care Program. The new contract commenced January 1, 2018.

*Terminated Medicare Acquisition.* In August 2016, we entered into agreements with each of Aetna Inc. and Humana Inc. to acquire certain assets related to their Medicare Advantage business. In February 2017, our agreements with each of Aetna and Humana were terminated by the parties pursuant to the terms of the agreements, under which we received an aggregate termination fee of $75 million from Aetna and Humana in the first quarter of 2017. This fee is reported in "Other income, net" in the accompanying consolidated statements of operations.

***Impairment Losses***

Refer to Note 8, "Goodwill and Intangible Assets, Net," for a discussion of goodwill and intangible assets impaired in 2017.

***Consolidation***

The consolidated financial statements include the accounts of Molina Healthcare, Inc., its subsidiaries, and variable interest entities in which Molina Healthcare, Inc. is considered to be the primary beneficiary. See Note 18, "Variable Interest Entities (VIEs)," for more information regarding these variable interest entities. All significant inter-company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments.

***Presentation and Reclassification***

The Centers for Medicare and Medicaid Services (CMS) incorporates the Health Insurer Fee (HIF) in our Medicare and Marketplace premium rates. We have therefore reclassified such amounts in our consolidated statements of operations to premium revenue, from health insurer fees reimbursed, for all applicable periods presented. The amounts reclassified from health insurer fees reimbursed to premium revenue for years ended December 31, 2016, and 2015, amounted to $53 million and $20 million, respectively.

***Use of Estimates***

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

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

- The determination of unrecognized tax benefits.

## 2. Significant Accounting Policies

Certain of our significant accounting policies are discussed within the note to which they specifically relate.

***Cash and Cash Equivalents***

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

***Investments***

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

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

In general, our available-for-sale securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for other-than-temporary impairment. For comprehensive discussions of the fair value and classification of our current and non-current investments, see Note 4, "Fair Value Measurements," Note 5, "Investments," and Note 9, "Restricted Investments, Non-current."

***Long-Lived Assets, including Intangible Assets***

Long-lived assets consist primarily of property, equipment, capitalized software (see Note 7, "Property, Equipment, and Capitalized Software, Net"), and intangible assets (see Note 8, "Goodwill and Intangible Assets, Net").

***Deferred Contract Costs***

Direct costs associated with our Molina Medicaid Solutions contracts, other than software-related costs for which we apply the guidance for internal-use software, are expensed as incurred unless corresponding revenue is deferred. We defer recognition of any contingent revenue until the contingency has been removed. If revenue is deferred, direct costs relating to delivered service elements are deferred as well, and recognized on a straight-line basis over the period of revenue recognition.

The recoverability of deferred contract costs associated with a particular contract is analyzed on a periodic basis using the undiscounted estimated cash flows of the whole contract over its remaining contract term. If such undiscounted cash flows are insufficient to recover the long-lived assets and deferred contract costs, the deferred contract costs are written down by the amount of the cash flow deficiency. If a cash flow deficiency remains after reducing the balance of the deferred contract costs to zero, any remaining long-lived assets are evaluated for impairment. Any such impairment recognized would equal the amount by which the carrying value of the long-lived assets exceeds the fair value of those assets.

***Business Combinations***

Accounting for acquisitions requires us to recognize separately from goodwill the assets acquired and the liabilities assumed at their acquisition date fair values. Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Upon the conclusion of the final determination of the values of assets acquired or

liabilities assumed, or one year after the date of acquisition, whichever comes first, any subsequent adjustments are recorded within our consolidated statements of operations.

***Premium Revenue - Health Plans***

Premium revenue is generated primarily from our Medicaid, Medicare and Marketplace contracts, including agreements with other managed care organizations for which we operate as a subcontractor. Premium revenue is generally received based on per member per month (PMPM) rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive health care services, and premiums collected in advance are deferred. The state Medicaid programs and the federal Medicare program periodically adjust premiums. Additionally, many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is earned under such provisions.

The following table summarizes premium revenue for the periods indicated:

| | Year Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2017 | | 2016 | | 2015 | |
| | Amount | % of Total | Amount | % of Total | Amount | % of Total |
| | (Dollars in millions) | | | | | |
| California | $ 2,701 | 14.3% | $ 2,378 | 14.4% | $ 2,200 | 16.6% |
| Florida | 2,568 | 13.6 | 1,938 | 11.8 | 1,199 | 9.1 |
| Illinois | 593 | 3.1 | 603 | 3.7 | 398 | 3.0 |
| Michigan | 1,596 | 8.5 | 1,527 | 9.3 | 1,072 | 8.1 |
| New Mexico | 1,368 | 7.3 | 1,305 | 7.9 | 1,237 | 9.3 |
| New York | 181 | 1.0 | 82 | 0.5 | — | — |
| Ohio | 2,216 | 11.8 | 1,967 | 12.0 | 2,035 | 15.3 |
| Puerto Rico | 732 | 3.9 | 726 | 4.4 | 567 | 4.3 |
| South Carolina | 445 | 2.4 | 378 | 2.3 | 348 | 2.6 |
| Texas | 2,813 | 14.9 | 2,461 | 15.0 | 1,963 | 14.8 |
| Utah | 535 | 2.8 | 447 | 2.7 | 334 | 2.5 |
| Washington | 2,608 | 13.8 | 2,222 | 13.5 | 1,605 | 12.1 |
| Wisconsin | 491 | 2.6 | 398 | 2.4 | 262 | 2.0 |
| Other | 7 | — | 13 | 0.1 | 41 | 0.3 |
| | $ 18,854 | 100.0% | $ 16,445 | 100.0% | $ 13,261 | 100.0% |

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

**Contractual Provisions That May Adjust or Limit Revenue or Profit**

Medicaid

*Medical Cost Floors (Minimums), and Medical Cost Corridors.* A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs. In the aggregate, we recorded a liability under the terms of such contract provisions of $135 million and $272 million at December 31, 2017 and December 31, 2016, respectively, to amounts due government agencies. Approximately $96 million and $244 million of the liability accrued at December 31, 2017 and December 31, 2016, respectively, relates to our participation in Medicaid Expansion programs.

In certain circumstances, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Receivables relating to such provisions were insignificant at December 31, 2017 and December 31, 2016.

*Profit Sharing and Profit Ceiling.* Our contracts with certain states contain profit-sharing or profit ceiling provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Liabilities for profits in excess of the amount we are allowed to retain under these provisions were insignificant at December 31, 2017 and December 31, 2016.

*Retroactive Premium Adjustments.* State Medicaid programs periodically adjust premium rates on a retroactive basis. In these cases, we must adjust our premium revenue in the period in which we learn of the adjustment, rather than in the months of service to which the retroactive adjustment applies.

Medicare

*Risk Adjustment:* Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices. Consolidated balance sheet amounts related to anticipated Medicare risk adjustment premiums and Medicare Part D settlements were insignificant at December 31, 2017 and December 31, 2016.

*Minimum MLR:* Additionally, federal regulations have established a minimum annual medical loss ratio (Minimum MLR) of 85% for Medicare. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

Marketplace

*Premium Stabilization Programs:* The Affordable Care Act (ACA) established Marketplace premium stabilization programs effective January 1, 2014. These programs, commonly referred to as the "3R's," include a permanent risk adjustment program, a transitional reinsurance program, and a temporary risk corridor program. We record receivables or payables related to the 3R programs and the Minimum MLR when the amounts are reasonably estimable as described below, and, for receivables, when collection is reasonably assured. Our receivables (payables) for each of these programs, as of the dates indicated, were as follows:

| | December 31, 2017 | | | |
|---|---|---|---|---|
| | Current Benefit Year | Prior Benefit Years | Total | December 31, 2016 |
| | (In millions) | | | |
| Risk adjustment | $ (912) | $ — | $ (912) | $ (522) |
| Reinsurance | — | 10 | 10 | 55 |
| Risk corridor | — | — | — | (1) |
| Minimum MLR | (2) | — | (2) | (1) |

- Risk adjustment: Under this permanent program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk transfer payment into the pool if their composite risk scores are below the average risk score, and will receive a risk transfer payment from the pool if their composite risk scores are above the average risk score. We estimate our ultimate premium based on insurance policy year-to-date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of operations.
- Reinsurance: This program was designed to provide reimbursement to insurers for high cost members and ended December 31, 2016; we expect to settle the outstanding receivable balance in the first quarter of 2018.
- Risk corridor: This program was intended to limit gains and losses of insurers by comparing allowable costs to a target amount as defined by CMS, and ended December 31, 2016; all outstanding payable balances were settled in the third quarter of 2017. We are owed, but have not recorded $128 million in risk corridor payments from CMS related to benefit year 2016 and 2015.

Additionally, the ACA established a Minimum MLR of 80% for the Marketplace. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. Each of the 3R programs is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of operations.

**Quality Incentives**

At several of our health plans, revenue ranging from approximately 1% to 3% of certain health plan premiums is earned only if certain performance measures are met.

The following table quantifies the quality incentive premium revenue recognized for the periods presented, including the amounts earned in the periods presented and prior periods. Although the reasonably possible effects of a change in estimate related to quality incentive premium revenue as of December 31, 2017 are not known, we have no reason to believe that the adjustments to prior periods noted below are not indicative of the potential future changes in our estimates as of December 31, 2017.

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Maximum available quality incentive premium - current period | $ 150 | $ 147 | $ 118 |
| Amount of quality incentive premium revenue recognized in current period: | | | |
| Earned current period | $ 97 | $ 104 | $ 66 |
| Earned prior periods | 10 | 47 | 13 |
| Total | $ 107 | $ 151 | $ 79 |
| Quality incentive premium revenue recognized as a percentage of total premium revenue | 0.6% | 0.9% | 0.6% |

***Medical Care Costs - Health Plans***

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

*Fee-for-service expenses.* Nearly all hospital services and the majority of our primary care and physician specialist services and LTSS costs are paid on a fee-for-service basis. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of services. Such expenses are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit manager are included in fee-for-service costs.

*Pharmacy expenses.* All drug, injectibles, and immunization costs paid through our pharmacy benefit manager are classified as pharmacy expenses. As noted above, drugs and injectibles not paid through our pharmacy benefit manager are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.

*Capitation expenses.* Many of our primary care physicians and a small number of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount PMPM to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated arrangements, we remain liable for the provision of certain health care services. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.

*Direct delivery expenses.* All costs associated with our direct delivery of medical care are separately identified.

*Other medical expenses.* All medically related administrative costs, certain provider incentive costs, and other health care expenses are classified as other medical expenses. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24-hour on-call nurses. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2017, 2016, and 2015, medically related administrative costs were $554 million, $488 million, and $398 million, respectively.

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

| | Year Ended December 31, | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | 2017 | | | 2016 | | | 2015 | | |
| | Amount | PMPM | % of Total | Amount | PMPM | % of Total | Amount | PMPM | % of Total |
| Fee-for-service | $ 12,682 | $ 229.63 | 74.3% | $ 10,993 | $ 217.84 | 74.4% | $ 8,572 | $ 218.35 | 72.7% |
| Pharmacy | 2,563 | 46.40 | 15.0 | 2,213 | 43.84 | 15.0 | 1,610 | 41.01 | 13.7 |
| Capitation | 1,360 | 24.63 | 8.0 | 1,218 | 24.13 | 8.2 | 982 | 25.02 | 8.3 |
| Direct delivery | 73 | 1.33 | 0.4 | 78 | 1.55 | 0.5 | 128 | 3.26 | 1.1 |
| Other | 395 | 7.15 | 2.3 | 272 | 5.39 | 1.9 | 502 | 12.79 | 4.2 |
| Total | $ 17,073 | $ 309.14 | 100.0% | $ 14,774 | $ 292.75 | 100.0% | $ 11,794 | $ 300.43 | 100.0% |

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

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are incurred but not paid (IBNP). Our IBNP claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors. For further information, see Note 10, “Medical Claims and Benefits Payable.”

We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. We limit our risk of catastrophic losses by maintaining high deductible reinsurance coverage. Such reinsurance coverage does not relieve us of our primary obligation to our policyholders. We do not consider this coverage to be material because the cost is not significant and the likelihood that coverage will apply is low.

***Taxes Based on Premiums***

*Health Insurer Fee (HIF).* The federal government under the ACA imposes an annual fee, or excise tax, on health insurers for each calendar year. The HIF is based on a company’s share of the industry’s net premiums written during the preceding calendar year, and is non-deductible for income tax purposes. We recognize expense for the HIF over the year on a straight-line basis. Within our Medicaid program, we must secure additional reimbursement from our state partners for this added cost. We recognize the related revenue when we have obtained a contractual commitment or payment from a state to reimburse us for the HIF; such HIF revenue is recognized ratably throughout the year. The Consolidated Appropriations Act of 2016 provided for a HIF moratorium in 2017. Therefore, there were no health insurer fees reimbursed, nor health insurer fees incurred, in 2017.

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

***Premium Deficiency Reserves on Loss Contracts***

We assess the profitability of our medical care policies to identify groups of contracts where current operating results or forecasts indicate probable future losses. If anticipated future variable costs exceed anticipated future premiums and investment income, a premium deficiency reserve is recognized. We recorded a premium deficiency reserve to “Medical claims and benefits payable” on our accompanying consolidated balance sheets relating to our Marketplace program of $30 million as of December 31, 2016. No premium deficiency reserves are recorded as of December 31, 2017.

Marketplace Cost Share Reduction (CSR) Update

In the fourth quarter of 2017, the federal government ceased payments of Marketplace CSR subsidies, which resulted in additional medical care costs of approximately $73 million in 2017.

***Concentrations of Credit Risk***

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

***Risks and Uncertainties***

Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

We operate health plans primarily as a direct contractor with the states (or Commonwealth), and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

***Recent Accounting Pronouncements***

*Comprehensive Income.* In February 2018, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2018-02, *Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*, which allows a reclassification from accumulated other comprehensive income to retained earnings for stranded tax effects resulting from the Tax Cuts and Jobs Act of 2017. ASU 2018-02 also requires certain disclosures about stranded tax effects. ASU 2018-02 is effective beginning January 1, 2019; we early adopted this ASU effective January 1, 2018, with no material impact to our financial condition, results of operations or cash flows. We are currently evaluating the required disclosures.

*Goodwill Impairment.* In January 2017, FASB issued ASU 2017-04, *Simplifying the Test for Goodwill Impairment*, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment loss. Instead, an impairment loss is measured as the excess of the carrying amount of the reporting unit, including goodwill, over the fair value of the reporting unit. ASU 2017-04 is effective beginning January 1, 2020; we early adopted ASU 2017-04 as of June 30, 2017, in connection with the interim assessment of our Pathways subsidiary. See further discussion at Note 8, “Goodwill and Intangible Assets, Net.”

*Restricted Cash.* In November 2016, the FASB issued ASU 2016-18, *Restricted Cash,* which will require us to include in our consolidated statements of cash flows the balances of cash, cash equivalents, restricted cash and restricted cash equivalents. When these items are presented in more than one line item on the balance sheet, the new guidance requires a reconciliation of the totals in the statement of cash flows to the related captions in the balance sheet. Transfers between cash and cash equivalents and restricted cash and restricted cash equivalents will no longer be presented in the statement of cash flows. ASU 2016-18 is effective beginning January 1, 2018. We are currently evaluating the classification changes that will be required in our presentation of the consolidated statements of cash flows.

*Stock Compensation.* In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which amends ASC Topic 718, *Compensation – Stock Compensation*. ASU 2016-09 simplifies several aspects of accounting for employee share-based payment transactions, including the accounting for income

taxes, forfeitures, statutory tax and classification in the statement of cash flows. We adopted ASU 2016-09 on January 1, 2017; such adoption did not significantly impact our consolidated financial statements. In addition, the prior period presentation in the statement of cash flows was not adjusted because such adjustments were insignificant.

*Leases.* In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* as modified by ASU 2017-03, *Transition and Open Effective Date Information*. Under ASU 2016-02, an entity will be required to recognize assets and liabilities for the rights and obligations created by leases on the entity's balance sheet for both finance and operating leases. For leases with a term of 12 months or less, an entity can elect to not recognize lease assets and lease liabilities and expense the lease over a straight-line basis for the term of the lease. ASU 2016-02 will require new disclosures that depict the amount, timing, and uncertainty of cash flows pertaining to an entity's leases. ASU 2016-02 is effective beginning January 1, 2019, and must be adopted using a modified retrospective approach for annual and interim periods beginning after December 15, 2018. Under this guidance, we will record assets and liabilities relating primarily to our long-term office leases. We are in the early stages of evaluating the effect to our consolidated financial statements.

*Financial Instruments.* In January 2016, the FASB issued ASU 2016-01, *Recognition and Measurement of Financial Assets and Financial Liabilities*, which will require public business entities to use the exit price notion when measuring the fair value of financial instruments for disclosure purposes. Also, entities will have to assess the realizability of a deferred tax asset related to an available-for-sale debt security in combination with the entity's other deferred tax assets. Effective on January 1, 2018, ASU 2016-01 is applied prospectively with a cumulative-effect adjustment to beginning retained earnings as of the beginning of the first reporting period in which the guidance is adopted. We have determined that there will be no impact to beginning retained earnings; we are in the process of determining the changes to required disclosures.

*Revenue Recognition.* In May 2014, the FASB issued ASU 2014-09, *Revenue from Contracts with Customers (Topic 606).* We intend to adopt this standard and the related modifications on January 1, 2018, using the modified retrospective approach. Under this approach, the cumulative effect of initially applying the guidance will be reflected as an adjustment to beginning retained earnings.

We have determined that the insurance contracts of our Health Plans segment, which segment constitutes the vast majority of our operations, are excluded from the scope of Topic 606 because the recognition of revenue under these contracts is dictated by other accounting standards governing insurance contracts.

For our Molina Medicaid Solutions segment, we have determined that revenue for contracts that include design, development and implementation (DDI) of Medicaid management information systems shall be deferred until the system 'go-live' date, and then generally recognized on a straight-line basis over the hosting period. This approach is similar to our historical revenue recognition methodology, with two exceptions. First, revenues contingent upon a state's acceptance of DDI and other services were previously deferred until the contingency was removed. Under Topic 606, we have determined that such revenues are appropriately recognized at the system 'go-live' date as noted above, resulting in a slight acceleration of revenue under Topic 606. Second, contract extensions were previously considered a single unit of account with the original contracts. Under Topic 606, contract extensions are considered to be standalone contracts, so revenues previously deferred over the original contract plus extension periods are now recognized over the original contract period, resulting in slightly accelerated revenue recognition. Cost of service revenue continues to be recognized in a manner consistent with the corresponding revenue recognition. As a result, the cumulative adjustment to retained earnings associated with the adoption of Topic 606 effective January 1, 2018, is insignificant for our Molina Medicaid Solutions segment.

For our Pathways behavioral health and social services provider, which is reported in the Other segment, there is no substantive change to revenue recognition under Topic 606, and therefore no impact to retained earnings effective January 1, 2018.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (SEC) did not have, or are not believed by management to have, a significant impact on our present or future consolidated financial statements.

## 3. Net (Loss) Income per Share

The following table sets forth the calculation of basic and diluted net (loss) income per share:

| | December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions, except net (loss) income per share) | | |
| ***Numerator:*** | | | |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| ***Denominator:*** | | | |
| Shares outstanding at the beginning of the period | 56 | 55 | 49 |
| Weighted-average number of shares issued: | | | |
| Common stock offering | — | — | 3 |
| Denominator for basic net (loss) income per share | 56 | 55 | 52 |
| Effect of dilutive securities: | | | |
| Share-based compensation | — | — | 1 |
| Convertible senior notes [1] | — | — | 1 |
| 1.125% Warrants [1] | — | 1 | 2 |
| Denominator for diluted net (loss) income per share | 56 | 56 | 56 |
| | | | |
| Net (loss) income per share: [2] | | | |
| Basic | $ (9.07) | $ 0.93 | $ 2.75 |
| Diluted | $ (9.07) | $ 0.92 | $ 2.58 |
| | | | |
| Potentially dilutive common shares excluded from calculations: [1] | | | |
| 1.125% Warrants | 2 | — | — |
| 1.625% Notes | 1 | — | — |

(1) For more information regarding the convertible senior notes, refer to Note 11, “Debt.” For more information regarding the 1.125% Warrants, refer to Note 14, “Stockholders' Equity.” The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Potentially dilutive common shares were not included in the computation of diluted net loss per share for the year ended December 31, 2017, because to do so would have been anti-dilutive.

(2) Source data for calculations in thousands.

## 4. Fair Value Measurements

We consider the carrying amounts of cash and cash equivalents and other current assets and current liabilities (not including derivatives and the current portion of long-term debt) to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three-tier fair value hierarchy as follows:

*Level 1 — Observable Inputs.* Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices on one or more securities exchanges.

*Level 2 — Directly or Indirectly Observable Inputs.* Level 2 financial instruments are traded frequently though not necessarily daily. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets.

*Level 3 — Unobservable Inputs.* Level 3 financial instruments are valued using unobservable inputs that represent management's best estimate of what market participants would use in pricing the financial instrument at the measurement date. Our Level 3 financial instruments include derivative financial instruments.

Derivative financial instruments include the 1.125% Call Option derivative asset and the 1.125% Conversion Option derivative liability. These derivatives are not actively traded and are valued based on an option pricing model that uses observable and unobservable market data for inputs. Significant market data inputs used to determine fair value as of December 31, 2017, included the price of our common stock, the time to maturity of the derivative instruments, the risk-free interest rate, and the implied volatility of our common stock. As described further in Note 12, "Derivatives," the 1.125% Call Option asset and the 1.125% Conversion Option liability were designed such that changes in their fair values offset, with minimal impact to the consolidated statements of operations. Therefore, the sensitivity of changes in the unobservable inputs to the option pricing model for such instruments is mitigated.

The net changes in fair value of Level 3 financial instruments were insignificant to our results of operations for the years ended December 31, 2017, and 2016.

Our financial instruments measured at fair value on a recurring basis at December 31, 2017, were as follows:

| | Total | Level 1 | Level 2 | Level 3 |
|---|---|---|---|---|
| | | (In millions) | | |
| Corporate debt securities | $ 1,588 | $ — | $ 1,588 | $ — |
| U.S. treasury notes | 388 | 388 | — | — |
| Government-sponsored enterprise securities (GSEs) | 253 | 253 | — | — |
| Municipal securities | 141 | — | 141 | — |
| Asset-backed securities | 117 | — | 117 | — |
| Certificates of deposit | 37 | — | 37 | — |
| Subtotal - current investments | 2,524 | 641 | 1,883 | — |
| Corporate debt securities | 101 | — | 101 | — |
| U.S. treasury notes | 68 | 68 | — | — |
| Subtotal - current restricted investments | 169 | 68 | 101 | — |
| 1.125% Call Option derivative asset | 522 | — | — | 522 |
| Total assets measured at fair value on a recurring basis | $ 3,215 | $ 709 | $ 1,984 | $ 522 |
| | | | | |
| 1.125% Conversion Option derivative liability | $ 522 | $ — | $ — | $ 522 |
| Total liabilities measured at fair value on a recurring basis | $ 522 | $ — | $ — | $ 522 |

Our financial instruments measured at fair value on a recurring basis at December 31, 2016, were as follows:

| | Total | Level 1 | Level 2 | Level 3 |
|---|---|---|---|---|
| | (In millions) | | | |
| Corporate debt securities | $ 1,179 | $ — | $ 1,179 | $ — |
| U.S. treasury notes | 84 | 84 | — | — |
| GSEs | 231 | 231 | — | — |
| Municipal securities | 142 | — | 142 | — |
| Asset-backed securities | 69 | — | 69 | — |
| Certificates of deposit | 53 | — | 53 | — |
| Subtotal - current investments | 1,758 | 315 | 1,443 | — |
| 1.125% Call Option derivative asset | 267 | — | — | 267 |
| Total assets measured at fair value on a recurring basis | $ 2,025 | $ 315 | $ 1,443 | $ 267 |
| | | | | |
| 1.125% Conversion Option derivative liability | $ 267 | $ — | $ — | $ 267 |
| Total liabilities measured at fair value on a recurring basis | $ 267 | $ — | $ — | $ 267 |

There were no current restricted investments as of December 31, 2016.

