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

FORM 8-K

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

Date of Report (Date of earliest event reported): September 17, 2015

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

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

200 Oceangate, Suite 100, Long Beach, California 90802
(Address of principal executive offices)

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

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

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

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

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

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

Item 7.01. Regulation FD Disclosure.

On September 17, 2015, the Company presented and webcast certain slides as part of the Company's presentation at its Investor Day Conference held in New York City. A copy of the Company's complete slide presentation is included as Exhibit 99.1 to this report. An audio and slide replay of the live webcast of the Company's Investor Day presentation will be available for 30 days from the date of the presentation at the Company's website, www.molinahealthcare.com, or at www.earnings.com. The information contained in such websites is not part of this current report.

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

Item 9.01. Financial Statements and Exhibits.

(d) Exhibits:

Exhibit No.	Description
99.1	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on September 17, 2015.

SIGNATURE

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

MOLINA HEALTHCARE, INC.

Date: September 17, 2015

By: */s/ Jeff D. Barlow*
Jeff D. Barlow
Chief Legal Officer and Secretary

EXHIBIT INDEX

Exhibit No.	Description
99.1	Slide presentation given at the Investor Day Conference of Molina Healthcare, Inc. on September 17, 2015.

Exhibit