***Fair Value Measurements – Disclosure Only***

The carrying amounts and estimated fair values of our senior notes are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. The carrying amount and estimated fair value of the amount due under our Credit Facility is classified as a Level 3 financial instrument, because certain inputs used to determine its fair value are not observable. As of December 31, 2017, the carrying value of the amount due under the Credit Facility approximates it fair value because of the recency of this borrowing during the third quarter of 2017.

| | December 31, 2017 | | December 31, 2016 | |
|---|---|---|---|---|
| | Carrying Value | Fair Value | Carrying Value | Fair Value |
| | (In millions) | | | |
| 5.375% Notes | $ 692 | $ 730 | $ 691 | $ 714 |
| 1.125% Convertible Notes | 496 | 1,052 | 471 | 792 |
| 4.875% Notes | 325 | 329 | — | — |
| Credit Facility | 300 | 300 | — | — |
| 1.625% Convertible Notes | 157 | 220 | 284 | 344 |
| | $ 1,970 | $ 2,631 | $ 1,446 | $ 1,850 |

## 5. Investments

We consider all of our investments, and our restricted investments that are classified as current assets, to be available-for-sale. As described further in Note 11, “Debt,” we maintain certain funds from the issuance of our 4.875% Notes in a segregated deposit account, a current asset reported as “Restricted investments” in the accompanying consolidated balance sheets. Such investments, while restricted as to their use and held in a segregated deposit account, are classified as available-for-sale based upon our contractual liquidity requirements.

The following tables summarize our investments as of the dates indicated:

| | December 31, 2017 | | | |
|---|---|---|---|---|
| | Amortized Cost | Gross Unrealized Gains | Gross Unrealized Losses | Estimated Fair Value |
| | (In millions) | | | |
| Corporate debt securities | $ 1,591 | $ 1 | $ 4 | $ 1,588 |
| U.S. Treasury notes | 389 | — | 1 | 388 |
| GSEs | 255 | — | 2 | 253 |
| Municipal securities | 142 | — | 1 | 141 |
| Asset-backed securities | 117 | — | — | 117 |
| Certificates of deposit | 37 | — | — | 37 |
| Subtotal - current investments | 2,531 | 1 | 8 | 2,524 |
| Corporate debt securities | 101 | — | — | 101 |
| U.S. treasury notes | 68 | — | — | 68 |
| Subtotal - restricted investments, current | 169 | — | — | 169 |
| | $ 2,700 | $ 1 | $ 8 | $ 2,693 |

| | December 31, 2016 | | | |
|---|---|---|---|---|
| | Amortized Cost | Gross Unrealized Gains | Gross Unrealized Losses | Estimated Fair Value |
| | (In millions) | | | |
| Corporate debt securities | $ 1,180 | $ 1 | $ 2 | $ 1,179 |
| U.S. treasury notes | 84 | — | — | 84 |
| GSEs | 232 | — | 1 | 231 |
| Municipal securities | 143 | — | 1 | 142 |
| Asset-backed securities | 69 | — | — | 69 |
| Certificates of deposit | 53 | — | — | 53 |
| | $ 1,761 | $ 1 | $ 4 | $ 1,758 |

There were no current restricted investments as of December 31, 2016.

The contractual maturities of our available-for-sale investments as of December 31, 2017 are summarized below:

| | Amortized Cost | Estimated Fair Value |
|---|---|---|
| | (In millions) | |
| Due in one year or less | $ 1,722 | $ 1,721 |
| Due after one year through five years | 972 | 966 |
| Due after five years through ten years | 6 | 6 |
| | $ 2,700 | $ 2,693 |

Gross realized gains and losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains and losses for the years ended December 31, 2017, 2016 and 2015 were insignificant.

We have determined that unrealized losses at December 31, 2017 and 2016 are temporary in nature, because the change in market value for these securities resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant.

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2017.

| | In a Continuous Loss Position for Less than 12 Months | | | In a Continuous Loss Position for 12 Months or More | | |
|---|---|---|---|---|---|---|
| | Estimated Fair Value | Unrealized Losses | Total Number of Positions | Estimated Fair Value | Unrealized Losses | Total Number of Positions |
| | (Dollars in millions) | | | | | |
| Corporate debt securities | $ 1,297 | $ 3 | 561 | $ 94 | $ 1 | 69 |
| U.S. Treasury notes | 470 | 1 | 89 | — | — | — |
| GSEs | 173 | 1 | 69 | 95 | 1 | 47 |
| Municipal securities | — | — | — | 38 | 1 | 48 |
| | $ 1,940 | $ 5 | 719 | $ 227 | $ 3 | 164 |

The following table segregates those available-for-sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2016.

| | In a Continuous Loss Position for Less than 12 Months | | | In a Continuous Loss Position for 12 Months or More | | |
|---|---|---|---|---|---|---|
| | Estimated Fair Value | Unrealized Losses | Total Number of Positions | Estimated Fair Value | Unrealized Losses | Total Number of Positions |
| | (Dollars in millions) | | | | | |
| Corporate debt securities | $ 542 | $ 2 | 378 | $ — | $ — | — |
| GSEs | 198 | 1 | 73 | — | — | — |
| Municipal securities | 101 | 1 | 129 | — | — | — |
| | $ 841 | $ 4 | 580 | $ — | $ — | — |

## 6. Receivables

Receivables consist primarily of amounts due from government Medicaid agencies, which may be subject to potential retroactive adjustments. Because all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for doubtful accounts is insignificant. Any amounts determined to be uncollectible are charged to expense when such determination is made. The information below is presented by segment.

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| | (In millions) | |
| California | $ 208 | $ 180 |
| Florida | 42 | 97 |
| Illinois | 91 | 134 |
| Michigan | 56 | 60 |
| New Mexico | 71 | 57 |
| New York | 21 | 26 |
| Ohio | 94 | 82 |
| Puerto Rico | 32 | 37 |
| South Carolina | 13 | 11 |
| Texas | 61 | 79 |
| Utah | 18 | 19 |
| Washington | 69 | 71 |
| Wisconsin | 19 | 33 |
| Other | 2 | 1 |
| Total Health Plans segment | 797 | 887 |
| Molina Medicaid Solutions segment | 30 | 34 |
| Other segment | 44 | 53 |
| | $ 871 | $ 974 |

## 7. Property, Equipment, and Capitalized Software, Net

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

The costs associated with certain of our Molina Medicaid Solutions segment equipment and software are capitalized and recorded as deferred contract costs. Such costs are amortized on a straight-line basis over the shorter of the useful life or the contract period, and the amortization is recorded within the heading “Cost of service revenue.”

A summary of property, equipment, and capitalized software is as follows:

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| | (In millions) | |
| Capitalized software | $ 417 | $ 443 |
| Furniture and equipment | 289 | 301 |
| Building and improvements | 161 | 159 |
| Land | 16 | 16 |
| | 883 | 919 |
| Less: accumulated amortization - capitalized software | (308) | (259) |
| Less: accumulated depreciation and amortization - building and improvements, furniture and equipment | (233) | (206) |
| | (541) | (465) |
| Property, equipment, and capitalized software, net | $ 342 | $ 454 |

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

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Recorded in depreciation and amortization: | | | |
| Amortization of capitalized software | $ 64 | $ 62 | $ 37 |
| Depreciation of property and equipment | 42 | 45 | 50 |
| Amortization of intangible assets | 31 | 32 | 17 |
| | 137 | 139 | 104 |
| Recorded in cost of service revenue: | | | |
| Amortization of capitalized software | 28 | 22 | 15 |
| Amortization of deferred contract costs | 13 | 21 | 6 |
| | 41 | 43 | 21 |
| Other | — | — | 1 |
| | $ 178 | $ 182 | $ 126 |

## 8. Goodwill and Intangible Assets, Net

***Goodwill***

Goodwill represents the excess of the purchase price over the fair value of net assets acquired in business combinations. Goodwill is not amortized, but is tested for impairment on an annual basis and more frequently if impairment indicators are present. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, cost factors, and changes in overall performance, to determine if it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment. We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment.

We estimated the fair values of our reporting units using the higher of the income approach using discounted cash flows, or the asset liquidation method. For the annual impairment test, the base year in the reporting units' discounted cash flows is derived from the most recent annual financial budgeting cycle, for which the planning process commences in the fourth quarter of the year. When computing discounted cash flows, we make assumptions about a wide variety of internal and external factors, and consider what the reporting unit's selling price would be in an orderly transaction between market participants at the measurement date. Significant assumptions include financial projections of free cash flow (including significant assumptions about operations,

capital requirements and income taxes), long-term growth rates for determining terminal value beyond the discretely forecasted periods, and discount rates. When determining the discount rate, we consider the overall level of inherent risk of the reporting unit, and the expected rate an outside investor would expect to earn. The asset liquidation method is computed as total assets minus total liabilities, excluding intangible assets and liabilities.

We apply the market approach for certain reporting units to reconcile the value of all of our reporting units to our consolidated market value. Under the market approach, we consider publicly traded comparable company information to determine revenue and earnings multiples which are used to estimate our reporting units' fair values.

Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss, and adjusted if necessary for the impact of tax deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit.

The following table presents the changes in the carrying amounts of goodwill for the year ended December 31, 2017. The 2017 goodwill impairment losses are recorded to the segments as indicated in following table, and reported as "Impairment losses" in the accompanying consolidated statements of operations.

| | Health Plans | Molina Medicaid Solutions | Other | Total |
|---|---|---|---|---|
| | | (In millions) | | |
| Historical goodwill | $ 445 | $ 71 | $ 162 | $ 678 |
| Accumulated impairment losses at December 31, 2016 | (58) | — | — | (58) |
| Balance, December 31, 2016 | 387 | 71 | 162 | 620 |
| Impairment losses, year ended December 31, 2017 | (244) | (28) | (162) | (434) |
| Balance, December 31, 2017 | $ 143 | $ 43 | $ — | $ 186 |
| Accumulated impairment losses at December 31, 2017 | $ 302 | $ 28 | $ 162 | $ 492 |

**2017 Impairment Analysis**

Health Plans Segment

On February 1, 2018, we were selected by the Florida Agency for Health Care Administration (AHCA) to negotiate for the award of a managed care contract in only one region of Florida. That region—Region 11—comprises Miami-Dade and Monroe counties, where we currently serve 59,000 Medicaid members. As of December 31, 2017, we served approximately 360,000 Medicaid members in Florida, which represented approximately $1,486 million premium revenue for the year ended December 31, 2017. Because we expect the Florida health plan to have significantly reduced cash flows following the contract termination currently expected on December 31, 2018, its entire goodwill balance was impaired, amounting to $124 million, in the fourth quarter of 2017.

In January 2018, our New Mexico health plan was notified by the New Mexico Human Services Department (HSD) that the health plan had not been selected for the tentative award of a Medicaid contract effective January 1, 2019. As of December 31, 2017, we served approximately 224,000 Medicaid members in New Mexico, which represented approximately $1,205 million premium revenue for the year ended December 31, 2017. Because we do not expect the New Mexico health plan to have cash flows following the contract termination currently expected on December 31, 2018, its entire goodwill balance was impaired, amounting to $74 million, in the fourth quarter of 2017.

When we conducted the annual impairment evaluation of the goodwill of our Illinois health plan, the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. This was primarily due to the Illinois health plan's current profit profile, which does not support the purchase prices paid for certain membership acquired years ago. As a result, we recorded a goodwill impairment loss of approximately $45 million in the fourth quarter of 2017. When we conducted the annual impairment evaluation of the goodwill of our New York health plan, the plan's future cash flow projections were insufficient to produce an estimated fair value in excess of its carrying amount. As a result, we recorded goodwill impairment losses amounting to $1 million in the fourth quarter of 2017.

Molina Medicaid Solutions Segment

As described in Note 15, "Restructuring and Separation Costs," in the third quarter of 2017 we wrote off certain costs capitalized at our Molina Medicaid Solutions segment that supported our Health Plans segment provider information management processes. Although the intercompany revenues recorded by Molina Medicaid Solutions under this arrangement were insignificant on a consolidated basis, the termination of such revenue resulted in a

triggering event for an interim goodwill impairment analysis of this reporting unit in the third quarter of 2017. In the Molina Medicaid Solutions' discounted cash flow model, we incorporated significant estimates and assumptions related to future periods, such as intercompany business support opportunities and prospects for new Medicaid management information systems contracts. Because management has determined that Molina Medicaid Solutions will provide fewer future benefits for its support of the Health Plans segment, the test resulted in a fair value less than Molina Medicaid Solutions' carrying amount; therefore, we recorded a goodwill impairment loss for the difference, or $28 million, in the third quarter of 2017.

Other Segment

In the course of developing the 2017 Restructuring Plan in the second quarter of 2017, we determined that future benefits to be derived from our Pathways subsidiary, including the integration of its operations with our Health Plans segment, would be less than previously anticipated. In addition, poorer than expected year-to-date operating results, as well as lower projections of operating results for periods in the near term at our Pathways subsidiary, led us to conclude that a triggering event for an interim impairment analysis had occurred in the second quarter of 2017. Further, in the third quarter of 2017, management determined that Pathways will not provide future benefits relating to the integration of its operations with the Health Plans segment to the extent previously expected. Therefore, we conducted an additional interim impairment analysis.

We estimated Pathways' fair value using discounted cash flows, incorporating significant estimates and assumptions related to future periods. Such estimates included anticipated client census which drives service revenue; the likelihood of future benefits to be derived from Pathways (including integration with our health plans); current prospects relating to the behavioral services labor market which drives cost of service revenue; and anticipated capital expenditures. The tests in each of the quarters ended June 30, 2017, and September 30, 2017, resulted in a fair value less than Pathways' carrying amount; therefore, we recorded impairment losses for the difference. The Pathways goodwill impairment losses amounted to $101 million in the third quarter of 2017, and $59 million in the second quarter of 2017. In the second quarter of 2017, we also recorded a goodwill impairment loss of $2 million for a separate subsidiary in the Other segment.

**2016 and 2015 Impairment Analysis**

No impairment charges relating to goodwill were recorded in the years ended December 31, 2016, and 2015.

***Intangible Assets, Net***

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

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

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

Based on the balances of our identifiable intangible assets as of December 31, 2017, we estimate that our intangible asset amortization will be $21 million in 2018, $18 million in 2019, $14 million in 2020, $5 million in 2021, and $3 million in 2022. For a presentation of our goodwill and intangible assets by reportable segment, refer to Note 20, "Segment Information."

The following table provides the details of identified intangible assets, by major class, for the periods indicated:

| | Cost | Accumulated Amortization | Carrying Amount |
|---|---|---|---|
| | | (In millions) | |
| Intangible assets: | | | |
| Contract rights and licenses | $ 201 | $ 141 | $ 60 |
| Provider networks | 20 | 11 | 9 |
| Balance at December 31, 2017 | $ 221 | $ 152 | $ 69 |
| Intangible assets: | | | |
| Contract rights and licenses | $ 267 | $ 148 | $ 119 |
| Customer relationships | 25 | 24 | 1 |
| Provider networks | 34 | 14 | 20 |
| Balance at December 31, 2016 | $ 326 | $ 186 | $ 140 |

**2017 Impairment Analysis**

During 2017, we noted the impairment indicators described above for the Florida health plan, New Mexico health plan, and Pathways.

Health Plans Segment

In the fourth quarter of 2017, prior to the goodwill impairment test noted above, we assessed the Florida health plan's primary definite-lived intangible assets (contract rights and provider networks) for impairment, using undiscounted cash flows expected over the asset's remaining useful life. Such undiscounted cash flows indicated impairment; therefore, the plan's estimated fair value, determined as noted above, indicated that its carrying amount exceeded its fair value. This resulted in impairment losses of $15 million in the fourth quarter of 2017.

In the fourth quarter of 2017, prior to the goodwill impairment test noted above, we assessed the New Mexico health plan's primary definite-lived intangible asset (contract rights) for impairment, using undiscounted cash flows expected over the asset's remaining useful life. Such undiscounted cash flows indicated impairment; therefore, the plan's estimated fair value, determined as noted above, indicated that its carrying amount exceeded its fair value. This resulted in impairment losses of $10 million in the fourth quarter of 2017.

Other Segment

In the second quarter of 2017, prior to the goodwill impairment tests noted above, we assessed Pathways' definite-lived intangible assets (customer relationships and contract licenses) for impairment, using undiscounted cash flows expected over the longest remaining useful life of the assets tested. Such undiscounted cash flows indicated impairment; therefore, Pathways' estimated fair value, determined as noted above, indicated that its carrying amount exceeded its fair value. This resulted in impairment losses of $11 million in the second quarter of 2017.

**2016 and 2015 Impairment Analysis**

No significant impairment charges relating to long-lived assets, including intangible assets, were recorded in the years ended December 31, 2016, and 2015.

## 9. Restricted Investments, Non-current

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

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| | (In millions) | |
| Florida | $ 31 | $ 22 |
| New Mexico | 43 | 43 |
| Ohio | 12 | 12 |
| Puerto Rico | 10 | 10 |
| Other | 23 | 23 |
| Total Health Plans segment | $ 119 | $ 110 |

The contractual maturities of our held-to-maturity restricted investments, which are carried at amortized cost, which approximates fair value, as of December 31, 2017 are summarized below.

| | Amortized Cost | Estimated Fair Value |
|---|---|---|
| | (In millions) | |
| Due in one year or less | $ 115 | $ 115 |
| Due after one year through five years | 4 | 4 |
| | $ 119 | $ 119 |

## 10. Medical Claims and Benefits Payable

The following table provides the details of our medical claims and benefits payable (including amounts payable for the provision of long-term services and supports, or LTSS) as of the dates indicated.

| | December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Fee-for-service claims incurred but not paid (IBNP) | $ 1,717 | $ 1,352 | $ 1,191 |
| Pharmacy payable | 112 | 112 | 88 |
| Capitation payable | 67 | 37 | 140 |
| Other | 296 | 428 | 266 |
| | $ 2,192 | $ 1,929 | $ 1,685 |

“Other” medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of operations. Non-risk provider payables amounted to $122 million, $225 million and $167 million, as of December 31, 2017, 2016 and 2015, respectively.

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

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Medical claims and benefits payable, beginning balance | $ 1,929 | $ 1,685 | $ 1,201 |
| Components of medical care costs related to: | | | |
| Current period | 17,037 | 14,966 | 11,935 |
| Prior periods | 36 | (192) | (141) |
| Total medical care costs | 17,073 | 14,774 | 11,794 |
| Change in non-risk provider payables | (106) | 58 | 48 |
| Payments for medical care costs related to: | | | |
| Current period | 15,130 | 13,304 | 10,448 |
| Prior periods | 1,574 | 1,284 | 910 |
| Total paid | 16,704 | 14,588 | 11,358 |
| Medical claims and benefits payable, ending balance | $ 2,192 | $ 1,929 | $ 1,685 |

Reinsurance recoverables of $16 million, $61 million, and $46 million, as of December 31, 2017, 2016, and 2015, respectively, are included in “Receivables” in the accompanying consolidated balance sheets.

The following tables provide information about incurred and paid claims development as of December 31, 2017, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements.

| | Incurred Claims and Allocated Claims Adjustment Expenses | | | | |
|---|---|---|---|---|---|
| Benefit Year | 2015 [1] | 2016 | 2017 | Total IBNP | Cumulative number of reported claims |
| | | | (In millions) | | |
| 2015 | $ 12,113 | $ 11,928 | $ 11,939 | $ 6 | 84 |
| 2016 | | 15,064 | 15,093 | 46 | 109 |
| 2017 | | | 17,037 | 1,665 | 114 |
| | | | $ 44,069 | $ 1,717 | |

| | Cumulative Paid Claims and Allocated Claims Adjustment Expenses | | |
|---|---|---|---|
| Benefit Year | 2015 [1] | 2016 | 2017 |
| | | (In millions) | |
| 2015 | $ 10,615 | $ 11,906 | $ 11,932 |
| 2016 | | 13,403 | 14,952 |
| 2017 | | | 15,130 |
| | | | $ 42,014 |

The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable.

| | 2017 |
|---|---|
| | (In millions) |
| Incurred claims and allocated claims adjustment expenses | $ 44,069 |
| Less: cumulative paid clams and allocated claims adjustment expenses | (42,014) |
| Non-risk provider payables and other | 137 |
| Medical claims and benefits payable | $ 2,192 |

(1) Data presented for this calendar year is required supplementary information, which is unaudited.

That portion of our total medical claims and benefits payable liability that is most subject to variability in the estimate is IBNP. Our IBNP, as included in medical claims and benefits payable, represents our best estimate of the total

amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNP monthly using actuarial methods based on a number of factors.

Assuming that our initial estimate of IBNP is accurate, we believe that amounts ultimately paid would generally be between 8% and 10% less than the IBNP liability recorded at the end of the period as a result of the inclusion in that liability of the provision for adverse claims development and the accrued cost of settling those claims. Because the amount of our initial liability is an estimate (and therefore not perfectly accurate), we will always experience variability in that estimate as new information becomes available with the passage of time. Therefore, there can be no assurance that amounts ultimately paid out will fall within the range of 8% to 10% lower than the liability that was initially recorded. Indeed, the amount we paid out during 2017 in satisfaction of our liability for medical claims and benefits payable at December 31, 2016, was in excess of the amount originally accrued. Furthermore, because our initial estimate of IBNP is derived from many factors, some of which are qualitative in nature rather than quantitative, we are seldom able to assign specific values to the reasons for a change in estimate—we only know when the circumstances for any one or more factors are out of the ordinary.

The use of a consistent methodology (including a consistent provision for adverse claims development) in estimating our liability for medical claims and benefits payable minimizes the degree to which the overestimation of that liability at the close of one period may affect consolidated results of operations in subsequent periods. In particular, the use of a consistent methodology should result in the replenishment of reserves during any given period in a manner that generally offsets the benefit of favorable prior period development in that period.

Facts and circumstances unique to the estimation process at any single date, however, may still lead to a material impact on consolidated results of operations in subsequent periods. For example, any absence of adverse claims development (as well as the expensing through general and administrative expense of the costs to settle claims held at the start of the period) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate, to the extent that replenishment of reserves is not equal to the benefit recognized due to the absence of adverse development.

Conversely, in the presence of adverse claims development, the financial impact of recording claims expense in the current period that is related to dates of service in the prior period will be compounded by the need to replenish the provision for adverse development.

As noted above, the amounts ultimately paid out in 2017 for dates of service in 2016 and prior were in excess of the liability we had established for medical and claims and benefits payable at December 31, 2016. In contrast, the amounts we paid out for prior period dates of service in 2016 and 2015 were less than the liabilities we had established at the end of the previous years. In all three years, the differences between our original estimates and the amounts ultimately paid out for the most part related to IBNP. While many related factors working in conjunction with one another serve to determine the accuracy of our estimates, we are seldom able to quantify the impact that any single factor has on a change in estimate. In addition, given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates.

***2017***

We recognized unfavorable prior period claims development in the amount of $36 million for the year ended December 31, 2017. This amount represented the extent to which our initial estimate of medical claims and benefits payable at December 31, 2016, was less than the amount that was ultimately paid out in satisfaction of that liability; but does not include additional amounts expensed to re-establish the margin for adverse development. We believe this underestimation was due primarily to the following:

- Inaccurate adjudication of provider claims at our Florida, Illinois, New Mexico and Puerto Rico health plans that created substantial payment backlogs which we were unable to adequately measure when we estimated our liability at December 31, 2016.

We believe that the most significant uncertainties relating to our estimated IBNP liability at December 31, 2017, are as follows:

- At our Florida health plan, the inventory of unpaid claims increased significantly during the first two quarters of 2017, then dropped in the third quarter and fourth quarters of 2017. Changes in claim inventories impact the timing between dates of service and the dates claims are paid, making our liability estimates subject to more than the usual amount of uncertainty.
- At our Illinois health plan, in 2017 we paid a large number of claims that had previously been denied and were subsequently disputed by providers. We have also established a liability for additional expected claims

resulting from provider disputes. This has created some distortion in the claims payment patterns, making our liability estimates subject to more than the usual amount of uncertainty.

- At our California health plan, adjustments to our inpatient authorization process have improved the timeliness of paying inpatient claims, making our liability estimates subject to more than the usual amount of uncertainty.
- In 2017 we implemented a new process for increased quality review of claims payments in six of our health plans. While we do not anticipate this new process will impact the percentage of claims paid within the timely turnaround requirements, we believe it will have a minor impact on the timing of some paid claims. For this reason, our liability estimates in the six health plans are subject to more than the usual amount of uncertainty.
- At our Puerto Rico health plan, Hurricane Maria had a significant impact on both utilization of services and our ability to process claims payments in Puerto Rico. For these reasons, we believe our liability estimates are subject to more than the usual amount of uncertainty.
- December 2017 data from the Centers for Disease Control and Prevention have indicated widespread influenza activity in several states in which we operate health plans. Although we have established liabilities for additional expected claims related to influenza, our liability estimates are subject to more than the usual amount of uncertainty.

***2016***

We recognized favorable prior period claims development in the amount of $192 million for the year ended December 31, 2016. This amount represented the extent to which our initial estimate of medical claims and benefits payable at December 31, 2015, was more than the amount that was ultimately paid out in satisfaction of that liability. We believe this overestimation was due primarily to the following:

- A new version of diagnostic codes was required for all claims with dates of service on October 1, 2015, and later. As a result, payment was delayed or denied for a significant number of claims due to provider submission of claims with diagnostic codes that were no longer valid. Once providers were able to submit claims with the correct diagnostic codes, our actual costs were ultimately less than expected.
- At our New Mexico health plan, we overestimated the impact of several pending high-dollar claims, and our actual costs were ultimately less than expected.
- At our Washington health plan, we overpaid certain outpatient facility claims in 2015 when the state converted to a new payment methodology. We did not include an estimate in our December 31, 2015, reserves for this potential recovery.
- At our California health plan, we enrolled approximately 55,000 new Medicaid Expansion members in 2015. For these new members, our actual costs were ultimately less than expected.

***2015***

We recognized favorable prior period claims development in the amount of $141 million for the year ended December 31, 2015. This amount represented the extent to which our initial estimate of medical claims and benefits payable at December 31, 2014 was more than the amount that was ultimately paid out in satisfaction of that liability. We believe this overestimation was due primarily to the following:

- At our Ohio and California health plans, approximately 61,000 and 100,000 members, respectively, were enrolled in the new Medicaid expansion program during 2014. Also in Ohio, approximately 17,000 members were enrolled in the new MMP program in 2014. Because we lacked sufficient historical claims data, we initially estimated the reserves for these new members based upon a number of factors that included pricing assumptions provided by the state; our expectations regarding pent up demand; our beliefs about the speed at which new members would utilize health care services; and other factors. Our actual costs were ultimately less than expected.

- At our New Mexico health plan, the state implemented a retroactive increase to the provider fee schedules in mid-2014. As a result, many claims that were previously settled were reopened, and subject to, additional payment. Because our reserving methodology is most accurate when claims payment patterns are consistent and predictable, the payment of additional amounts on claims that in some cases had been settled more than six months before added a substantial degree of complexity to our liability estimation process. Due to the difficulties in addressing that added complexity, liabilities recorded as of December 31, 2014 were in excess of amounts ultimately paid.

- At our Washington health plan, we collected amounts in 2015 related to certain claims paid in 2013. Such collections were not anticipated in our reserves as of December 31, 2014.

## 11. Debt

As of December 31, 2017, contractual maturities of debt for the years ending December 31 were as follows. All amounts represent the principal amounts of the debt instruments outstanding.

| | Total | 2018 | 2019 | 2020 | 2021 | 2022 | Thereafter |
|---|---|---|---|---|---|---|---|
| | | | | (In millions) | | | |
| 5.375% Notes | $ 700 | $ — | $ — | $ — | $ — | $ 700 | $ — |
| 1.125% Convertible Notes | 550 | — | — | 550 | — | — | — |
| 4.875% Notes | 330 | — | — | — | — | — | 330 |
| Credit Facility | 300 | — | — | — | — | 300 | — |
| 1.625% Convertible Notes [(1)] | 161 | — | — | — | — | — | 161 |
| | $ 2,041 | $ — | $ — | $ 550 | $ — | $ 1,000 | $ 491 |

(1) The 1.625% Convertible Notes have a contractual maturity date in 2044. However, on contractually specified dates beginning in 2018, holders may convert, or may require us to repurchase some or all of the 1.625% Convertible Notes.

Substantially all of our debt is held at the parent, which is reported in the Other segment. The following table summarizes our outstanding debt obligations and their classification in the accompanying consolidated balance sheets (in millions):

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| **Current portion of long-term debt:** | | |
| 1.125% Convertible Notes, net of unamortized discount | $ 499 | $ 477 |
| 1.625% Convertible Notes, net of unamortized premium and discount | 157 | — |
| Lease financing obligations | 1 | 1 |
| Debt issuance costs | (4) | (6) |
| | 653 | 472 |
| **Non-current portion of long-term debt:** | | |
| 5.375% Notes | 700 | 700 |
| 4.875% Notes | 330 | — |
| Credit Facility | 300 | — |
| 1.625% Convertible Notes, net of unamortized premium and discount | — | 286 |
| Debt issuance costs | (12) | (11) |
| | 1,318 | 975 |
| **Lease financing obligations** | 198 | 198 |
| | $ 2,169 | $ 1,645 |

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

| | Years Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | | (In millions) | |
| Contractual interest at coupon rate | $ 11 | $ 11 | $ 11 |
| Amortization of the discount | 32 | 30 | 29 |
| | $ 43 | $ 41 | $ 40 |

***Bridge Credit Agreement***

In January 2018, we entered into a bridge credit agreement (Bridge Credit Agreement) with several banks. Under the Bridge Credit Agreement, the banks agreed to lend us up to $550 million to be used to: (i) satisfy conversions of our 1.125% Convertible Notes; (ii) satisfy and/or refinance indebtedness incurred to satisfy conversion of the 1.125% Convertible Notes; (iii) repay or refinance our Credit Facility; (iv) pay fees and expenses in connection with the foregoing; and, subject to the satisfaction of specified conditions, for general corporate purposes.

Borrowings under the Bridge Credit Agreement are reduced by the following:

- Any future debt and/or equity transactions:
    - Including term loans, but excluding any Credit Facility drawing; and
    - Excluding transactions with proceeds used for working capital purposes and acquisition financings up to $300 million.
- On August 1, 2018 (the put date for the 1.625% Convertible Notes), the Bridge Credit Agreement shall permanently be reduced by the greater of:
    - $150 million; and
    - The principal amount of the 1.625% Convertible Notes that are exchanged into equity prior to that date.

The Bridge Credit Agreement matures on January 1, 2019 and, subject to the satisfaction of certain conditions, we may elect to extend twice the initial maturity date by a period of six months each.

Borrowings under the Bridge Credit Agreement will bear interest based, at our election, at a base rate or an adjusted LIBOR rate, plus in each case the applicable margin. Our wholly owned subsidiaries that guarantee our obligations under the indenture governing the 4.875% Notes, the 5.375% Notes, and the Credit Facility have jointly and severally guaranteed our obligations under the Bridge Credit Agreement.

The Bridge Credit Agreement contains usual and customary (a) affirmative covenants for credit facilities of this type and substantially similar to those contained in the Credit Facility, (b) negative covenants consistent with those contained in the 4.875% Notes and (c) events of default for credit facilities of this type and substantially similar to those contained in the 4.875% Notes.

***4.875% Notes due 2025***

On June 6, 2017, we completed the private offering of $330 million aggregate principal amount of senior notes (4.875% Notes) due June 15, 2025, unless earlier redeemed. Interest on the 4.875% Notes is payable semiannually in arrears on June 15 and December 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 4.875% Notes; subsidiary guarantors are defined under the Credit Facility, as described below. See Note 23, “Supplemental Condensed Consolidating Financial Information,” for more information on the guarantors. The 4.875% Notes contain customary non-financial covenants and change of control provisions. At December 31, 2017, we were in compliance with all covenants under the 4.875% Notes.

The 4.875% Notes and the guarantees described above are senior unsecured obligations of Molina and the guarantors, respectively, and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina and the guarantors.

A portion of the proceeds from the issuance of the 4.875% Notes are required to be maintained in a segregated deposit account, which may be used as follows:

- On or prior to August 20, 2018, to:
    - Redeem, repurchase, repay, tender for, or acquire for value all or any portion of our 1.625% Convertible Notes, defined and discussed further below, or to satisfy the cash portion of any consideration due upon any conversion of the 1.625% Convertible Notes; and/or
    - Pay any interest due on all or any portion of the 4.875% Notes.
- On or after August 20, 2018, to repurchase all or any portion of the 1.625% Convertible Notes that we are obligated to repurchase; and
- Subsequent to August 20, 2018 (or such earlier date in the event that there are no longer any 1.625% Convertible Notes outstanding), in any other manner not otherwise prohibited in the indenture governing the 4.875% Notes.

The investments that constitute the segregated funds are current assets reported as “Restricted investments” in the accompanying consolidated balance sheets. As a result of the 1.625% Exchange transaction described below, approximately $157 million of such investments were transferred to unrestricted current investments in the fourth quarter of 2017. As of December 31, 2017, the balance of current restricted investments was $169 million.

***5.375% Notes due 2022***

We have outstanding $700 million aggregate principal amount of senior notes (5.375% Notes) due November 15, 2022, unless earlier redeemed. Interest on the 5.375% Notes is payable semiannually in arrears on May 15 and November 15. Certain of our wholly owned subsidiaries guarantee our obligations under the 5.375% Notes; subsidiary guarantors are defined under the Credit Facility, as described below. The 5.375% Notes contain customary non-financial covenants and change in control provisions. At December 31, 2017, we were in compliance with all covenants under the 5.375% Notes.

The 5.375% Notes and the guarantees described above are senior unsecured obligations of Molina and the guarantors, respectively, and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina and the guarantors.

***Credit Facility***

In January 2017, we entered into an amended unsecured $500 million revolving credit facility (Credit Facility), referred to as the First Amendment. The Credit Facility has a term of five years and all amounts outstanding will be due and payable on January 31, 2022. As of December 31, 2017, $300 million was outstanding under the Credit Facility. Also as of December 31, 2017, outstanding letters of credit amounting to $6 million reduced our remaining borrowing capacity under the Credit Facility to $194 million.

Borrowings under our Credit Facility bear interest based, at our election, on a base rate or an adjusted London Interbank Offered Rate (LIBOR), plus in each case the applicable margin. In addition to interest payable on the principal amount of indebtedness outstanding from time to time under the Credit Facility, we are required to pay a quarterly commitment fee. The Credit Facility contains customary non-financial and financial covenants, including a net leverage ratio and an interest coverage ratio. As of December 31, 2017, we were in compliance with all financial and non-financial covenants under the Credit Facility.

During 2017, we entered into several amendments to the Credit Facility which provided for, or modified the following:

- Automatic and unconditional release of all subsidiaries that were guarantors immediately prior to January 3, 2017, from their obligations as guarantors, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC, and Pathways Health and Community Support LLC;

- The definition of the earnings measure used in the financial covenant computations;

- The definition of specified cash, to permit cash that is either subject to customary escrow arrangements or held in a segregated account to be netted from the Credit Facility’s consolidated net leverage ratio if the use of the cash is limited to the repayment of other indebtedness;

- The definition of consolidated adjusted EBITDA, to permit the add-back of certain restructuring charges and cost savings subject to certain limitations, and the definition of the consolidated interest coverage ratio to include, when calculating such ratio, consolidated interest expense “paid in cash” only; and

- The list of indebtedness exceptions to include the new Bridge Credit Agreement discussed above.

***1.125% Cash Convertible Senior Notes due 2020***

We have outstanding $550 million aggregate principal amount of 1.125% cash convertible senior notes due January 15, 2020 (1.125% Convertible Notes), unless earlier repurchased or converted. Interest is payable semiannually in arrears on January 15 and July 15. The 1.125% Convertible Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.125% Convertible Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The 1.125% Convertible Notes are convertible only into cash, and not into shares of our common stock or any other securities. The initial conversion rate for the 1.125% Convertible Notes is 24.5277 shares of our common stock per $1,000 principal amount, or approximately $40.77 per share of our common stock. Upon conversion, in lieu of receiving shares of our common stock, a holder will receive an amount in cash, per $1,000 principal amount of

1.125% Convertible Notes, equal to the settlement amount, determined in the manner set forth in the indenture. We may not redeem the 1.125% Convertible Notes prior to the maturity date. Holders may convert their 1.125% Convertible Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ending on June 30, 2013 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period immediately after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.125% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events; or
- at any time on or after July 15, 2019 until the close of business on the second scheduled trading day immediately preceding the maturity date.

The stock price trigger for the 1.125% Convertible Notes is $53.00 per share. The 1.125% Convertible Notes met this trigger in the quarter ended December 31, 2017; therefore, they are convertible into cash and are reported in current portion of long-term debt as of December 31, 2017.

The 1.125% Convertible Notes contain an embedded cash conversion option (the 1.125% Conversion Option), which was separated from the 1.125% Convertible Notes and accounted for separately as a derivative liability, with changes in fair value reported in our consolidated statements of operations until the 1.125% Conversion Option settles or expires. The initial fair value liability of the 1.125% Conversion Option simultaneously reduced the carrying value of the 1.125% Convertible Notes (effectively an original issuance discount). This discount is amortized to the 1.125% Convertible Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. This has resulted in our recognition of interest expense on the 1.125% Convertible Notes at an effective rate of approximately 6%. As of December 31, 2017, the 1.125% Convertible Notes have a remaining amortization period of 2.0 years. The 1.125% Convertible Notes' if-converted value exceeded their principal amount by approximately $406 million and $182 million as of December 31, 2017 and December 31, 2016, respectively.

***1.625% Convertible Senior Notes due 2044***

In December 2017, we entered into separate, privately negotiated, synthetic exchange agreements (1.625% Exchange) with certain holders of our outstanding 1.625% convertible senior notes due 2044 (1.625% Convertible Notes). In this transaction, we exchanged $141 million aggregate principal amount and accrued interest for 2.6 million shares of our common stock. We recorded a loss on debt extinguishment, including transaction fees, of $14 million, for the transaction, primarily relating to the inducement premium paid to the bondholders, which is recorded in "Other expenses, net," in the accompanying consolidated statement of operations. We did not receive any proceeds under the 1.625% Exchange.

Following the 1.625% Exchange, we have outstanding $161 million aggregate principal amount of the 1.625% Convertible Notes. Interest is payable semiannually in arrears on February 15 and August 15. In addition, beginning with the semiannual interest period commencing immediately following the interest payment date on August 15, 2018, contingent interest will accrue on the 1.625% Convertible Notes during any semiannual interest period in which certain conditions or events occur, or under certain events of default. For example, additional interest of 0.25% per year will be payable on the 1.625% Notes for any semiannual interest period for which the principal amount of 1.625% Convertible Notes outstanding is less than $100 million.

The 1.625% Convertible Notes are senior unsecured obligations and rank senior in right of payment to any of our indebtedness that is expressly subordinated in right of payment to the 1.625% Notes; equal in right of payment to any of our unsecured indebtedness that is not subordinated; effectively junior in right of payment to any of our secured indebtedness to the extent of the value of the assets securing such indebtedness; and structurally junior to all indebtedness and other liabilities of our subsidiaries.

The initial conversion rate for the 1.625% Convertible Notes is 17.2157 shares of our common stock per $1,000 principal amount, or approximately $58.09 per share of our common stock. Upon conversion, we will pay cash and, if applicable, deliver shares of our common stock to the converting holder in an amount per $1,000 principal amount of 1.625% Notes equal to the settlement amount (as defined in the related indenture).

Holders may convert their 1.625% Convertible Notes only under the following circumstances:

- during any calendar quarter commencing after the calendar quarter ended on September 30, 2014 (and only during such calendar quarter), if the last reported sale price of the common stock for at least 20 trading days (whether or not consecutive) during a period of 30 consecutive trading days ending on the last trading day of the immediately preceding calendar quarter is greater than or equal to 130% of the conversion price on each applicable trading day;
- during the five business day period after any five consecutive trading day period (the measurement period) in which the trading price per $1,000 principal amount of 1.625% Notes for each trading day of the measurement period was less than 98% of the product of the last reported sale price of our common stock and the conversion rate on each such trading day;
- upon the occurrence of specified corporate events;
- if we call any 1.625% Notes for redemption, at any time until the close of business on the business day immediately preceding the redemption date;
- during the period from, and including, May 15, 2018 to the close of business on the business day immediately preceding August 19, 2018; or
- at any time on or after February 15, 2044 until the close of business on the second scheduled trading day immediately preceding the maturity date, holders may convert their 1.625% Notes, in integral multiples of $1,000 principal amount, at the option of the holder regardless of the foregoing circumstances.

The stock price trigger for the 1.625% Convertible Notes is $75.51 per share. The 1.625% Convertible Notes did not meet this stock price trigger in the quarter ended December 31, 2017. However, on contractually specified dates beginning in 2018, holders of the 1.625% Convertible Notes may require us to repurchase some or all of such notes. In addition, beginning May 15, 2018 until August 19, 2018, holders may convert some or all of the 1.625% Convertible Notes. Because of these put and conversion features, the 1.625% Convertible Notes are reported in current portion of long-term debt as of December 31, 2017. As noted above, because the proceeds from the 4.875% Notes are initially restricted to payments upon conversion or redemption of the 1.625% Convertible Notes, such restricted investments are also classified as current in the accompanying consolidated balance sheets.

We may not redeem the 1.625% Convertible Notes prior to August 19, 2018. On or after August 19, 2018, we may redeem for cash all or part of the 1.625% Convertible Notes, except for the 1.625% Convertible Notes we are required to repurchase in connection with a fundamental change or on any specified repurchase date. The redemption price for the 1.625% Convertible Notes will equal 100% of the principal amount of the 1.625% Convertible Notes being redeemed, plus accrued and unpaid interest. In addition, holders of the 1.625% Convertible Notes may require us to repurchase some or all of the 1.625% Convertible Notes for cash on August 19, 2018, August 19, 2024, August 19, 2029, August 19, 2034 and August 19, 2039, in each case, at a specified price equal to 100% of the principal amount of the 1.625% Convertible Notes to be repurchased, plus accrued and unpaid interest.

Because the 1.625% Convertible Notes are net share settled and have cash settlement features, we have allocated the principal amount between a liability component and an equity component. The reduced carrying value on the 1.625% Convertible Notes resulted in a debt discount that is amortized back to the 1.625% Convertible Notes' principal amount through the recognition of non-cash interest expense over the expected life of the debt. The expected life of the debt is approximately four years, beginning on the issuance date and ending on the first date we may redeem the 1.625% Convertible Notes in August 2018. As of December 31, 2017, the 1.625% Convertible Notes have a remaining amortization period of 0.6 years. This has resulted in our recognition of interest expense on the 1.625% Convertible Notes at an effective rate approximating what we would have incurred had nonconvertible debt with otherwise similar terms been issued, or approximately 5%. The outstanding 1.625% Convertible Notes' if-converted value exceeded their principal amount at December 31, 2017 by approximately $50 million, and did not exceed their principal amount at December 31, 2016. At December 31, 2017 and 2016, the equity component of the 1.625% Convertible Notes, including the impact of deferred taxes, was $12 million and $23 million, respectively.

***Cross-Default Provisions***

The terms of our 4.875% Notes, 5.375% Notes and each of the 1.125% and 1.625% Convertible Notes contain cross-default provisions with the Credit Facility that are triggered upon an event of default under the Credit Facility, and when borrowings under the Credit Facility equal or exceed certain amounts as defined in the related indentures.

***Lease Financing Obligations***

As a result of our continuing involvement in the leasing transactions described below, we are the "accounting owner" of the properties under the leases. The assets are therefore included in our consolidated balance sheets, and are depreciated over their remaining useful lives. The lease financing obligations are amortized over the initial lease terms, such that there will be no gain or loss recorded if the leases are not extended beyond their expiration dates. Payments under the leases adjust the lease financing obligations, and the imputed interest is recorded to interest expense in our consolidated statements of operations. Aggregate interest expense under these leases amounted to $17 million in each of the years ended December 31, 2017, 2016 and 2015. For information regarding the future minimum lease obligations, refer to Note 19, "Commitments and Contingencies."

*Molina Center and Ohio Exchange.* In 2013, we entered into a sale-leaseback transaction for the Molina Center and our Ohio health plan office building located in Columbus, Ohio, also known as the Ohio Exchange. The sale of these properties did not qualify for sales recognition, because certain lease terms resulted in our continuing involvement with these leased properties. Rent increases 3% per year through the initial term, which expires in 2038. The lease provides for six five-year renewal options, with renewal rent to be the higher of the 3% annual escalator or the then-fair market value.

*6th and Pine.* Also in 2013, we entered into a construction and lease transaction for two office buildings in Long Beach, California (6th and Pine). Due to our participation in the construction project, we retained continuing involvement in the properties. Rent increases 3.4% per year through the initial term, which expires in 2029. The lease provides for two five-year renewal options, with renewal rent to be determined based on the then-fair market value.

***Debt Commitment Letter***

In connection with the terminated Medicare acquisition described in Note 1, "Basis of Presentation," we entered into a debt commitment letter with Barclays Bank PLC (Barclays) in August 2016. Under this debt commitment letter, Barclays agreed to lend us up to $400 million, subject to satisfaction of certain conditions, including consummation of the terminated Medicare acquisition. The debt commitment letter automatically terminated in February 2017 upon termination of the Medicare acquisition.

## 12. Derivatives

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

| | | December 31, | |
|---|---|---|---|
| | **Balance Sheet Location** | **2017** | **2016** |
| | | **(In millions)** | |
| Derivative asset: | | | |
| 1.125% Call Option | Current assets: Derivative asset | $ 522 | $ 267 |
| | | | |
| Derivative liability: | | | |
| 1.125% Conversion Option | Current liabilities: Derivative liability | $ 522 | $ 267 |

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

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

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

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

As of December 31, 2017, the 1.125% Call Option and the 1.125% Conversion Option were classified as a current asset and current liability, respectively, because the 1.125% Convertible Notes may be converted within twelve months of December 31, 2017, as described in Note 11, “Debt.”

## 13. Income Taxes

The (benefit) provision for income taxes is determined using an estimated annual effective tax rate, which generally differs from the U.S. federal statutory rate primarily because of state taxes, nondeductible expenses such as the HIF, goodwill impairment, certain compensation, and other general and administrative expenses. The effective tax rate was not impacted by the HIF in 2017, given the 2017 HIF moratorium. The effective tax rate may be subject to fluctuations during the year, particularly as a result of the level of pretax earnings, and also as new information is obtained. Such information may affect the assumptions used to estimate the annual effective tax rate, including factors such as the mix of pretax earnings in the various tax jurisdictions in which we operate, valuation allowances against deferred tax assets, the recognition or the reversal of the recognition of tax benefits related to uncertain tax positions, and changes in or the interpretation of tax laws in jurisdictions where we conduct business. We recognize deferred tax assets and liabilities for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities, along with net operating loss and tax credit carryovers.

The Tax Cuts and Jobs Act (TCJA) was enacted on December 22, 2017. The TCJA, in part, reduces the U.S. federal corporate tax rate from 35% to 21% effective January 1, 2018. TCJA’s change in the federal rate requires that we revalue deferred tax assets and liabilities based on the rates at which they are expected to reverse in the future, which is generally the new 21% federal corporate tax rate plus applicable state tax rate. At December 31, 2017, we have not completed our accounting for the tax effects of enactment of the TCJA; however, we have made a reasonable estimate of the effects on our existing deferred tax balances and we recognized a provisional deferred federal income tax expense of $54 million, which is included as a reduction of income tax benefit for the year ended December 31, 2017. We will continue to make and refine our calculations as additional analysis is completed. In addition, our estimates may also be affected as we gain a more thorough understanding of the tax law based on expected future guidance from the Internal Revenue Service and U.S. Treasury.

The (benefit) provision for income taxes consisted of the following:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Current: | | | |
| Federal | $ (9) | $ 134 | $ 172 |
| State | 3 | 3 | 8 |
| Foreign | — | (6) | 6 |
| Total current | (6) | 131 | 186 |
| Deferred: | | | |
| Federal | (85) | 19 | (10) |
| State | (9) | 2 | 4 |
| Foreign | — | 1 | (1) |
| Total deferred | (94) | 22 | (7) |
| | $ (100) | $ 153 | $ 179 |

In 2017, the income tax benefit of $100 million is net of $54 million in deferred income tax expense as a result of the revaluation of net deferred tax assets in connection with the TCJA.

A reconciliation of the U.S. federal statutory income tax rate to the combined effective income tax rate is as follows:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| Statutory federal tax (benefit) rate | (35.0)% | 35.0 % | 35.0% |
| State income provision (benefit), net of federal | (0.7) | 1.6 | 2.4 |
| Nondeductible health insurer fee (HIF) | — | 37.0 | 17.0 |
| Nondeductible compensation | 2.8 | 3.1 | 0.6 |
| Nondeductible goodwill impairment | 6.6 | — | — |
| Revaluation of net deferred tax assets | 8.8 | — | — |
| Change in purchase agreement that increased tax basis in assets | — | (2.2) | — |
| Other | 1.1 | 0.3 | 0.5 |
| Effective tax (benefit) rate | (16.4)% | 74.8 % | 55.5% |

Our effective tax rate is based on expected (loss) income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws.

During 2016, and 2015, excess tax benefits from share-based compensation amounted to $2 million and $8 million, respectively. These amounts were recorded as a decrease to income taxes payable and an increase to additional paid-in capital. Effective 2017, excess tax benefits are no longer recorded through additional paid-in capital but rather through the income statement as an income tax benefit pursuant to ASU 2016-09.

Deferred tax assets and liabilities are classified as non-current. Significant components of our deferred tax assets and liabilities as of December 31, 2017 and 2016 were as follows:

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| | (In millions) | |
| Accrued expenses | $ 15 | $ 22 |
| Reserve liabilities | 11 | 28 |
| Other accrued medical costs | 16 | 5 |
| Net operating losses | 27 | 13 |
| Fixed assets and intangibles | 23 | — |
| Unrealized losses | 2 | 1 |
| Unearned premiums | 19 | 27 |
| Lease financing obligation | 30 | 38 |
| Deferred compensation | 1 | 6 |
| Tax credit carryover | 15 | 7 |
| Valuation allowance | (41) | (16) |
| Total deferred income tax assets, net of valuation allowance | 118 | 131 |
| Prepaid expenses | (6) | (9) |
| Fixed assets and intangibles | — | (104) |
| Basis in debt | (9) | (23) |
| Total deferred income tax liabilities | (15) | (136) |
| Net deferred income tax asset (liability) | $ 103 | $ (5) |

At December 31, 2017, we had state net operating loss carryforwards of $578 million, which begin expiring in 2018.

At December 31, 2017, we had California research and development and enterprise zone tax credit carryovers of $14 million, which will begin to expire in 2024. In 2017, we generated federal research and development and other tax credit carryovers of $4 million, which will expire in 2038.

We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary

differences. We have determined that as of December 31, 2017, $41 million of deferred tax assets did not satisfy the recognition criteria due to uncertainty regarding the realization of some of our state net operating loss and credit carryforwards. Therefore, we increased our valuation allowance by $25 million, from $16 million at December 31, 2016, to $41 million as of December 31, 2017.

We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax-related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate.

The roll forward of our unrecognized tax benefits is as follows:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Gross unrecognized tax benefits at beginning of period | $ (11) | $ (9) | $ (3) |
| Increases in tax positions for current year | (1) | (1) | (1) |
| Increases in tax positions for prior years | (4) | (1) | (5) |
| Decreases in tax positions for prior years | 3 | — | — |
| Gross unrecognized tax benefits at end of period | $ (13) | $ (11) | $ (9) |

The total amount of unrecognized tax benefits at December 31, 2017, 2016 and 2015 that, if recognized, would affect the effective tax rates is $12 million, $9 million, and $7 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by as much as $2 million due to the expiration of statutes of limitation.

Our continuing practice is to recognize interest and/or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2017, 2016 and 2015 were insignificant.

We may be subject to federal examination for calendar years 2014 through 2016. We are under examination, or may be subject to examination, in Puerto Rico and certain state and local jurisdictions, with the major state jurisdictions being California, Michigan, and Illinois for the years 2009 through 2016.

## 14. Stockholders' Equity

***1.625% Exchange***

As described in Note 11, “Debt,” we issued 2.6 million shares of our common stock in connection with the 1.625% Exchange in December 2017.

***1.125% Warrants***

In connection with the Call Spread Overlay transaction described in Note 12, “Derivatives,” in 2013, we issued 13,490,236 warrants with a strike price of $53.8475 per share. The number of warrants and the strike price are subject to adjustment under certain circumstances. If the market value per share of our common stock exceeds the strike price of the 1.125% Warrants on any trading day during the 160 trading day measurement period (beginning on April 15, 2020) under the 1.125% Warrants, we will be obligated to issue to the Counterparties a number of shares equal in value to the product of the amount by which such market value exceeds such strike price and 1/160th of the aggregate number of shares of our common stock underlying the 1.125% Warrants, subject to a share delivery cap. The 1.125% Warrants could separately have a dilutive effect to the extent that the market value per share of our common stock exceeds the applicable strike price of the 1.125% Warrants. Refer to Note 3, “Net (Loss) Income per Share,” for dilution information for the periods presented. We will not receive any additional proceeds if the 1.125% Warrants are exercised.

***Share-Based Compensation***

At December 31, 2017, we had employee equity incentives outstanding under our 2011 Equity Incentive Plan (2011 Plan). The 2011 Plan provides for the award of restricted shares and units, performance shares and units, stock options and stock bonuses to the company's officers, employees, directors, consultants, advisers, and other service providers. The 2011 Plan provides for the issuance of up to 4.5 million shares of common stock.

In connection with the 2011 Plan and employee stock purchase plan, approximately 857,000 shares of common stock were purchased or vested, net of shares used to settle employees' income tax obligations, during the year ended December 31, 2017.

Except as noted below, we record share-based compensation as "General and administrative expenses" in the accompanying consolidated statements of operations. Total share-based compensation expense was as follows:

| | Year Ended December 31, | | | | | |
|---|---|---|---|---|---|---|
| | 2017 | | 2016 | | 2015 | |
| | (In millions) | | | | | |
| | Pretax Charges | Net-of-Tax Amount | Pretax Charges | Net-of-Tax Amount | Pretax Charges | Net-of-Tax Amount |
| Restricted stock and performance awards | $ 39 | $ 35 | $ 20 | $ 17 | $ 19 | $ 13 |
| Employee stock purchase plan and stock options | 7 | 5 | 6 | 5 | 4 | 3 |
| | $ 46 | $ 40 | $ 26 | $ 22 | $ 23 | $ 16 |

*Restricted stock awards*. Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. We recognize expense for these awards on a straight-line basis. Stock option awards generally have an exercise price equal to the fair market value of our common stock on the date of grant, vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant.

RSAs, PSAs and PSUs activity for the year ended December 31, 2017 is summarized below:

| | Restricted Stock Awards | Performance Stock Awards | Performance Stock Units | Total Shares | Weighted Average Grant Date Fair Value |
|---|---|---|---|---|---|
| Unvested balance as of December 31, 2016 | 577,244 | 345,656 | — | 922,900 | $ 58.15 |
| Granted | 395,946 | — | 231,100 | 627,046 | 57.34 |
| Vested | (424,556) | (260,894) | (139,272) | (824,722) | 57.78 |
| Forfeited | (146,830) | — | — | (146,830) | 53.89 |
| Unvested balance as of December 31, 2017 | 401,804 | 84,762 | 91,828 | 578,394 | $ 58.35 |

As of December 31, 2017, there was $19 million of total unrecognized compensation expense related to unvested restricted stock awards (RSAs), performance stock awards (PSAs) and performance stock units (PSUs), which we expect to recognize over a remaining weighted-average period of 2.2 years, 0.4 years and 1.6 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 11.8% for non-executive employees as of December 31, 2017, which is based on actual forfeitures over the last 4 years. Also as of December 31, 2017, there was $15 million of total unrecognized compensation expense related to unvested stock options, which we expect to recognize over a weighted-average period of 2.8 years.

The total fair value of awards granted and vested is presented in the following table:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Granted: | | | |
| Restricted stock awards | $ 20 | $ 19 | $ 17 |
| Performance stock awards | — | 15 | 11 |
| Performance stock units | 16 | — | — |
| | $ 36 | $ 34 | $ 28 |
| Vested: | | | |
| Restricted stock awards | $ 23 | $ 22 | $ 23 |
| Performance stock awards | 15 | — | 16 |
| Performance stock units | 9 | — | — |
| | $ 47 | $ 22 | $ 39 |

During the year ended December 31, 2017, the vesting of 133,957 RSAs, 153,574 PSAs and 139,272 PSUs was accelerated in connection with the termination of our former Chief Executive Officer (CEO) and former Chief Financial Officer (CFO) in May 2017. The incremental charge relating to this acceleration, or $23 million, is reported in “Restructuring and separation costs” in the accompanying consolidated statements of operations. This amount is included in the 2017 “Pretax Charges” in the table above. See Note 15, “Restructuring and Separation Costs” for further discussion.

*Stock Options.* Stock option activity for the year ended December 31, 2017 is summarized below:

| | Shares | Weighted Average Exercise Price | Aggregate Intrinsic Value | Weighted Average Remaining Contractual term |
|---|---|---|---|---|
| | | | (In millions) | (Years) |
| Stock options outstanding as of December 31, 2016 | 90,000 | $ 24.93 | | |
| Granted | 375,000 | 67.33 | | |
| Exercised | (60,000) | 20.88 | | |
| Stock options outstanding as of December 31, 2017 | 405,000 | 64.79 | $ 5 | 9.5 |
| Stock options exercisable and expected to vest as of December 31, 2017 | 405,000 | 64.79 | $ 5 | 9.5 |
| Exercisable as of December 31, 2017 | 30,000 | 33.02 | $ 1 | 5.2 |

The weighted-average grant date fair value per share of stock options awarded in 2017 was $41.43. We estimate the fair value of each stock option award on the grant date using the Black-Scholes option pricing model. To determine the fair value of the stock options awarded in 2017 we applied a risk-free interest rate of 2.3%, expected volatility of 38.4%, dividend yield of 0% and expected life of 8.4 years. No stock options were granted in 2016 and 2015.

The total intrinsic value of options exercised during the years ended December 31, 2017, 2016, and 2015 was $2 million, $1 million, and $6 million, respectively. The following is a summary of information about stock options outstanding and exercisable at December 31, 2017:

| | Options Outstanding | | | Options Exercisable | |
|---|---|---|---|---|---|
| Range of Exercise Prices | Number Outstanding | Weighted Average Remaining Contractual Life (Years) | Weighted-Average Exercise Price | Number Exercisable | Weighted-Average Exercise Price |
| $33.02 | 30,000 | 5.2 | $ 33.02 | 30,000 | $ 33.02 |
| $67.33 | 375,000 | 9.9 | 67.33 | — | — |
| | 405,000 | | | 30,000 | |

*Employee Stock Purchase Plan.* Under our employee stock purchase plan (ESPP), eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of each six-month offering period. Each participant is limited to a maximum purchase of $25,000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using the Black-Scholes option pricing model. For the years ended December 31, 2017, 2016, and 2015, the inputs to this model were as follows: risk-free interest rates of approximately 0.1% to 1.1%; expected volatilities ranging from approximately 30% to 40%, dividend yields of 0%, and an average expected life of 0.5 years. We issued approximately 351,000, 410,000 and 302,000 shares of our common stock under the ESPP during the years ended December 31, 2017, 2016, and 2015, respectively. The 2011 ESPP provides for the issuance of up to three million shares of common stock.

## 15. Restructuring and Separation Costs

Following a management-initiated, broad operational assessment in early 2017, designed to improve our profitability and expand our core Medicaid business, in June 2017, we accelerated the implementation of a comprehensive restructuring and profitability improvement plan (the 2017 Restructuring Plan). Under the 2017 Restructuring Plan, we have taken the following actions:

1. We have streamlined our organizational structure, including the elimination of redundant layers of management, the consolidation of regional support services, and other reductions to our workforce, to improve efficiency as well as the speed and quality of our decision-making.

2. We re-designed core operating processes such as provider payment, utilization management, quality monitoring and improvement, and information technology to achieve more effective and cost efficient outcomes.

3. We are remediating high cost provider contracts and building around high quality, cost-effective networks.

4. We restructured our existing direct delivery operations.

5. We reviewed our vendor base to ensure that we are partnering with the lowest-cost, most-effective vendors.

In addition to costs incurred under the 2017 Restructuring Plan, we have recorded costs associated with the separation of our former CEO and former CFO, described in further detail below.

***Costs Incurred***

2017 Restructuring Plan

Restructuring costs in 2017 consisted primarily of one-time termination benefits, write-offs of long-lived assets (primarily capitalized software, and leasehold improvements and other assets relating to restructured direct delivery operations), consulting fees, and contract termination costs (including office leases and other contracts).

We previously anticipated that we would incur costs under the 2017 Restructuring Plan in 2018. However, we incurred substantially all costs relating to this plan in 2017, or approximately $234 million. Such costs are presented, by type and reportable segment, below. Since the initiation of our 2017 Restructuring Plan in the second quarter of 2017, the range of total estimated costs increased by approximately $50 million due primarily to non-cash write-offs of certain capitalized software in connection with the re-design of core processes. Such write-offs were

not included in our initial total cost estimates, but as our evaluation of core operating processes proceeded in the third quarter, we determined that certain projects were inconsistent with our future operating goals and were therefore written off.

In addition, in the second quarter of 2017, we reported that we expected restructuring costs to relate only to the Health Plans and Other segments. In the third quarter of 2017, however, we wrote off certain costs capitalized at our Molina Medicaid Solutions segment that supported our Health Plans segment provider information management processes. These processes are now subject to re-design under the 2017 Restructuring Plan.

Separation Costs

On May 2, 2017, we terminated the employment of our former CEO and CFO without cause. Under their amended and restated employment agreements, they were each entitled to receive 400% of their base salary, a prorated termination bonus (150% of base salary for the former CEO and 125% of base salary for the former CFO), full vesting of equity compensation, and a cash payment for health and welfare benefits. We recorded separation costs of $36 million primarily related to these former executives under FASB ASC Topic 712, *Nonretirement and Postemployment Benefits*. Of this total, $23 million related to the acceleration of their share-based compensation, as further discussed in Note 14, “Stockholders' Equity.” Employee separation costs were insignificant in 2016 and 2015.

Restructuring and separation costs are reported in “Restructuring and separation costs” in the accompanying consolidated statements of operations. The following tables present the major types of such costs by segment. Long-lived assets include capitalized software, intangible assets and furniture, fixtures and equipment.

| | Year Ended December 31, 2017 | | | | | |
|---|---|---|---|---|---|---|
| | | | Other Restructuring Costs | | | |
| | Separation Costs - Former Executives | One-Time Termination Benefits | Write-offs of Long-lived Assets | Consulting Fees | Contract Termination Costs | Total |
| | (In millions) | | | | | |
| Health Plans | $ — | $ 33 | $ 16 | $ — | $ 24 | $ 73 |
| Molina Medicaid Solutions | — | — | 8 | — | — | 8 |
| Other | 36 | 34 | 37 | 44 | 2 | 153 |
| | $ 36 | $ 67 | $ 61 | $ 44 | $ 26 | $ 234 |

***Reconciliation of Liability***

For those restructuring and separation costs that require cash settlement (primarily separation costs not including equity incentives, termination benefits, consulting fees and contract termination costs), the following table presents a roll-forward of the accrued liability, which is reported primarily in “Accounts payable and accrued liabilities” in the accompanying consolidated balance sheets. Certain contract termination cost accruals are non-current, recorded in “Other long-term liabilities.”

| | Separation Costs - Former Executives | One-Time Termination Benefits | Other Restructuring Costs | Total |
|---|---|---|---|---|
| | (In millions) | | | |
| Accrued as of December 31, 2016 | $ — | $ — | $ — | $ — |
| Charges | 13 | 66 | 71 | 150 |
| Cash payments | (11) | (55) | (36) | (102) |
| Accrued as of December 31, 2017 | $ 2 | $ 11 | $ 35 | $ 48 |

## 16. Employee Benefits

We sponsor defined contribution 401(k) plans that cover substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We generally match up to the first 4% of compensation contributed by employees. Expense

recognized in connection with our contributions to the 401(k) plans totaled $43 million, $36 million, and $27 million in the years ended December 31, 2017, 2016, and 2015, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in corporate-owned life insurance, under a rabbi trust.

## 17. Related Party Transactions

As described in Note 15, “Restructuring and Separation Costs,” we terminated the employment of Dr. J. Mario Molina and John C. Molina without cause in May 2017. In addition, Dr. Molina resigned his board directorship in December 2017, and John C. Molina resigned his board directorship on February 23, 2018.

As of December 31, 2017, we held a receivable of $5 million in connection with the termination of the provider and other services agreements with Dr. Molina’s professional corporation in Michigan. Such agreements are described in further detail in Note 18, “Variable Interest Entities (VIEs).”

Our California health plan has entered into a provider agreement with Pacific Healthcare IPA (Pacific), which is 50% owned by the brother-in-law of Dr. Molina and Mr. Molina. Under the terms of this provider agreement, the California health plan pays Pacific for medical care services that Pacific provides to health plan members. For the years ended December 31, 2017 and 2016, the amounts the California health plan paid to Pacific Healthcare were insignificant. For 2015, the California health plan paid Pacific approximately $1 million.

## 18. Variable Interest Entities (VIEs)

***Joseph M. Molina M.D., Professional Corporations***

The Joseph M. Molina, M.D. Professional Corporations (JMMPC) constitute medical provider groups originally created to advance our direct delivery business. JMMPC’s primary shareholder is Dr. J. Mario Molina, who was formerly both Molina’s CEO, and a member of our board of directors. When JMMPC was created, we concluded that we were the primary beneficiary of the JMMPC VIE because we had the power to direct the activities (excluding clinical decisions) that most significantly affected JMMPC’s economic performance, and the obligation to absorb losses or right to receive benefits that were potentially significant to the VIE, under the agreements described below. Because we were its primary beneficiary, we consolidated JMMPC as of December 31, 2017 and 2016.

In 2017, we made the strategic decision to restructure our direct delivery business. Effective September 30, 2017, we terminated our relationship with JMMPC in Florida, Michigan, New Mexico, Washington, and Utah. Therefore, the agreements among JMMPC, our wholly owned subsidiary Molina Medical Management, Inc. (MMM), and the Florida, Michigan, New Mexico, Washington and Utah health plans were terminated effective September 30, 2017.

In early January 2018, the agreements among JMMPC, MMM, and our California health plan terminated. In connection with the termination of the agreements in California, MMM entered into an asset purchase agreement with JMMPC, under which MMM sold various clinic and other assets to JMMPC for approximately $2 million. In addition, our California health plan entered into a new provider agreement with JMMPC. Following the termination of the agreements noted above, we will no longer have a) the power to direct the activities that most significantly affect JMMPC’s economic performance, or b) the obligation to absorb losses or right to receive benefits that are potentially significant to JMMPC.

JMMPC’s assets were available to settle only JMMPC’s obligations, and JMMPC’s creditors had no recourse to the general credit of Molina Healthcare, Inc. As of December 31, 2017, JMMPC had total assets of $8 million, and total liabilities of $8 million. As of December 31, 2016, JMMPC had total assets of $18 million, and total liabilities of $18 million. The health plans were parties to primary care services agreements with JMMPC, under which the health plans paid $119 million, $122 million, and $117 million to JMMPC for such services in the years ended December 31, 2017, 2016, and 2015, respectively. These agreements directed our health plans to either fund JMMPC’s operating deficits, or be reimbursed for JMMPC’s operating surpluses, such that JMMPC would derive no profits or losses. MMM was a party to services agreements with JMMPC to provide clinic facilities, clinic administrative support staff, patient scheduling services, and medical supplies to JMMPC. In the years ended December 31, 2017, 2016, and 2015, JMMPC paid $50 million, $55 million and $69 million, respectively, to MMM for such services. The

administrative services charged under these agreements were reviewed annually to assure that JMMPC would operate at break-even.

***New Markets Tax Credit***

In 2011, our New Mexico data center subsidiary entered into a financing transaction with Wells Fargo Community Investment Holdings, LLC (Wells Fargo), its wholly owned subsidiary New Mexico Healthcare Data Center Investment Fund, LLC (Investment Fund), and certain of Wells Fargo's affiliated Community Development Entities (CDEs), in connection with our participation in the federal government's New Markets Tax Credit Program (NMTC). The credit amounts to 39% of the original investment amount and is claimed over a period of seven years (five percent for each of the first three years, and six percent for each of the remaining four years). The investment in the CDE cannot be redeemed before the end of the seven-year period, which ends in the fourth quarter of 2018.

As a result of a series of simultaneous financing transactions, Wells Fargo contributed capital of $6 million to the Investment Fund, and Molina Healthcare, Inc. loaned the principal amount of $16 million to the Investment Fund. The Investment Fund then contributed the proceeds to certain CDEs, which, in turn, loaned the proceeds of $21 million to our New Mexico data center subsidiary. We have determined that the financing arrangement with Investment Fund and CDEs is a VIE, that we are the primary beneficiary of the VIE, and we have included it in our consolidated financial statements.

## 19. Commitments and Contingencies

***Regulatory Capital Requirements and Dividend Restrictions***

Our health plans, which are operated by our respective wholly owned subsidiaries in those states, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Regulators in some states may also enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. Such statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $1,691 million at December 31, 2017, and $1,492 million at December 31, 2016. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company – Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $696 million and $264 million as of December 31, 2017 and 2016, respectively.

The National Association of Insurance Commissioners (NAIC), adopted rules effective December 31, 1998, which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules which may vary from state to state. All of the states in which our health plans operate, except California, Florida and New York, have adopted these rules. Such requirements, if adopted by California, Florida and New York, may increase the minimum capital required for those states.

As of December 31, 2017, our health plans had aggregate statutory capital and surplus of approximately $1,777 million compared with the required minimum aggregate statutory capital and surplus of approximately $1,186 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2017. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

***Legal Proceedings***

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

We are involved in legal actions in the ordinary course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We have accrued liabilities for certain

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

***States' Budgets***

Nearly all of our premium revenues come from the joint federal and state funding of the Medicaid and CHIP programs. The states in which we operate our health plans regularly face significant budgetary pressures. For example, the government of Puerto Rico continues to struggle with major fiscal and liquidity challenges. The extreme financial difficulties faced by the Commonwealth may make it very difficult for ASES, the Puerto Rico Medicaid agency, to pay our Puerto Rico health plan under the terms of the parties' Medicaid contract. As of December 31, 2017, our Puerto Rico health plan served approximately 314,000 members and recorded premium revenue of approximately $732 million for the year ended December 31, 2017. As of February 23, 2018, the Commonwealth is current with its premium payments.

***Operating Leases***

We lease administrative and clinic facilities and certain equipment under non-cancelable operating leases expiring at various dates through 2027. Facility lease terms generally range from five to 10 years with one to two renewal options for extended terms. In most cases, we are required to make additional payments under facility operating leases for taxes, insurance and other operating expenses incurred during the lease period. Certain of our leases contain rent escalation clauses or lease incentives, including rent abatements and tenant improvement allowances. Rent escalation clauses and lease incentives are taken into account in determining total rent expense to be recognized during the lease term.

Future minimum lease payments by year and in the aggregate under operating leases and lease financing obligations consist of the following amounts:

| | Lease Financing Obligations | Operating Leases | Total |
|---|---|---|---|
| | | (In millions) | |
| 2018 | $ 17 | $ 67 | $ 84 |
| 2019 | 18 | 65 | 83 |
| 2020 | 19 | 44 | 63 |
| 2021 | 19 | 30 | 49 |
| 2022 | 20 | 22 | 42 |
| Thereafter | 317 | 34 | 351 |
| | $ 410 | $ 262 | $ 672 |

Rental expense related to operating leases amounted to $75 million, $64 million, and $44 million for the years ended December 31, 2017, 2016, and 2015, respectively. The amounts reported in "Lease Financing Obligations" above represent our contractual lease commitments for the properties described in Note 11, "Debt" under the subheading "Lease Financing Obligations."

***Professional Liability Insurance***

We carry medical professional liability insurance for health care services rendered in the primary care institutions that we manage. In addition, we also carry errors and omissions insurance for all Molina entities.

***Provider Claims***

Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations have led certain medical providers to pursue us for additional compensation. The claims made by providers in such circumstances often involve issues

of contract compliance, interpretation, payment methodology, and intent. These claims often extend to services provided by the providers over a number of years.

Various providers have contacted us seeking additional compensation for claims that we believe to have been settled. These matters, when finally concluded and determined, will not, in our opinion, have a material adverse effect on our business, consolidated financial position, results of operations, or cash flows.

## 20. Segment Information

We have three reportable segments. These segments consist of our Health Plans segment, which constitutes the vast majority of our operations; our Molina Medicaid Solutions segment; and our Other segment.

Our reportable segments are consistent with how we currently manage our business and view the markets we serve. The Health Plans segment consists of our health plans. Our health plans are operating segments that have been aggregated for reporting purposes because they share similar economic characteristics. The Molina Medicaid Solutions segment provides support to state government agencies in the administration of their Medicaid programs including business processing, information technology development, and administrative services. The Other segment includes primarily our Pathways behavioral health and social services provider, and corporate amounts not allocated to other reportable segments.

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

Gross margin for our Health Plans segment is referred to as “Medical margin,” and for our Molina Medicaid Solutions and Other segments, as “Service margin.” Medical margin represents the amount earned by the Health Plans segment after medical costs are deducted from premium revenue. The medical care ratio represents the amount of medical care costs as a percentage of premium revenue, and is one of the key metrics used to assess the performance of the Health Plans segment. Therefore, the underlying medical margin is the most important measure of earnings reviewed by the chief operating decision maker. The service margin is equal to service revenue minus cost of service revenue.

| | Health Plans | Molina Medicaid Solutions | Other | Consolidated |
|---|---|---|---|---|
| | | (In millions) | | |
| **2017** | | | | |
| Total revenue | $ 19,352 | $ 187 | $ 344 | $ 19,883 |
| Gross margin [1] | 1,781 | 16 | 13 | 1,810 |
| Depreciation and amortization [2] | 126 | 43 | 9 | 178 |
| Goodwill, and intangible assets, net | 212 | 43 | — | 255 |
| Total assets | 6,347 | 219 | 1,905 | 8,471 |
| **2016** | | | | |
| Total revenue | 17,234 | 195 | 353 | 17,782 |
| Gross margin [1] | 1,671 | 21 | 33 | 1,725 |
| Depreciation and amortization [2] | 122 | 45 | 15 | 182 |
| Goodwill, and intangible assets, net | 513 | 72 | 175 | 760 |
| Total assets | 5,897 | 267 | 1,285 | 7,449 |
| **2015** | | | | |
| Total revenue | 13,917 | 195 | 66 | 14,178 |
| Gross margin [1] | 1,467 | 55 | 5 | 1,527 |
| Depreciation and amortization [2] | 95 | 25 | 6 | 126 |
| Goodwill, and intangible assets, net | 393 | 73 | 175 | 641 |
| Total assets | 4,707 | 213 | 1,656 | 6,576 |

(1) In connection with the reclassification of Medicare and Marketplace health insurer fees to premium revenue, from health insurer fees reimbursed, amounts differ from amounts previously reported as follows: the Health Plans segment gross

margin for the years ended December 31, 2016 and 2015 increased $53 million, and $20 million, respectively. The Consolidated gross margin increased by the same amounts.

(2) Depreciation and amortization reported in accompanying consolidated statements of cash flows.

The following table reconciles gross margin by segment to consolidated (loss) income before income tax (benefit) expense:

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Gross margin: | | | |
| Health Plans | $ 1,781 | $ 1,671 | $ 1,467 |
| Molina Medicaid Solutions | 16 | 21 | 55 |
| Other | 13 | 33 | 5 |
| Total gross margin | 1,810 | 1,725 | 1,527 |
| Add: other operating revenues [1] | 508 | 798 | 664 |
| Less: other operating expenses [2] | (2,873) | (2,217) | (1,804) |
| Operating (loss) income | (555) | 306 | 387 |
| Other expenses, net | 57 | 101 | 65 |
| (Loss) income before income tax (benefit) expense | $ (612) | $ 205 | $ 322 |

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

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

## 21. Quarterly Results of Operations (Unaudited)

The following table summarizes quarterly unaudited results of operations for the years ended December 31, 2017 and 2016.

| | For The Quarter Ended | | | |
|---|---|---|---|---|
| | March 31, 2017 | June 30, 2017 | Sept. 30, 2017 | December 31, 2017 |
| | (In millions, except per-share data) | | | |
| Total revenue | $ 4,904 | $ 4,999 | $ 5,031 | $ 4,949 |
| Gross margin | 546 | 254 | 564 | 446 |
| Impairment losses | — | 72 | 129 | 269 |
| Restructuring and separation costs | — | 43 | 118 | 73 |
| Net income (loss) | 77 | (230) | (97) | (262) |
| | | | | |
| Net income (loss) per share [1]: | | | | |
| Basic | $ 1.38 | $ (4.10) | $ (1.70) | $ (4.59) |
| Diluted | $ 1.37 | $ (4.10) | $ (1.70) | $ (4.59) |

| | For The Quarter Ended | | | |
|---|---|---|---|---|
| | March 31, 2016 | June 30, 2016 | Sept. 30, 2016 | December 31, 2016 |
| | (In millions, except per-share data) | | | |
| Total revenue | $ 4,343 | $ 4,359 | $ 4,546 | $ 4,534 |
| Gross margin [2] | 434 | 466 | 471 | 354 |
| Net income (loss) | 24 | 33 | 42 | (47) |
| | | | | |
| Net income (loss) per share [1]: | | | | |
| Basic | $ 0.44 | $ 0.58 | $ 0.77 | $ (0.85) |
| Diluted | $ 0.43 | $ 0.58 | $ 0.76 | $ (0.85) |

(1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted net income (loss) per share because to do so would be anti-dilutive.

(2) The Centers for Medicare and Medicaid Services (CMS) incorporates the Health Insurer Fee (HIF) in our Medicare and Marketplace premium rates. We have therefore reclassified such amounts in our consolidated statements of operations to premium revenue, from health insurer fees reimbursed, for all applicable periods presented. As a result, gross margin amounts differ from amounts previously reported as follows: for the quarters ended March 31, June 30, September 30, and December 31, 2016, gross margin increased $14 million, $12 million, $14 million, and $13 million, respectively.

## 22. Condensed Financial Information of Registrant

The condensed balance sheets as of December 31, 2017 and 2016, and the related condensed statements of operations, comprehensive (loss) income and cash flows for each of the three years in the period ended December 31, 2017 for our parent company Molina Healthcare, Inc. (the Registrant), are presented below.

**Condensed Balance Sheets**

| | December 31, | |
|---|---|---|
| | 2017 | 2016 |
| | (In millions, except per-share data) | |
| **ASSETS** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 504 | $ 86 |
| Investments | 192 | 178 |
| Restricted investments | 169 | — |
| Receivables | 2 | 2 |
| Income taxes refundable | 16 | 17 |
| Due from affiliates | 148 | 104 |
| Prepaid expenses and other current assets | 87 | 58 |
| Derivative asset | 522 | 267 |
| Total current assets | 1,640 | 712 |
| Property, equipment, and capitalized software, net | 223 | 301 |
| Goodwill and intangible assets, net | 15 | 58 |
| Investments in subsidiaries | 2,306 | 2,609 |
| Deferred income taxes | 17 | 10 |
| Advances to related parties and other assets | 32 | 48 |
| | $ 4,233 | $ 3,738 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | |
| Current liabilities: | | |
| Medical claims and benefits payable | $ 3 | $ 1 |
| Accounts payable and accrued liabilities | 178 | 146 |
| Current portion of long-term debt | 653 | 472 |
| Derivative liability | 522 | 267 |
| Total current liabilities | 1,356 | 886 |
| Senior notes | 1,318 | 975 |
| Lease financing obligations | 198 | 198 |
| Deferred income taxes | — | 11 |
| Other long-term liabilities | 24 | 19 |
| Total liabilities | 2,896 | 2,089 |
| Stockholders' equity: | | |
| Common stock, $0.001 par value; 150 shares authorized; outstanding: | | |
| 60 shares at December 31, 2017 and 57 shares at December 31, 2016 | — | — |
| Preferred stock, $0.001 par value; 20 shares authorized, no shares issued and outstanding | — | — |
| Additional paid-in capital | 1,044 | 841 |
| Accumulated other comprehensive loss | (5) | (2) |
| Retained earnings | 298 | 810 |
| Total stockholders' equity | 1,337 | 1,649 |
| | $ 4,233 | $ 3,738 |

See accompanying notes.

## Condensed Statements of Operations

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| **Revenue:** | | | |
| Management fees | $ 1,317 | $ 1,062 | $ 914 |
| Investment income and other revenue | 16 | 16 | 17 |
| Total revenue | 1,333 | 1,078 | 931 |
| **Expenses:** | | | |
| Medical care costs | 16 | 73 | 55 |
| General and administrative expenses | 1,082 | 899 | 797 |
| Depreciation and amortization | 93 | 95 | 82 |
| Impairment losses | 39 | — | — |
| Restructuring and separation costs | 153 | — | — |
| Total operating expenses | 1,383 | 1,067 | 934 |
| Operating (loss) income | (50) | 11 | (3) |
| Interest expense | 117 | 101 | 66 |
| Other income | (61) | — | — |
| Loss before income taxes and equity in net income of subsidiaries | (106) | (90) | (69) |
| Income tax expense (benefit) | 8 | (24) | (21) |
| Net loss before equity in net income of subsidiaries | (114) | (66) | (48) |
| Equity in net (loss) income of subsidiaries | (398) | 118 | 191 |
| Net (loss) income | $ (512) | $ 52 | $ 143 |

## Condensed Statements of Comprehensive (Loss) Income

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| Net (loss) income | $ (512) | $ 52 | $ 143 |
| Other comprehensive (loss) income: | | | |
| Unrealized investment (loss) gain | (5) | 3 | (5) |
| Less: effect of income taxes | (2) | 1 | (2) |
| Other comprehensive (loss) income, net of tax | (3) | 2 | (3) |
| Comprehensive (loss) income | $ (515) | $ 54 | $ 140 |

See accompanying notes.

**Condensed Statements of Cash Flows**

| | Year Ended December 31, | | |
|---|---|---|---|
| | 2017 | 2016 | 2015 |
| | (In millions) | | |
| **Operating activities:** | | | |
| Net cash provided by operating activities | $ 166 | $ 55 | $ 113 |
| **Investing activities:** | | | |
| Capital contributions to subsidiaries | (370) | (386) | (770) |
| Dividends received from subsidiaries | 286 | 101 | 142 |
| Purchases of investments | (352) | (115) | (244) |
| Proceeds from sales and maturities of investments | 168 | 188 | 118 |
| Purchases of property, equipment and capitalized software | (67) | (125) | (91) |
| Change in amounts due to/from affiliates | (49) | (18) | (68) |
| Other, net | — | 6 | — |
| Net cash used in investing activities | (384) | (349) | (913) |
| **Financing activities:** | | | |
| Proceeds from senior notes offerings, net of issuance costs | 325 | — | 689 |
| Proceeds from borrowings under credit facility | 300 | — | — |
| Proceeds from common stock offering, net of issuance costs | — | — | 373 |
| Proceeds from employee stock plans | 19 | 18 | 18 |
| Cash paid for financing transaction fees | (7) | — | — |
| Other, net | (1) | 2 | 5 |
| Net cash provided by financing activities | 636 | 20 | 1,085 |
| Net increase (decrease) in cash and cash equivalents | 418 | (274) | 285 |
| Cash and cash equivalents at beginning of year | 86 | 360 | 75 |
| Cash and cash equivalents at end of year | $ 504 | $ 86 | $ 360 |

See accompanying notes.

**Notes to Condensed Financial Information of Registrant**

**Note A - Basis of Presentation**

The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant.

The Registrant's investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes.

**Note B - Transactions with Subsidiaries**

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2017, 2016, and 2015 for these services amounted to $1,317 million, $1,062 million, and $914 million, respectively, and are included in operating revenue.

The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would

be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns.

**Note C - Dividends and Capital Contributions**

When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries.

For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund business combinations. Such amounts have been recorded as an increase in investment in the respective subsidiaries, net of insignificant returns of capital.

**Note D - Related Party Transactions**

The Registrant's related party transactions are described in Note 17, "Related Party Transactions."

## 23. Supplemental Condensed Consolidating Financial Information

As discussed in Note 11, “Debt,” we have outstanding $700 million aggregate principal amount of 5.375% Notes due November 15, 2022, unless earlier redeemed. The 5.375% Notes were registered in September 2016, and are fully and unconditionally guaranteed by certain of our wholly owned subsidiaries on a joint and several basis, with exceptions considered customary for such guarantees.

All guarantors immediately prior to January 3, 2017, other than Molina Information Systems, LLC, d/b/a Molina Medicaid Solutions, Molina Pathways, LLC and Pathways Health and Community Support LLC, were automatically and unconditionally released as guarantors of our amended Credit Facility, the 5.375% Notes, and the 4.875% Notes.

For all periods presented, the following condensed consolidating financial statements present Molina Healthcare, Inc. (as “Parent Guarantor”), the subsidiary guarantors (as “Other Guarantors”), the subsidiary non-guarantors (as “Non-Guarantors”) and “Eliminations,” according to the guarantor structure as assessed as of and for the year ended December 31, 2017.

**CONDENSED CONSOLIDATING STATEMENTS OF OPERATIONS**

| | Year Ended December 31, 2017 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **Revenue:** | | | | | |
| Total revenue | $ 1,333 | $ 194 | $ 19,712 | $ (1,356) | $ 19,883 |
| **Expenses:** | | | | | |
| Medical care costs | 16 | — | 17,058 | (1) | 17,073 |
| Cost of service revenue | — | 171 | 321 | — | 492 |
| General and administrative expenses | 1,082 | 17 | 1,850 | (1,355) | 1,594 |
| Premium tax expenses | — | — | 438 | — | 438 |
| Depreciation and amortization | 93 | 1 | 43 | — | 137 |
| Impairment losses | 39 | 28 | 403 | — | 470 |
| Restructuring and separation costs | 153 | 8 | 73 | — | 234 |
| Total operating expenses | 1,383 | 225 | 20,186 | (1,356) | 20,438 |
| Operating loss | (50) | (31) | (474) | — | (555) |
| Interest expense | 117 | — | 1 | — | 118 |
| Other income | (61) | — | — | — | (61) |
| Loss before income taxes | (106) | (31) | (475) | — | (612) |
| Income tax expense (benefit) | 8 | (21) | (87) | — | (100) |
| Net loss before equity in earnings of subsidiaries | (114) | (10) | (388) | — | (512) |
| Equity in net earnings of subsidiaries | (398) | (156) | — | 554 | — |
| Net loss | $ (512) | $ (166) | $ (388) | $ 554 | $ (512) |

| | Year Ended December 31, 2016 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **Revenue:** | | | | | |
| Total revenue | $ 1,078 | $ 202 | $ 17,584 | $ (1,082) | $ 17,782 |
| **Expenses:** | | | | | |
| Medical care costs | 73 | — | 14,702 | (1) | 14,774 |
| Cost of service revenue | — | 174 | 311 | — | 485 |
| General and administrative expenses | 899 | 16 | 1,559 | (1,081) | 1,393 |
| Premium tax expenses | — | — | 468 | — | 468 |
| Health insurer fees | — | — | 217 | — | 217 |
| Depreciation and amortization | 95 | 1 | 43 | — | 139 |
| Total operating expenses | 1,067 | 191 | 17,300 | (1,082) | 17,476 |
| Operating income | 11 | 11 | 284 | — | 306 |
| Total other expenses, net | 101 | — | — | — | 101 |
| (Loss) income before income taxes | (90) | 11 | 284 | — | 205 |
| Income tax (benefit) expense | (24) | 3 | 174 | — | 153 |
| Net (loss) income before equity in earnings of subsidiaries | (66) | 8 | 110 | — | 52 |
| Equity in net earnings of subsidiaries | 118 | 1 | — | (119) | — |
| Net income | $ 52 | $ 9 | $ 110 | $ (119) | $ 52 |

| | Year Ended December 31, 2015 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **Revenue:** | | | | | |
| Total revenue | $ 931 | $ 195 | $ 13,980 | $ (928) | $ 14,178 |
| **Expenses:** | | | | | |
| Medical care costs | 55 | — | 11,740 | (1) | 11,794 |
| Cost of service revenue | — | 140 | 53 | — | 193 |
| General and administrative expenses | 797 | 31 | 1,245 | (927) | 1,146 |
| Premium tax expenses | — | — | 397 | — | 397 |
| Health insurer fees | — | — | 157 | — | 157 |
| Depreciation and amortization | 82 | 1 | 21 | — | 104 |
| Total operating expenses | 934 | 172 | 13,613 | (928) | 13,791 |
| Operating (loss) income | (3) | 23 | 367 | — | 387 |
| Total other expenses, net | 66 | — | (1) | — | 65 |
| (Loss) income before income taxes | (69) | 23 | 368 | — | 322 |
| Income tax (benefit) expense | (21) | 7 | 193 | — | 179 |
| Net (loss) income before equity in earnings of subsidiaries | (48) | 16 | 175 | — | 143 |
| Equity in net earnings of subsidiaries | 191 | (1) | — | (190) | — |
| Net income | $ 143 | $ 15 | $ 175 | $ (190) | $ 143 |

## CONDENSED CONSOLIDATING STATEMENTS OF COMPREHENSIVE (LOSS) INCOME

| | Year Ended December 31, 2017 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| Net loss | $ (512) | $ (166) | $ (388) | $ 554 | $ (512) |
| Other comprehensive loss, net of tax | (3) | — | (2) | 2 | (3) |
| Comprehensive loss | $ (515) | $ (166) | $ (390) | $ 556 | $ (515) |

| | Year Ended December 31, 2016 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| Net income | $ 52 | $ 9 | $ 110 | $ (119) | $ 52 |
| Other comprehensive income, net of tax | 2 | — | 1 | (1) | 2 |
| Comprehensive income | $ 54 | $ 9 | $ 111 | $ (120) | $ 54 |

| | Year Ended December 31, 2015 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| Net income | $ 143 | $ 15 | $ 175 | $ (190) | $ 143 |
| Other comprehensive loss, net of tax | (3) | — | (3) | 3 | (3) |
| Comprehensive income | $ 140 | $ 15 | $ 172 | $ (187) | $ 140 |

**MOLINA HEALTHCARE, INC.**
**CONDENSED CONSOLIDATING BALANCE SHEETS**

| | December 31, 2017 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **ASSETS** | | | | | |
| Current assets: | | | | | |
| Cash and cash equivalents | $ 504 | $ 28 | $ 2,654 | $ — | $ 3,186 |
| Investments | 192 | — | 2,332 | — | 2,524 |
| Restricted investments | 169 | — | — | — | 169 |
| Receivables | 2 | 30 | 839 | — | 871 |
| Income tax refundable | 16 | (8) | 46 | — | 54 |
| Due from (to) affiliates | 148 | (6) | (142) | — | — |
| Prepaid expenses and other current assets | 87 | 22 | 92 | (16) | 185 |
| Derivative asset | 522 | — | — | — | 522 |
| Total current assets | 1,640 | 66 | 5,821 | (16) | 7,511 |
| Property, equipment, and capitalized software, net | 223 | 33 | 86 | — | 342 |
| Deferred contract costs | — | 101 | — | — | 101 |
| Goodwill and intangible assets, net | 15 | 43 | 197 | — | 255 |
| Restricted investments | — | — | 119 | — | 119 |
| Investment in subsidiaries, net | 2,306 | 82 | — | (2,388) | — |
| Deferred income taxes | 17 | — | 101 | (15) | 103 |
| Other assets | 32 | 2 | 7 | (1) | 40 |
| | $ 4,233 | $ 327 | $ 6,331 | $ (2,420) | $ 8,471 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | | | | |
| Current liabilities: | | | | | |
| Medical claims and benefits payable | $ 3 | $ — | $ 2,189 | $ — | $ 2,192 |
| Amounts due government agencies | — | 1 | 1,541 | — | 1,542 |
| Accounts payable and accrued liabilities | 178 | 40 | 148 | — | 366 |
| Deferred revenue | — | 49 | 233 | — | 282 |
| Current portion of long-term debt | 653 | — | 16 | (16) | 653 |
| Derivative liability | 522 | — | — | — | 522 |
| Total current liabilities | 1,356 | 90 | 4,127 | (16) | 5,557 |
| Long-term debt | 1,516 | — | — | — | 1,516 |
| Deferred income taxes | — | 15 | — | (15) | — |
| Other long-term liabilities | 24 | 2 | 36 | (1) | 61 |
| Total liabilities | 2,896 | 107 | 4,163 | (32) | 7,134 |
| Total stockholders' equity | 1,337 | 220 | 2,168 | (2,388) | 1,337 |
| | $ 4,233 | $ 327 | $ 6,331 | $ (2,420) | $ 8,471 |

**MOLINA HEALTHCARE, INC.**
**CONDENSED CONSOLIDATING BALANCE SHEETS**

| | December 31, 2016 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **ASSETS** | | | | | |
| Current assets: | | | | | |
| Cash and cash equivalents | $ 86 | $ 6 | $ 2,727 | $ — | $ 2,819 |
| Investments | 178 | — | 1,580 | — | 1,758 |
| Receivables | 2 | 34 | 938 | — | 974 |
| Income tax refundable | 17 | 4 | 18 | — | 39 |
| Due from (to) affiliates | 104 | (5) | (99) | — | — |
| Prepaid expenses and other current assets | 58 | 30 | 43 | — | 131 |
| Derivative asset | 267 | — | — | — | 267 |
| Total current assets | 712 | 69 | 5,207 | — | 5,988 |
| Property, equipment, and capitalized software, net | 301 | 46 | 107 | — | 454 |
| Deferred contract costs | — | 86 | — | — | 86 |
| Goodwill and intangible assets, net | 58 | 73 | 629 | — | 760 |
| Restricted investments | — | — | 110 | — | 110 |
| Investment in subsidiaries, net | 2,609 | 246 | — | (2,855) | — |
| Deferred income taxes | 10 | — | — | — | 10 |
| Other assets | 48 | 3 | 6 | (16) | 41 |
| | $ 3,738 | $ 523 | $ 6,059 | $ (2,871) | $ 7,449 |
| **LIABILITIES AND STOCKHOLDERS' EQUITY** | | | | | |
| Current liabilities: | | | | | |
| Medical claims and benefits payable | $ 1 | $ — | $ 1,928 | $ — | $ 1,929 |
| Amounts due government agencies | — | — | 1,202 | — | 1,202 |
| Accounts payable and accrued liabilities | 146 | 34 | 205 | — | 385 |
| Deferred revenue | — | 40 | 275 | — | 315 |
| Current portion of long-term debt | 472 | — | — | — | 472 |
| Derivative liability | 267 | — | — | — | 267 |
| Total current liabilities | 886 | 74 | 3,610 | — | 4,570 |
| Long-term debt | 1,173 | — | 16 | (16) | 1,173 |
| Deferred income taxes | 11 | 39 | (35) | — | 15 |
| Other long-term liabilities | 19 | 1 | 22 | — | 42 |
| Total liabilities | 2,089 | 114 | 3,613 | (16) | 5,800 |
| Total stockholders' equity | 1,649 | 409 | 2,446 | (2,855) | 1,649 |
| | $ 3,738 | $ 523 | $ 6,059 | $ (2,871) | $ 7,449 |

**MOLINA HEALTHCARE, INC.**
**CONDENSED CONSOLIDATING STATEMENTS OF CASH FLOWS**

| | Year Ended December 31, 2017 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **Operating activities:** | | | | | |
| Net cash provided by operating activities | $ 166 | 83 | 555 | — | $ 804 |
| **Investing activities:** | | | | | |
| Purchases of investments | (352) | — | (2,366) | — | (2,718) |
| Proceeds from sales and maturities of investments | 168 | — | 1,603 | — | 1,771 |
| Purchases of property, equipment and capitalized software | (67) | (11) | (8) | — | (86) |
| Increase in restricted investments | — | — | (12) | — | (12) |
| Capital contributions to subsidiaries | (370) | 2 | 368 | — | — |
| Dividends received from subsidiaries | 286 | (25) | (261) | — | — |
| Change in amounts due to/from affiliates | (49) | 1 | 48 | — | — |
| Other, net | — | (28) | — | — | (28) |
| Net cash used in by investing activities | (384) | (61) | (628) | — | (1,073) |
| **Financing activities:** | | | | | |
| Proceeds from senior notes offering, net of issuance costs | 325 | — | — | — | 325 |
| Proceeds from borrowings under credit facility | 300 | — | — | — | 300 |
| Proceeds from employee stock plans | 19 | — | — | — | 19 |
| Cash paid for financing transaction fees | (7) | — | — | — | (7) |
| Other, net | (1) | — | — | — | (1) |
| Net cash provided by financing activities | 636 | — | — | — | 636 |
| Net increase (decrease) in cash and cash equivalents | 418 | 22 | (73) | — | 367 |
| Cash and cash equivalents at beginning of period | 86 | 6 | 2,727 | — | 2,819 |
| Cash and cash equivalents at end of period | $ 504 | $ 28 | $ 2,654 | $ — | $ 3,186 |

| | Year Ended December 31, 2016 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | (In millions) | | | | |
| **Operating activities:** | | | | | |
| Net cash provided by operating activities | $ 55 | 48 | 570 | — | $ 673 |
| **Investing activities:** | | | | | |
| Purchases of investments | (115) | — | (1,814) | — | (1,929) |
| Proceeds from sales and maturities of investments | 188 | — | 1,778 | — | 1,966 |
| Purchases of property, equipment and capitalized software | (125) | (29) | (22) | — | (176) |
| Decrease in restricted investments | — | — | 4 | — | 4 |
| Net cash paid in business combinations | — | (5) | (43) | — | (48) |
| Capital contributions to subsidiaries | (386) | 7 | 379 | — | — |
| Dividends received from subsidiaries | 101 | — | (101) | — | — |
| Change in amounts due to/from affiliates | (18) | (2) | 20 | — | — |
| Other, net | 6 | (26) | 1 | — | (19) |
| Net cash (used in) provided by investing activities | (349) | (55) | 202 | — | (202) |
| **Financing activities:** | | | | | |
| Proceeds from employee stock plans | 18 | — | — | — | 18 |
| Other, net | 2 | — | (1) | — | 1 |
| Net cash provided by financing activities | 20 | — | (1) | — | 19 |
| Net (decrease) increase in cash and cash equivalents | (274) | (7) | 771 | — | 490 |
| Cash and cash equivalents at beginning of period | 360 | 13 | 1,956 | — | 2,329 |
| Cash and cash equivalents at end of period | $ 86 | $ 6 | $ 2,727 | $ — | $ 2,819 |

| | Year Ended December 31, 2015 | | | | |
|---|---|---|---|---|---|
| | Parent Guarantor | Other Guarantors | Non-Guarantors | Eliminations | Consolidated |
| | | | (In millions) | | |
| **Operating activities:** | | | | | |
| Net cash provided by operating activities | $ 113 | 51 | 961 | — | $ 1,125 |
| **Investing activities:** | | | | | |
| Purchases of investments | (244) | — | (1,679) | — | (1,923) |
| Proceeds from sales and maturities of investments | 118 | — | 1,008 | — | 1,126 |
| Purchases of property, equipment and capitalized software | (91) | (20) | (21) | — | (132) |
| Decrease in restricted investments | — | 5 | (11) | — | (6) |
| Net cash paid in business combinations | — | (174) | (276) | — | (450) |
| Capital contributions to subsidiaries | (770) | 236 | 534 | — | — |
| Dividends received from subsidiaries | 142 | — | (142) | — | — |
| Change in amounts due to/from affiliates | (68) | (63) | 131 | — | — |
| Other, net | — | (35) | — | — | (35) |
| Net cash used in investing activities | (913) | (51) | (456) | — | (1,420) |
| **Financing activities:** | | | | | |
| Proceeds from senior notes offerings, net of issuance costs | 689 | — | — | — | 689 |
| Proceeds from common stock offering, net of issuance costs | 373 | — | — | — | 373 |
| Proceeds from employee stock plans | 18 | — | — | — | 18 |
| Other, net | 5 | — | — | — | 5 |
| Net cash provided by financing activities | 1,085 | — | — | — | 1,085 |
| Net increase in cash and cash equivalents | 285 | — | 505 | — | 790 |
| Cash and cash equivalents at beginning of period | 75 | 13 | 1,451 | — | 1,539 |
| Cash and cash equivalents at end of period | $ 360 | $ 13 | $ 1,956 | $ — | $ 2,329 |

# DIRECTORS, EXECUTIVE OFFICERS, AND CORPORATE GOVERNANCE

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

| Name | Age | Position |
|---|---|---|
| Joseph M. Zubretsky | 61 | President and Chief Executive Officer |
| Joseph W. White | 59 | Chief Financial Officer |
| Jeff D. Barlow | 55 | Chief Legal Officer and Corporate Secretary |
| Pamela S. Sedmak | 56 | Executive Vice President, Health Plan Operations |
| Mark L. Keim | 52 | Executive Vice President, Strategic Planning, Corporate Development & Transformation |
| Lisa A. Rubino | 60 | Senior Vice President, Medicare and Duals Integration |

*Mr. Zubretsky* has served as President and Chief Executive Officer since November 6, 2017. He joins the Company from The Hanover Insurance Group, Inc., where he served as its President and Chief Executive Officer from June 2016 to October 2017. Prior to that, Mr. Zubretsky served almost nine years at Aetna, Inc., where he most recently served as Chief Executive Officer of Healthagen Holdings, a group of healthcare services and information technology companies at Aetna, from January 2015 to October 2015. Prior to that, he served as a Senior Executive Vice President leading Aetna's National Businesses from 2013 to 2014, and served as Aetna's Chief Financial Officer from 2007 to 2013. None of the entities where Mr. Zubretsky was previously employed is a parent, subsidiary or other affiliate of the Company.

*Mr. White* has served as Chief Financial Officer since May 2, 2017. Prior to that, Mr. White had served as Chief Accounting Officer since 2007. Mr. White also served as our Interim President and Chief Executive Officer from May 2, 2017 to November 6, 2017.

*Mr. Barlow* has served as Chief Legal Officer and Corporate Secretary since 2010.

*Ms. Sedmak* has served as Executive Vice President, Health Plan Operations since February 2018. Ms. Sedmak brings more than 25 years of Medicaid managed care leadership experience in operations, strategy, and finance. Most recently, she was a senior adviser at McKinsey & Company, serving clients in the health care services and global corporate finance practice areas. Prior to McKinsey, she served as president and CEO for Aetna Medicaid/Dual Eligibles. Before Aetna, Ms. Sedmak held C-level leadership positions at Blue Cross and Blue Shield of Minnesota, CareSource and General Electric. None of the entities where Ms. Sedmak was previously employed is a parent, subsidiary or other affiliate of the Company.

*Mr. Keim* has served as Executive Vice President, Strategic Planning, Corporate Development and Transformation since January 2018. Most recently, he served as executive vice president of corporate development and strategy for The Hanover Insurance Group. Prior to The Hanover Insurance Group, Mr. Keim spent six years with Aetna where he led major strategic initiatives. Before Aetna, he was senior vice president of strategy and business development at GE Capital. None of the entities where Mr. Keim was previously employed is a parent, subsidiary or other affiliate of the Company.

*Ms. Rubino* has served as our Senior Vice President, Medicare & Duals Integration since 2013. From 2012 to 2013, Ms. Rubino served as Senior Vice President of Health Plans, Western Region. From 2007 to 2012, Ms. Rubino served as the President of Molina Healthcare of California.

Each executive officer serves at the pleasure of the board of directors.

The remaining information called for by Item 10 of Form 10-K is incorporated by reference to "Election of Directors," "Corporate Governance and Board of Directors Matters," and "Section 16(a) Beneficial Ownership Reporting Compliance" in our definitive proxy statement for our 2018 Annual Meeting of Stockholders.

# EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) The consolidated financial statements and exhibits listed below are filed as part of this Form 10-K.

(1) The financial statements included in Financial Statements and Supplementary Data, above, are filed as part of this annual report.

(2) Financial Statement Schedules

None of the schedules apply, or the information required is included in the Notes to the Consolidated Financial Statements.

(3) Exhibits

Reference is made to the accompanying Index to Exhibits.

# SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 1st day of March, 2018.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Zubretsky

**Joseph M. Zubretsky**

**Chief Executive Officer**
**(Principal Executive Officer)**

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

| Signature | Title | Date |
|---|---|---|
| /s/ Joseph M. Zubretsky<br>**Joseph M. Zubretsky** | Chief Executive Officer, President and Director<br>(Principal Executive Officer) | March 1, 2018 |
| /s/ Joseph W. White<br>**Joseph W. White** | Chief Financial Officer and Treasurer<br>(Principal Financial Officer) | March 1, 2018 |
| /s/ Garrey E. Carruthers<br>**Garrey E. Carruthers, Ph.D.** | Director | March 1, 2018 |
| /s/ Daniel Cooperman<br>**Daniel Cooperman** | Director | March 1, 2018 |
| /s/ Charles Z. Fedak<br>**Charles Z. Fedak** | Director | March 1, 2018 |
| /s/ Steven J. Orlando<br>**Steven J. Orlando** | Director | March 1, 2018 |
| /s/ Ronna E. Romney<br>**Ronna E. Romney** | Director | March 1, 2018 |
| /s/ Richard M. Schapiro<br>**Richard M. Schapiro** | Director | March 1, 2018 |
| /s/ Dale B. Wolf<br>**Dale B. Wolf** | Chairman of the Board | March 1, 2018 |

# INDEX TO EXHIBITS

The following exhibits, which are furnished with this Annual Report on Form 10-K (this "Form 10-K") or incorporated herein by reference, are filed as part of this annual report.

The agreements included or incorporated by reference as exhibits to this Form 10-K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of "materiality" that are different from "materiality" under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Form 10-K not misleading.

| Number | Description | Method of Filing |
|---|---|---|
| 2.1 | Membership Interest Purchase Agreement, dated as of September 3, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Healthcare, Inc. | Filed as Exhibit 2.1 to registrant's Form 8-K filed September 8, 2015. |
| 2.2 | Amendment to Membership Interest Purchase Agreement, dated as of October 30, 2015, by and among The Providence Service Corporation, Ross Innovative Employment Solutions Corp., and Molina Pathways, LLC, as assignee of all rights and obligations of Molina Healthcare, Inc. | Filed as Exhibit 2.2 to registrant's Form 10-K filed February 26, 2016. |
| 3.1 | Certificate of Incorporation | Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002. |
| 3.2 | Certificate of Amendment to Certificate of Incorporation | Filed as Appendix A to registrant's Definitive Proxy Statement on Form DEF 14A filed March 25, 2013. |
| 3.3 | Third Amended and Restated Bylaws of Molina Healthcare, Inc. | Filed as Exhibit 3.1 to registrant's Form 10-Q filed July 30, 2014. |
| 4.1 | Indenture, dated as of February 15, 2013, by and between Molina Healthcare, Inc. and U.S. Bank, National Association | Filed as Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013. |
| 4.2 | Form of 1.125% Cash Convertible Senior Note due 2020 | Included in Exhibit 4.1 to registrant's Form 8-K filed February 15, 2013. |
| 4.3 | Indenture, dated as of September 5, 2014, by and between Molina Healthcare, Inc. and U.S. Bank National Association | Filed as Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014. |
| 4.4 | Form of 1.625% Convertible Senior Note due 2044 | Included in Exhibit 4.1 to registrant's Form 8-K filed September 8, 2014. |
| 4.5 | First Supplemental Indenture, dated as of September 16, 2014, by and between Molina Healthcare, Inc. and the U.S. Bank National Association | Filed as Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014. |
| 4.6 | Form of 1.625% Convertible Senior Note due 2044 | Included in Exhibit 4.1 to registrant's Form 8-K filed September 17, 2014. |
| 4.7 | Indenture dated November 10, 2015, by and among Molina Healthcare, Inc., the guarantor parties thereto and U.S. Bank National Association, as Trustee | Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015. |
| 4.8 | Form of 5.375% Senior Notes due 2022 | Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015. |
| 4.9 | Form of Guarantee pursuant to Indenture, dated as of November 10, 2015, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as Trustee | Filed as Exhibit 4.1 to registrant's Form 8-K filed November 10, 2015. |
| 4.10 | First Supplemental Indenture, dated as of February 16, 2016, by and among Molina Healthcare, Inc., the guarantors party thereto and U.S. Bank National Association, as trustee | Filed as Exhibit 4.1 to registrant's Form 8-K filed February 18, 2016. |
| 4.11 | Indenture, dated June 6, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto and U.S. Bank National Association, as Trustee. | Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017. |

| Number | Description | Method of Filing |
|---|---|---|
| 4.12 | Form of Notes (included in Exhibit 4.1 to registrant's Form 8-K filed June 6, 2017). | Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017. |
| 4.13 | Form of Guarantees (included in Exhibit 4.1 to registrant's Form 8-K filed June 6, 2017). | Filed as Exhibit 1.1 to registrant's Form 8-K filed June 6, 2017. |
| *10.1 | Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018) | Filed herewith. |
| *10.2 | 2011 Equity Incentive Plan | Filed as Exhibit 10.8 to registrant's Form 10-K filed February 26, 2014. |
| *10.3 | 2011 Employee Stock Purchase Plan | Filed as Exhibit 10.6 to registrant's Form 10-K filed February 26, 2015. |
| *10.4 | Molina Healthcare, Inc. Change in Control Severance Plan (2017) | Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 4, 2017. |
| *10.5 | 2011 Equity Incentive Plan - Form of Stock Option Agreement (Director) | Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 4, 2017. |
| *10.6 | 2011 Equity Incentive Plan - Form of Restricted Stock Award Agreement (Employee) | Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 4, 2017. |
| *10.7 | 2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 1 (Executive Officer) | Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 4, 2017. |
| *10.8 | 2011 Equity Incentive Plan - Form of Performance Unit Award Agreement 2 (Executive Officer) | Filed as Exhibit 10.5 to registrant's Form 10-Q filed May 4, 2017. |
| *10.9 | Amended and Restated Employment Agreement with Joseph W. White, dated June 5, 2017, and effective as of May 2, 2017. | Filed as Exhibit 10.1 to registrant's Form 8-K filed June 7, 2017. |
| *10.10 | Employment Agreement with Jeff Barlow dated June 14, 2013 | Filed as Exhibit 10.3 to registrant's Form 8-K filed June 14, 2013. |
| *10.11 | Amended and Restated Change in Control Agreement with Joseph W. White, dated as of December 31, 2009 | Filed as Exhibit 10.6 to registrant's Form 8-K filed January 7, 2010. |
| *10.12 | Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012 | Filed as Exhibit 10.16 to registrant's Form 10-K filed February 28, 2013. |
| *10.13 | Form of Indemnification Agreement | Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007. |
| *10.14 | Waiver and Release Agreement, dated June 24, 2017, by and between J. Mario Molina and Molina Healthcare, Inc. | Filed as Exhibit 10.1 to registrant's Form 8-K/A filed June 28, 2017. |
| *10.15 | Waiver and Release Agreement, dated June 26, 2017, by and between John Molina and Molina Healthcare, Inc. | Filed as Exhibit 10.2 to registrant's Form 8-K/A filed June 28, 2017. |
| *10.16 | Employment Agreement, dated October 9, 2017, by and between Molina Healthcare, Inc. and Joseph M. Zubretsky. | Filed as Exhibit 10.1 to registrant's Form 8-K filed October 10, 2017. |
| *10.17 | Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch | Filed as Exhibit 10.1 to registrant's Form 8-K filed February 15, 2013. |
| *10.18 | Base Call Option Transaction Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A. | Filed as Exhibit 10.2 to registrant's Form 8-K filed February 15, 2013. |
| 10.19 | Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch | Filed as Exhibit 10.3 to registrant's Form 8-K filed February 15, 2013. |
| 10.20 | Base Warrants Confirmation, dated as of February 11, 2013, between Molina Healthcare, Inc. and Bank of America, N.A. | Filed as Exhibit 10.4 to registrant's Form 8-K filed February 15, 2013. |
| 10.21 | Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch | Filed as Exhibit 10.5 to registrant's Form 8-K filed February 15, 2013. |
| 10.22 | Amendment to Base Call Option Transaction Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A. | Filed as Exhibit 10.6 to registrant's Form 8-K filed February 15, 2013. |
| 10.23 | Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch | Filed as Exhibit 10.7 to registrant's Form 8-K filed February 15, 2013. |
| 10.24 | Additional Base Warrants Confirmation, dated as of February 13, 2013, between Molina Healthcare, Inc. and Bank of America, N.A. | Filed as Exhibit 10.8 to registrant's Form 8-K filed February 15, 2013. |

| Number | Description | Method of Filing |
|---|---|---|
| 10.25 | Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch | Filed as Exhibit 10.1 to registrant's Form 10-Q filed May 3, 2013. |
| 10.26 | Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A. | Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 3, 2013. |
| 10.27 | Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and JPMorgan Chase Bank, National Association, London Branch | Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 3, 2013. |
| 10.28 | Additional Amended and Restated Base Warrants Confirmation, dated as of April 22, 2013, between Molina Healthcare, Inc. and Bank of America, N.A. | Filed as Exhibit 10.4 to registrant's Form 10-Q filed May 3, 2013. |
| 10.29 | Settlement Agreement entered into on October 30, 2013, by and between the Department of Health Care Services and Molina Healthcare of California and Molina Healthcare of California Partner Plan, Inc. | Filed as Exhibit 10.1 to registrant's Form 10-Q filed October 30, 2013. |
| 10.30 | Credit Agreement, dated as of June 12, 2015, by and among Molina Healthcare, Inc., Molina Information Systems, LLC, Molina Medical Management, Inc., certain lenders named on the signature pages thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank | Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2015. |
| 10.31 | First Amendment to Credit Agreement, dated as of January 3, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank, including the amended and restated Credit Agreement attached as Exhibit A thereto | Filed as Exhibit 10.1 to registrant's Form 8-K filed January 3, 2017. |
| 10.32 | Second Amendment to Credit Agreement, dated as of February 15, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, as Administrative Agent, Swingline Lender and Issuing Bank | Filed as Exhibit 10.1 to registrant's Form 8-K filed February 17, 2017. |
| 10.33 | Guarantor Joinder Agreement, dated February 16, 2016, by and among the guarantors party thereto and SunTrust Bank, as Administrative Agent | Filed as Exhibit 10.1 to registrant's Form 8-K filed February 18, 2016. |
| 10.34 | Third Amendment to Credit Agreement, dated as of May 19, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender. | Filed as Exhibit 10.1 to registrant's Form 8-K filed May 22, 2017. |
| 10.35 | Purchase Agreement, dated May 22, 2017, by and among the Company, the guarantors party thereto and SunTrust Robinson Humphrey, Inc., as representative of the several initial purchasers named in Schedule A thereto. | Filed as Exhibit 1.1 to registrant's Form 8-K filed May 23, 2017. |
| 10.36 | Fourth Amendment to Credit Agreement, dated as of August 29, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender. | Filed as Exhibit 10.1 to registrant's Form 8-K filed September 1, 2017. |
| 10.37 | Commitment Letter, dated December 4, 2017, by and among Molina Healthcare, Inc., SunTrust Bank and SunTrust Robinson Humphrey, Inc. | Filed as Exhibit 10.1 to registrant's Form 8-K filed December 7, 2017. |
| 10.38 | Form of Fifth Amendment to Credit Agreement, dated as of December 19, 2017, by and among Molina Healthcare, Inc., the Guarantors party thereto, the Lenders party thereto and SunTrust Bank, in its capacities as Administrative Agent, Issuing Bank and Swingline Lender. | Filed as Exhibit 10.1 to registrant's Form 8-K filed December 26, 2017. |
| 10.39 | Amended and Restated Commitment Letter, dated as of January 2, 2018, by and among Molina Healthcare, Inc., SunTrust Bank, SunTrust Robinson Humphrey, Inc., Barclays Bank PLC, MUFG, Bank of America, N.A., Merrill Lynch, Pierce, Fenner & Smith Incorporated, and Morgan Stanley Senior Funding, Inc. | Filed as Exhibit 10.1 to registrant's Form 8-K filed January 2, 2018. |

| Number | Description | Method of Filing |
|---|---|---|
| 10.40 | Bridge Credit Agreement, dated as of January 2, 2018, by and among Molina Healthcare, Inc., as the Borrower, Molina Information Systems, LLC, Molina Pathways LLC and Pathways Health and Community Support LLC, as the Guarantors, SunTrust Bank, Barclays Bank PLC, The Bank of Tokyo-Mitsubishi UFJ, Ltd., Bank of America, N.A., and Morgan Stanley Senior Funding, Inc., as Lenders, and SunTrust Bank, as Administrative Agent. | Filed as Exhibit 10.2 to registrant's Form 8-K filed January 2, 2018. |
| 10.41 | Capitated Medical Group/IPA Provider Services Agreement, effective May 1, 2013, by and between Molina Healthcare of California and Pacific Healthcare IPA | Filed as Exhibit 10.42 to registrant's Form 10-K filed February 26, 2016. |
| 10.42 | Regulatory Amendment for the Capitated Financial Alignment Demonstration Product to Molina Healthcare of California Group/IPA Provider Services Agreement(s), effective September 26, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc. | Filed as Exhibit 10.43 to registrant's Form 10-K filed February 26, 2016. |
| 10.43 | Capitated Financial Alignment Demonstration Amendment to Molina Healthcare of California Group/IPA Provider Services Agreement, effective as of July 1, 2014, by and between Molina Healthcare of California and Pacific Healthcare IPA Associates, Inc. | Filed as Exhibit 10.44 to registrant's Form 10-K filed February 26, 2016. |
| 12.1 | Computation of Ratio of Earnings to Fixed Charges | Filed herewith. |
| 21.1 | List of subsidiaries | Filed herewith. |
| 23.1 | Consent of Independent Registered Public Accounting Firm | Filed herewith. |
| 31.1 | Section 302 Certification of Chief Executive Officer | Filed herewith. |
| 31.2 | Section 302 Certification of Chief Financial Officer | Filed herewith. |
| 32.1 | Certificate of Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 | Filed herewith. |
| 32.2 | Certificate of Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 | Filed herewith. |
| 101.INS | XBRL Taxonomy Instance Document | Filed herewith. |
| 101.SCH | XBRL Taxonomy Extension Schema Document | Filed herewith. |
| 101.CAL | XBRL Taxonomy Extension Calculation Linkbase Document | Filed herewith. |
| 101.DEF | XBRL Taxonomy Extension Definition Linkbase Document | Filed herewith. |
| 101.LAB | XBRL Taxonomy Extension Label Linkbase Document | Filed herewith. |
| 101.PRE | XBRL Taxonomy Extension Presentation Linkbase Document | Filed herewith. |

* Management contract or compensatory plan or arrangement required to be filed (and/or incorporated by reference) as an exhibit to this Annual Report on Form 10-K pursuant to Item 15(b) of Form 10-K.

**MOLINA HEALTHCARE, INC.**

**AMENDED AND RESTATED**

**DEFERRED COMPENSATION PLAN (2018)**

This Deferred Compensation Plan (the "Plan") is amended and restated effective for amounts earned and deferred on or after January 1, 2018 (the "Restatement"), by MOLINA HEALTHCARE, INC., a Delaware corporation (the "Company") with reference to the following:

A. The Company originally established a Deferred Compensation Plan for key employees, effective September 1, 1999 (the "Original Plan"). The Original Plan was amended on March 29, 2001.

B. As a result of the adoption of section 409A of the Internal Revenue Code of 1986 (the "Code"), the Original Plan was frozen effective at midnight on December 31, 2004.

C. This Plan was implemented effective January 1, 2005 to replace the Original Plan with a new plan that complies with the requirements of Code section 409A and the related Treasury Regulations (and other guidance from the Internal Revenue Service) thereunder (collectively, the "409A Requirements") and amended and restated as of October 1. 2013, and subsequently amended November 14, 2013, October 29, 2014 and September 1, 2016.

D. This Plan was established to provide key employees of the Company and its subsidiaries a tax deferred, capital accumulation program. The Plan is intended to provide benefits to a select group of management or highly compensated personnel in order to attract and retain the highest quality executives. The Company does not intend for this to be a qualified plan within the meaning of Sections 401(a) and 501(a) of the Code. This Plan is intended to be an unfunded plan for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Company contributions and voluntary compensation deferrals shall be held in a "Rabbi Trust," as that term is defined in Revenue Procedure 92-64, 1992-2 C.B. 422.

E. This Plan is hereby amended and restated to incorporate the prior amendments to the Plan, to provide for installment payments from in-service accounts and to modify the minimum death benefit under the Plan.

NOW, THEREFORE, the Company hereby adopts this Plan on the following terms and conditions:

1. Definitions. Whenever used in this Plan, the following words and phrases shall have the meaning set forth below, unless a different meaning is expressly provided or plainly required by the context in which the words or phrases are used:

1.1. Beneficiary means a person designated by a Participant to receive Plan benefits in the event of the Participant's death.

1.2. Board means the Board of Directors of the Company and its successors.

1.3. Change in Control means, a Change in Ownership, a Change in the Effective Control, a Change in Assets or a termination of the Plan and distribution of compensation deferred hereunder within twelve (12) months after any of the foregoing events. For purposes of this Section, "Company" shall include (i) the company for which a Participant is performing services at the time of the Change in Control, (ii) the company liable for the payment of the deferred compensation (or all companies liable if more than one company is liable), or a company that is a majority shareholder of a company identified in (i) or (ii), or any company in a chain of companies in which each company is a majority shareholder of another company in the chain, ending in a company identified in (i) or (ii). The events described in this section will not be considered to occur, with respect to an employee of a participating entity, if a participating entity is sold and the employee of the participating entity continues employment with the Company subsequent to the sale. The events described in this section have the following meanings:

a. Change in Ownership means the acquisition of stock by any one person or persons acting in concert (a "group") of the Company, that when added to the stock of the person or group constitutes more than 50% of the total fair market value or total voting power of the stock of the Company. The acquisition of additional stock by any person or group who are already considered to own more than 50% of the stock of the Company shall not constitute a change in ownership of the Company. An increase in the percentage of stock owned by any person or group, as result of a transaction in which the Company acquires its stock in exchange for property will be treated as an acquisition of stock for purposes of this section.

b. Change in the Effective Control means the occurrence of any of the following events, despite the fact that the Company has not undergone a Change in Ownership as described above:

i. The acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of ownership of stock of the Company possessing 35% or more of the total voting power of the stock, except if such acquisition is the result of a change in "record ownership" and not a change in "beneficial ownership;"

ii. The replacement of a majority of the Company's board of directors during any 12-month period by directors whose appointment or election is not endorsed by a majority of the members of the Company's board of directors prior to the date of the appointment or election; or

iii A transaction between the Company and another company resulting in a Change in Control.

iv. Provided that this section shall not apply to the acquisition of additional control of the Company by any person or group, if that person or group is considered to effectively control the Company prior to the acquisition.

c. Change in Assets means the acquisition by any person or group (or acquisition during the 12-month period ending on the date of the most recent acquisition by such person or persons) of assets from the Company, that have a total gross fair market value equal to, or more than, 40% of the total gross fair market value of all the assets of the Company immediately prior to such acquisition or acquisitions. A transfer of assets by the Company will not be treated as a Change in Assets if the assets are transferred to any of the following (determined immediately after the transfer):

i. A shareholder of the Company (as determined, immediately before the asset transfer) in exchange for or with respect to its stock;

ii. An entity, 50% or more of the total value or voting power of which is owned directly or indirectly by the Company;

iii. A person or group that owns, directly or indirectly, 50% or more of the total value or voting power of all the outstanding stock of the Company; or

iv. An entity, at least 50% of the total value or voting power of which is owned, directly or indirectly, by a person described in (iii).

For purposes of this subsection (c), the gross fair market value of assets is the value of the assets of the Company or the value of the assets being disposed of with regard to any liabilities associated with such assets. If assets are transferred to an entity that is controlled by the shareholders of the transferring company immediately after the transfer, there is no Change in Control.

1.4. Company means MOLINA HEALTHCARE, INC., a Delaware corporation.

1.5. Company Stock means shares of stock issued by the Company.

1.6. Disability or Disabled means with respect to a Participant (i) the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months, or (ii) the receipt of income replacement benefits for a period of not less than three (3) months under an accident and health plan covering employees of the Company, by reason of any medically determinable physical or mental impairment which can be expected to result in death or can be expected to last for a continuous period of not less than twelve (12) months.

1.7. The original Effective Date of this Plan means January 1, 2005. The Effective Date of this Restatement shall mean January 1, 2018.

1.8. Key Employee means an employee of the Company or a Subsidiary, who is (A) a member of a select group of management or highly compensated employees within the meaning of §2520.104-23 of the Department of Labor ERISA Regulations, (B) projected to receive Plan Year Compensation (base pay plus bonus), plus amounts deferred to any 401(k) plan, deferred compensation plan, or cafeteria plan maintained by the Company, of $200,000 or more and (C) designated by the Plan Committee as a Key Employee.

1.9. Participant means (A) a Key Employee who timely files a Written Election pursuant to Section 2.3, below, and (B) a former Employee who, at the time of his Separation from Service, death, or Disability, retains, or whose beneficiary retains, benefits earned under the Plan in accordance with its terms. A Participant is considered an Active Participant in the Plan (even if the Participant no longer satisfies the requirements of Section 1.8(B) but subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee) until the Participant separates from service under the terms of this Plan.

1.10. Plan means the Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2018) evidenced by this document and the Trust Agreement previously established in connection herewith.

1.11. Plan Committee means the individuals appointed by the Board from time to time to administer the Plan as provided herein.

1.12. Plan Year means the calendar year.

1.13. Plan Year Compensation means the total taxable income (other than Share Awards) paid to an Active Participant by the Company or a Subsidiary during any Plan Year, or portion thereof in which he is a Participant in this Plan, as reflected on a Key Employee's form W-2.

1.14. Separation from Service. A separation from service with the Company, provided such separation constitutes a "separation from service" under Treasury Regulation Section 1.409A-1(h).

1.15. Share Awards means shares of Company Stock which are awarded to a Participant as an employee by the Company.

1.16. Specified Employee means a "key employee" of the Company, as defined in section 416(i) of the Code without regard to paragraph five (5) thereof.

1.17. Subsidiary means any entity in which the Company owns not less than 80% of the outstanding voting interests.

1.18. Trust Agreement means the grantor trust established in connection with this Plan between the Company as grantor and the Trustee.

1.19. Trustee means Union Bank of California and any successor institutional trustee named to succeed such Trustee under the terms of the Trust Agreement established in connection with this Plan.

1.20. Unforeseeable Financial Emergency means: (i) an illness or accident of the Participant or beneficiary, the Participant's or beneficiary's spouse, or the Participant's or beneficiary's dependent; (ii) the loss of the Participant's or beneficiary's property due to casualty; or (iii) other similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the Participant or beneficiary. Determination of whether a Participant has incurred an Unforeseeable Financial Emergency shall be made by the Plan Committee, in accordance with the requirements of Section 409A of the Code and any guidance issued thereunder.

2. Participation.

2.1. Eligibility. An employee of the Company or a Subsidiary is eligible to participate in this Plan upon meeting the criteria for Key Employee specified in Section 1.8. Any Key Employee who was a Participant in the Original Plan and who continued in the employ of the Company on the effective date of the Restatement will continue to be a Participant in this Plan, subject to the right of the Company's Chief Executive Officer to no longer designate such employee as a Key Employee thereafter.

2.2. Entry Date. An employee of the Company or a Subsidiary who met the eligibility requirement specified in Section 2.1 as of the Effective Date of this Plan Restatement is a Participant in the Plan as of the Effective Date. Newly eligible employees of the Company who have met the enrollment requirements under Section 2.3 of the Plan shall commence participation in the Plan within thirty (30) days of their date of hire. An employee of the Company or a Subsidiary who meets the eligibility requirements specified in Section 2.1 but fails to meet the requirements in accordance with Section 2.3 within the period required, shall become a Participant in this Plan on the first day of the next Plan Year following submission of a Written Election form as specified in Section 2.3.

2.3. Written Election by Participant. As a condition to participation in the Plan, each newly eligible Employee shall complete, sign and return to the Plan Committee a Written Election within thirty (30) days after the date the Participant becomes eligible to participate in the Plan. Annual enrollment shall be in December each year for the following Plan Year. Each Participant shall submit a Written Election prior to the first day of the Plan Year in which he or she will be a Participant.

a. Such Written Election shall be made on the form presented to the Participant by the Plan Committee and shall set forth:

i. his election to participate in this Plan under the terms hereof;

ii. the amount of Plan Year Compensation the Participant has determined to defer under the Plan for the Plan Year, pursuant to Section 3.1 below;

iii. the investment vehicles into which the Participant desires to have his Account attributable to deferral of Plan Year Compensation invested, as provided in Section 3.5 below, and the percentage of such Account allocated to each elected investment vehicle;

iv. the date on which his benefit is to be distributed which is the earliest of: (a) the date specified for an In-Service Withdrawal; (b) an Unforeseeable Financial Emergency; (c) the later of (i) when he separates from service with the Company for any reason or (ii) a date subsequent to his termination of employment specified by the Participant;

v. the form in which his benefit is to be distributed upon an In-Service Withdrawal, Separation from Service, Disability or death.

b. A Participant must provide a separate Written Election for each subsequent Plan Year that specifies the percentage of the Plan Year Compensation that Participant has determined to defer for each such Plan Year. Such Written Election is only effective for the Plan Year for which the election is made and if no Written Election to defer Plan Year Compensation is executed in relation to a subsequent Plan Year, no Plan Year Compensation will be deferred for such subsequent Plan Year. Any election of the amount of Plan Year Compensation to defer for a given Plan Year shall be irrevocable on and after the first day of the Plan Year for which the election was made.

c. A Participant may change the investment vehicle(s) in which the Participant desires to have that portion of the Participant's Account attributable to Plan Year Compensation and investment income invested and the percentage of the Participant's Account allocated to each investment vehicle by completing and submitting any form or forms required by the Company. Changes in investment vehicle(s) will be made as of the applicable business day (or as soon as practicable thereafter) following the date that the change is requested.

d. Notwithstanding the foregoing, the Trustee shall, at the direction of the Plan Committee, have the duty and authority to invest the trust assets and funds in accordance with the terms of the Trust Agreement, and all rights associated with the trust assets shall be exercised by the Trustee as designated by the Plan Committee and shall in no event be exercisable by or be settled upon Participants or their Beneficiaries.

e. A Participant may change the date or form of distribution by submitting a new Written Election to the Company, provided that the following conditions are met:

i. That such election may not take effect until at least twelve (12) months after the date on which the election is made;

ii. In the case of an election related to a payment other than a payment on account of death, disability or the occurrence of a financial hardship, such payment must be deferred for a period of not less than five (5) years from the date such payment would have otherwise been made, and

iii. Any election related to a payment at a specified time or pursuant to a fixed schedule may not be made less than twelve (12) months prior to the date of the first scheduled payment.

iv. Such election may be made among the payment options set forth in Section 5.4.

2.4. Duration of Participation. Any Key Employee who has become a Participant at any time shall remain a Participant, even though he is no longer an Active Participant, until his entire benefit under the terms of the Plan has been paid to him (or to his Beneficiary in the event of his death), at which time he ceases to be a Participant.

2.5. Maintenance of Records. The annual Designation of Participants by the Plan Committee shall be maintained in the corporate minute book. The Written Elections by Participants shall be maintained in the corporate records with all other files pertaining to this Plan by the Plan Committee.

3. Contributions and Allocation.

3.1 Participant Contributions. A Participant may elect to defer a portion of (i) up to 75% of Plan Year Compensation constituting base pay and (ii) up to 100% of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay). For a Participant's initial Plan Year of participation, the minimum deferral percentage for base pay and bonus pay must be 3% for each such component. For succeeding years of participation, a Participant may not defer an amount less than the minimum percentage established from year to year by the Plan Committee. A written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of Plan Year Compensation constituting base pay the Participant has chosen to defer. A separate written election must be submitted, pursuant to the terms of Section 2.3, specifying the percentage of all other Plan Year Compensation eligible for deferral under this Plan (including bonus pay) the Participant has chosen to defer. Once a Participant's contributions for a Plan Year reach the Participant's elected percentage, such Participant shall not be allowed to defer additional portions of such Participant's Plan Year Compensation for the remainder of the Plan Year. Any amounts in excess of the Participant's elected percentage inadvertently deferred shall be refunded to the Participant as soon as practicable.

3.2. Company Contributions. The Company may, subject to the sole discretion of its Board of Directors, make contributions for the Participants, reserving the right to discriminate

among the Participants in the amount or percentage of contributions made in any Plan Year.

3.3. Allocation of Participant Contributions. All amounts which a Participant elects to defer under the terms of this Plan shall be allocated to his Account as of the last business day of each month. Each such Participant Deferral Account shall be credited with earnings as provided in Section 3.5 below.

3.4. Allocation of Company Contributions. Any amounts contributed by the Company on behalf of a Participant under Section 3.2 above shall be allocated to the Company Contribution Account of each Participant. Each such Company Contribution Account shall be credited with earnings as provided in Section 3.5 below.

3.5 Credited Earnings. The Account of each Participant (which includes such Participant's Participant Deferral Account established under Section 3.1 and such Participant's Company Contribution Account established under Section 3.2) shall be credited as of each applicable business day with the actual earnings on the investments allocated to the Participant's Account.

3.6. Funding. The assets of the Plan shall be held under the Trust Agreement (a "grantor trust") designated in Section 8. As such, the Plan is intended to be an unfunded plan for purposes of the requirements of ERISA and the Code.

Notwithstanding the provisions under the terms of the Plan that amounts contributed to this Plan, plus earnings thereon, shall be allocated to separate Accounts of Participants, all such amounts credited to such individual Accounts shall remain the general assets of the Company, and as such shall remain subject to the claims of the general creditors of the Company. This Plan and the related Trust Agreement do not create, nor does any employee, Participant or Beneficiary have, any right with respect to any specific assets of the Company or the Plan.

4. Vesting of Accounts. The Participant Deferral Accounts and the Company Contribution Account of each Participant shall be 100% vested in such Participant at all times.

5. Types of Benefits.

5.1. Separation from Service Benefit. A Participant's Separation from Service Benefit is the unpaid balance of his Accounts which equals the total of all contributions made by the Participant and the Company allocated to his Account and all earnings credited to his Account in accordance with the terms of the Plan and the Trust Agreement, less any distributions already paid.

5.2. Disability Benefit. If a Participant becomes Disabled as defined in Section 1.6 above, the Company will pay his Separation from Service Benefit, calculated under Section 5.1, in the applicable form elected by the Participant in his Written Election.

A Participant who believes he has suffered a Disability within the meaning of Section 1.6 shall make application to the Plan Committee, on a form prescribed by the Plan Committee, for a determination of whether he is Disabled under the terms of Section 1.6. The Participant shall make such written application to the Plan Committee on or after the date which is at least five (5) consecutive months following the date he first suffered the impairment under consideration. Any determination by the Plan Committee that a Disability exists under the provisions of Section 1.6 shall be effective only after the date the Disability has existed for six (6) consecutive months. All determinations made by the Plan Committee shall be final, and no Participant shall be considered Disabled for any purpose whatsoever under the provisions of this Plan if determined not to be Disabled by the Plan Committee under the procedures set forth in this Section.

The Plan Committee shall notify each Participant who has made application under this Section 5.2, in writing, of its determination within three (3) months of the date the Plan Committee receives the Participant's application hereunder. The Participant shall cooperate in providing any information to the Plan Committee which it requires in making its determination, including, but not limited to, access to the Participant's medical records, direct contact with his physician, and physical examination by a physician selected by the Company. Any Participant who does not fully cooperate shall be deemed not Disabled by the Plan Committee and so notified.

5.3. Death Benefit.

a. If a Participant dies after a distribution has commenced or if the Company has not purchased a life insurance contract in connection with the Participant's Separation from Service Benefit, the Company will continue the payments of such distribution otherwise due to the Participant to his designated Beneficiary, in the applicable form elected by the Participant in his Written Election.

b. If a Participant dies while still employed by the Company and the Company has purchased a life insurance contract in connection with such Participant's Separation from Service Benefit, the Company will pay the Participant's designated Beneficiary the greatest of: (i) twice the Participant's base salary upon initial eligibility for the Plan; (ii) $500,000; or (iii) if the Participant was a Participant prior to January 1, 2018, the amount specified under the Plan prior to such date, in the applicable form elected by the Participant in his Written Election.

5.4. In-Service Withdrawal. A Participant may designate a year in the future for receipt of an In-Service Withdrawal with respect to the Participant's contribution for a given Plan Year. Such withdrawal may be paid while the Participant remains employed with the Company. Initial designations made with respect to the 2018 Plan Year in accordance with Section 2.3(a)(iv) (as may be subsequently modified under Section 2.3(b)) shall include Credited Earnings attributable to such Participant Contribution. The In-Service Withdrawal will be paid in a lump sum unless the Participant elects to receive substantially equal annual installments from two (2) to five (5) years, commencing no earlier than three (3) years after the Plan Year during which such Participant Contributions are made; provided, however, that a Participant may make a subsequent deferral election with respect to any initial In-Service Withdrawal election made under this Plan subject to the following requirements:

a. the Participant must deliver to the Company a written election not later than twelve (12) months prior to the date the payment is scheduled to be paid;

b. the payments that are subject to the election must be delayed at least five (5) years from the date the payments would have otherwise been made; and

c. the election will not take effect until at least twelve (12) months after the election is made.

5.5. Unforeseeable Financial Emergency Benefit. A Participant may request a portion of his Separation from Service Benefit as an Unforeseeable Financial Emergency Benefit at any time by providing the Plan Committee, to its satisfaction, with a written request, proof of an Unforeseeable Financial Emergency, and proof that all other financial resources have been explored and utilized to: (i) receive a partial or full payout from the Plan and/or (ii) suspend any deferrals required to be made by a Participant. The amount of an Unforeseeable Financial Emergency Benefit shall be limited to the lesser of the amount needed for the financial hardship or such Participant's Separation from Service Benefit. If a Participant receives a distribution as a result of an Unforeseeable Financial Emergency, such Participant may not participate in the Plan during the Plan Year following the year of the hardship distribution.

6. Distributions.

6.1. Form of Benefits. The Company shall pay benefits in the form associated with Type of Benefit elected by the Participant, and, to the extent a Type of Benefit may be distributed in various forms, the Company shall pay benefits in the form elected by the Participant. The forms of benefits associated with the Types of Benefits are the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit shall be paid in (i) one lump sum; (ii) 5 yearly installments; (iii) 10 yearly installments; or (iv) 15 yearly installments;

b. In-Service Withdrawal shall be paid as provided in Section 5.4 above; and

c. Unforeseeable Financial Emergency Benefit shall be paid in one lump sum.

6.2. Commencement of Payments. The Company will pay, or begin to pay, the Types of Benefits under this Plan to the Participant in accordance with the following:

a. Separation from Service Benefit, Disability Benefit, and Death Benefit payments shall commence no later than sixty-five (65) days following the date on which the Participant retires, terminates service, becomes disabled, or dies;

b. In-Service Withdrawal payments shall commence on the date designated by the Participant on his Written Election pursuant to Section 2.3, provided that such payments are from Participant Contributions that have been in such Participant's Participant Deferral Account for at least two years;

c. Unforeseeable Financial Emergency Benefit payments shall commence no later than sixty-five (65) days after a request for an Unforeseeable Financial Emergency Benefit is approved by the Plan Committee.

6.3. Domestic Relations Order. In the event the Plan Committee receives a Domestic Relations Order from a potential Alternate Payee, the Plan Committee shall notify the Participant whose benefit is the subject of such order and provide him/her with information concerning the Plan's procedures for administering Qualified Domestic Relations Orders ("QDROs"). Unless and until the order is set aside, the following provisions shall apply:

a. The Plan Committee shall within a reasonable time determine whether the order is a QDRO and shall notify the Participant whose benefit is the subject of the order, of its determination. The Plan Committee may designate a representative to carry out its duties under this provision.

b. Nothing in this Section shall be deemed to allow payment under a QDRO to an Alternate Payee of any benefit which would violate Section 409A of the Code and the regulations thereunder.

c. QDRO definitions. For purposes of Section 6.3 the following definitions and rules shall apply:

i. Alternate Payee means any spouse, former spouse, child or other dependent of a Participant who is recognized by a QDRO as having a right to receive all, or a portion of, the benefits payable under this Plan with respect to the Participant.

ii. Domestic Relations Order means any judgment, decree, or order (including approval of a property settlement agreement) which:

(1) relates to the provision of child support, alimony payments, or marital property rights to a spouse, child, or other dependent of a Participant; and

(2) is made pursuant to a state domestic relations law (including a community property law).

iii. Qualified Domestic Relations Order means any Domestic Relations Order meeting the requirements for a Qualified Domestic Relations

Order under Code section 414(p), which satisfies any additional criteria under policies established by the Plan Committee.

6.4 Limited Cashout. Notwithstanding any Written Election made by the Participant, if, upon the Participant's Separation from Service, such Participant's accrued benefit under the Plan (and any other deferred compensation plan required to be aggregated with this Plan) does not exceed the then-current limit under Section 402(g)(1)(B) of the Code, the Company shall immediately distribute such Participant's accrued benefit under the Plan in a single lump sum payment to the Participant (or the Beneficiary, if the Participant is deceased), provided that such distribution results in a termination and complete liquidation of such Participant's interest under the Plan (and any other deferred compensation plan required to be aggregated by this Plan).

Notwithstanding sections 6.2 and 7.3, distributions to a Specified Employee shall not commence earlier than six (6) months after the date such Specified Employee experiences a Separation from Service (or, if earlier, the date of death of the employee).

7. Amendment, Termination of Plan, Change in Control.

7.1. Amendment. The Company reserves the right to amend the Plan at any time by resolution of the Plan Committee. The Plan Committee will determine the effective date of any such amendment. The amendment may not deprive any Participant or Beneficiary of any portion of a benefit under the terms of this Plan at the time of the amendment.

7.2. Termination of Plan. The Company reserves the right to terminate the Plan under the following circumstances:

a. The Plan Committee may resolve to terminate the Plan provided that:

i. all arrangements of the same type (account balance plans, nonaccount balance plans, separation pay plans or other arrangements) are terminated with respect to all participants;

ii no payments other than those otherwise payable under the terms of the Plan absent a termination of the Plan are made within twelve (12) months of the termination of the arrangement;

iii. all payments are made within twenty-four (24) moths of the termination of the arrangement; and

iv. the Company does not adopt a new arrangement that would be aggregated with any terminated arrangement under the plan aggregation rules at any time for a period of five years following the date of termination of the arrangement.

b. The Plan Committee may terminate the Plan and make payments to the Participants at any time during the twelve (12) months following a change in control of the corporation;

c. A corporate dissolution taxed under Section 331, or with the approval of a bankruptcy court pursuant to 11 U.S.C. §503(b)(l)(A), provided that the amounts deferred under the Plan are included in the Participants' gross incomes by the latest of:

i. the calendar year in which the Plan termination occurs,

ii. the calendar year in which the amount is no longer subject to a substantial risk of forfeiture, or

iii. the first calendar year in which the payment is administratively practicable.

7.3. Change in Control. In the event of a Change in Control, the Company shall, as soon as possible, but in no event later than ten days after the Change in Control, notify the Trustee, and the Trustee or its agent shall immediately calculate the Separation from Service Benefit of each Participant and distribute such amounts to the Participant or Beneficiary in a lump sum within thirty (30) days of the notification. If the Company fails to notify the Trustee as specified in this section, the Trustee may act upon notification of the "Change of Control" obtained in an alternate manner. The Trustee shall incur no liability to any person for any action taken pursuant to such notification and in conformity with the terms of the Plan.

8. Benefits Not Funded. Participants and Beneficiaries have the status of unsecured creditors of the Company, and the Plan constitutes a mere promise by the Company to make benefit payments in the future. A Participant's or Beneficiary's interest in the Plan is an unsecured claim against the general assets of the Company, and neither the Participant nor a Beneficiary has any right against the account until the Plan has distributed the benefit. All amounts credited to an account are the general assets of the Company and may be disposed of or used by the Company in such manner as it determines.

Notwithstanding the first paragraph of this Section 8, the Company will make deposits to a trust pursuant to a Trust Agreement, a copy of which is attached, as provided above. Such Trust Agreement created by the Company is intended to be a grantor trust, and any assets held by such trust to assist the Company in meeting its obligations under the Plan will conform to the terms of the model trust, as described in Revenue Procedure 92-64, 1992-2 C.B. 422, promulgated by the Internal Revenue Service. The Company will make a transfer of cash to the trust annually in the amount necessary to pay the deferred compensation required.

It is the intention of the parties that this Plan and the accompanying Trust Agreement shall constitute an unfunded arrangement maintained for the purpose of providing deferred compensation for a select group of management or highly compensated employees for purposes of Title I of ERISA.

9. Administration.

9.1. Plan Committee. The Plan shall be administered by the Plan Committee. The Plan Committee shall have full authority and power to administer and construe the Plan, subject to applicable requirements of law. Without limiting the generality of the foregoing, the Plan Committee shall have the powers indicated in the foregoing Sections of the Plan and the following additional powers and duties:

a. To make and enforce such rules and regulations as it deems necessary or proper for the administration of the Plan;

b. To interpret the Plan and to decide all questions concerning the Plan;

c. To determine the amount and the recipient of any payments to be made under the Plan;

d. To designate and value any investments deemed held in the Accounts; and

e. To make all other determinations and to take all other steps necessary or advisable for the administration of the Plan.

All decisions made by the Plan Committee pursuant to the provisions of the Plan shall be made in its sole discretion and shall be final; conclusive, and binding upon all parties.

9.2. Delegation of Duties. The Plan Committee may delegate such of its duties and may engage such experts and other persons as it deems appropriate in connection with administering the Plan. The Plan Committee shall be fully protected in any action taken, in good faith, in reliance upon any opinions or reports furnished them by any such experts or other persons.

9.3. Indemnification of Committee. The Company agrees to indemnify and to defend to the fullest extent permitted by law any person serving as a member of the Plan Committee, and each employee of the Company or any of its affiliates appointed by the Plan Committee to carry out duties under this Plan, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

9.4. Liability. To the extent permitted by law, neither the Plan Committee nor any other person shall incur any liability for any acts or for any failure to act except for liability arising out of such person's own willful misconduct or willful breach of the Plan.

9.5. Claims Review Procedure.

a. A claim for benefits may be filed, in writing, with the Plan Committee. A written disposition of a claim shall be furnished to the claimant within a reasonable time after the claim for benefits is filed. In the event a claim for benefits is denied, the Plan Committee shall provide the claimant with the reasons for denial.

b. A claimant whose claim for benefits was denied may file for a review of such denial, with the Plan Committee, no later than 60 days after he has received written notification of the denial.

c. The Plan Committee shall give a request for review a full and fair review. If the claim for benefits is denied upon completion of a full and fair review, notice of such denial shall be provided to the claimant within 60 days after the Plan Committee's receipt of such written claim for review. This 60-day period may be extended in the event of special circumstances. Such special circumstances shall be communicated to the claimant in writing within the 60-day period. If there is an extension, a decision shall be made as soon as possible, but not later than 120 days after receipt by the Plan Committee of such claim for review.

d. If benefits are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of a state, the claims procedure relating to these benefits may provide for review. If so, that company, service, or organization will be the entity to which claims are addressed.

10. General Provisions

10.1. Designation of Beneficiary. Each Participant shall designate, in writing, prior to the date he first becomes a Participant in the Plan, one or more beneficiaries to receive his benefit under the provisions of Section 5.3. The Participant shall file the written designation with the Plan Committee. The Participant may revoke a previous beneficiary designation by filing a new written beneficiary designation with the Plan Committee.

In any event, if a Participant or Beneficiary who has designated another Beneficiary is divorced, all beneficiary designations executed prior to the effective date of the dissolution of marriage (or other decree or order entered under applicable state law) are automatically revoked under the terms of this Section 10.1. In such event, the Participant or Beneficiary may designate one or more Beneficiaries in accordance with the terms of this Section 10.1. If none is made following the effective date of the dissolution of the marriage, the individual's benefit shall pass under the laws of intestate succession and the terms of the next following paragraph.

If a Participant fails to file a valid designation of beneficiary with the Plan Committee under the provisions of this Section 10.1, or if a designated Beneficiary fails to survive to receive any or all payments due hereunder, then the death benefit payable under this Plan shall be payable to the Participant's (or the Beneficiary's) spouse; if no spouse survives, then to the Participant's (or Beneficiary's) children, with equal shares among living children and with the living descendants of a deceased child receiving equal portions of

the deceased child's share; in the absence of spouse or descendants, to the Participant's (or Beneficiary's) parents; and in the absence of spouse, descendants or parents, to the Participant's (or Beneficiary's) brothers and sisters, with the living descendants of a deceased brother and those of a deceased sister receiving equal portions of the deceased brother's or sister's share; in the absence of any of the persons named herein, to the Participant's (or Beneficiary's) estate.

For purposes of this Section 10.1, the term "descendant" means all persons who are descended from the person referred to either by birth to or legal adoption by such person, and "child" or "children" includes adopted children.

10.2. Benefits Not Assignable. The rights of each Participant are not subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, attachment, or garnishment by creditors of the Participant or any Beneficiary. Neither the Participant nor Beneficiary may assign, transfer or pledge the benefits under this Plan. Any attempt to assign, transfer or pledge a Participant's benefits under this Plan is void.

10.3. Benefit. This Plan constitutes an agreement between the Company and each of the Participants which is binding upon and inures to the Company, its successors and assigns and upon the Participant and his heirs and legal representatives.

10.4. Headings. The headings of the Articles and Sections of this Plan are included for purposes of convenience only, and shall not affect the construction or interpretation of any of it provisions.

10.5. Notices. All notices, requests, demands, and other communications under this Plan shall be in writing and shall be deemed to have been duly given on the date of service if served personally on the party to whom notice is to be given, or on the third day after mailing if mailed to the party to whom notice is to be given, by first class mail, registered or certified (return receipt requested), postage prepaid, and properly addressed to the last known address to each party as set forth on the first page thereof. Any party may change its address for purposes of this Section by giving the other parties written notice of the new address in the manner set forth above.

10.6. No Loans. The Plan does not permit any loans to be made to any Participant or Beneficiary.

10.7. Gender Usage. The use of the masculine gender includes the feminine gender for all purposes of this Plan.

10.8. Expenses. Costs of administration of the Plan shall be paid by the Company.

IN WITNESS WHEREOF, the Company has executed this Amended and Restated Deferred Compensation Plan (2018) on November 7, 2017, effective as of the Effective Date.

MOLINA HEALTHCARE, INC.

By: _____
Joseph White
Chief Financial Officer

**EXHIBIT 12.1**

**MOLINA HEALTHCARE, INC.**

**COMPUTATION OF RATIO OF EARNINGS TO FIXED CHARGES**

| | Year Ended December 31, | | | | |
|---|---|---|---|---|---|
| | **2017** | **2016** | **2015** | **2014** | **2013** |
| | (Dollars in millions) | | | | |
| **Earnings:** | | | | | |
| (Loss) income before income taxes, continuing operations | $ (612) | $ 205 | $ 322 | $ 135 | $ 81 |
| Add fixed charges: | | | | | |
| Interest expense, including amortization of debt discount | 118 | 101 | 66 | 57 | 52 |
| Estimated interest portion of rental expense | 11 | 12 | 8 | 5 | 4 |
| Total fixed charges | 129 | 113 | 74 | 62 | 56 |
| Total earnings available for fixed charges | $ (483) | $ 318 | $ 396 | $ 197 | $ 137 |
| **Fixed charges from above:** | $ 129 | $ 113 | $ 74 | $ 62 | $ 56 |
| **Ratio of Earnings to Fixed Charges** [1] | — | 2.8 | 5.4 | 3.2 | 2.4 |
| Total rent expense | $ 75 | $ 64 | $ 44 | $ 32 | $ 25 |
| Interest factor | 14% | 18% | 18% | 16% | 16% |
| Interest component of rental expense | $ 11 | $ 12 | $ 8 | $ 5 | $ 4 |

(1) Earnings were inadequate to cover fixed charges by $612 million for the year ended December 31, 2017.

**EXHIBIT 21.1**

LIST OF SUBSIDIARIES

| Name | Jurisdiction of Incorporation |
|---|---|
| Molina Healthcare Data Center, Inc. | New Mexico |
| Molina Healthcare of Arizona, Inc.* | Arizona |
| Molina Healthcare of California | California |
| Molina Healthcare of California Partner Plan, Inc. | California |
| Molina Healthcare of Florida, Inc. | Florida |
| Molina Healthcare of Georgia, Inc.* | Georgia |
| Molina Healthcare of Illinois, Inc. | Illinois |
| Molina Healthcare of Iowa, Inc.* | Iowa |
| Molina Healthcare of Maryland, Inc.* | Maryland |
| Molina Healthcare of Michigan, Inc. | Michigan |
| Molina Healthcare of Mississippi, Inc.* | Mississippi |
| Molina Healthcare of New Mexico, Inc. | New Mexico |
| Molina Healthcare of New York, Inc. | New York |
| Molina Healthcare of North Carolina, Inc.* | North Carolina |
| Molina Healthcare of Ohio, Inc. | Ohio |
| Molina Healthcare of Oklahoma, Inc.* | Oklahoma |
| Molina Healthcare of Pennsylvania, Inc.* | Pennsylvania |
| Molina Healthcare of Puerto Rico, Inc. | Puerto Rico/Nevada |
| Molina Healthcare of South Carolina, LLC | South Carolina |
| Molina Healthcare of Texas, Inc. | Texas |
| Molina Healthcare of Texas Insurance Company | Texas |
| Molina Healthcare of Utah, Inc. | Utah |
| Molina Healthcare of Virginia, Inc. | Virginia |
| Molina Healthcare of Washington, Inc. | Washington |
| Molina Healthcare of Wisconsin, Inc. | Wisconsin |
| Molina Hospital Management, LLC | California |
| Molina Information Systems, LLC, dba Molina Medicaid Solutions | California |
| Molina Youth Academy* | California |
| Molina Medical Management, Inc. | California |
| Molina Holdings Corporation* | New York |
| Molina Clinical Services, LLC | Delaware |
| Molina Healthcare of Louisiana, Inc.* | Louisiana |
| Molina Healthcare of Nevada, Inc.* | Nevada |
| Molina Pathways, LLC | Delaware |
| Molina Pathways of Texas, Inc.+ | Texas |
| Pathways Health and Community Support LLC+ | Delaware |
| AmericanWork, Inc.- | Delaware |
| Children's Behavioral Health, Inc.- | Pennsylvania |
| Choices Group, Inc.- | Delaware |
| College Community Services- | California |
| Dockside Services, Inc.- | Indiana |
| Family Preservation Services, Inc.- | Virginia |

**EXHIBIT 21.1**

| | |
|---|---|
| Family Preservation Services of Florida, Inc.- | Florida |
| Family Preservation Services of North Carolina, Inc.- | North Carolina |
| Family Preservation Services of Washington D.C., Inc.- | District of Columbia |
| Family Preservation Services of West Virginia, Inc.- | West Virginia |
| Maple Star Nevada, Inc.- | Nevada |
| Maple Star Oregon, Inc.- | Oregon |
| Pathways Community Corrections, Inc.- | Delaware |
| Camelot Care Centers, Inc.> | Illinois |
| Pathways Community Services LLC- | Delaware |
| Pathways Community Services LLC- | Pennsylvania |
| Pathways of Massachusetts LLC- | Delaware |
| Pathways of Washington, Inc.- | Washington |
| Pathways of Arizona, Inc.- | Arizona |
| Pathways of Idaho LLC- | Delaware |
| Pathways of Delaware, Inc.- | Delaware |
| Pathways of Maine, Inc.- | Maine |
| Pathways of Oklahoma, Inc.- | Oklahoma |
| Pathways Community Support of Texas, Inc.- | Texas |
| Transitional Family Services, Inc.- | Georgia |
| Pathways Human Services, LLC.-* | Delaware |
| The RedCo Group, Inc.- | Pennsylvania |
| Raystown Developmental Services, Inc./ | Pennsylvania |

* Non-operational entity

\+ Wholly owned subsidiary of Molina Pathways, LLC

\- Wholly owned subsidiary of Pathways Health and Community Support LLC

/ Wholly owned subsidiary of The RedCo Group, Inc.

> Wholly owned subsidiary of Pathways Community Corrections, Inc.

**EXHIBIT 23.1**

**CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM**

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-204558) of Molina Healthcare, Inc.;
(2) Registration Statement (Form S-4 No. 333-213136) of Molina Healthcare, Inc.;
(3) Registration Statement (Form S-8 No. 333-174912) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan;
(4) Registration Statements (Forms S-8 No. 333-138552, No. 333-153246, and No. 333-170571) pertaining to the Molina Healthcare, Inc. 2011 Equity Incentive Plan and 2011 Employee Stock Purchase Plan; and
(5) Registration Statement (Form S-8 No. 333-108317) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan and 2002 Employee Stock Purchase Plan;

of our reports dated March 1, 2018, with respect to the consolidated financial statements of Molina Healthcare, Inc., and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10-K) for the year ended December 31, 2017.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 1, 2018

**EXHIBIT 31.1**

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

I, Joseph M. Zubretsky, certify that:

1. I have reviewed the report on Form 10-K for the period ended December 31, 2017 of Molina Healthcare, Inc.;

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

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

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

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

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

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

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

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

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

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

Dated: March 1, 2018

/s/ Joseph M. Zubretsky

**Joseph M. Zubretsky**

**Chief Executive Officer, President and Director**

**EXHIBIT 31.2**

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

I, Joseph W. White, certify that:

1. I have reviewed this annual report on Form 10-K for the period ended December 31, 2017 of Molina Healthcare, Inc.;

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

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

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

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

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

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

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

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

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

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

Dated: March 1, 2018

/s/ Joseph W. White

**Joseph W. White**

**Chief Financial Officer and Treasurer**

**EXHIBIT 32.1**

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

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2017 (the "Report"), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

Dated: March 1, 2018

/s/ Joseph M. Zubretsky

**Joseph M. Zubretsky**

**Chief Executive Officer, President and Director**

**EXHIBIT 32.2**

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

In connection with the report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ended December 31, 2017 (the "Report"), I, Joseph W. White, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

Dated: March 1, 2018

/s/ Joseph W. White

**Joseph W. White**

**Chief Financial Officer and Treasurer**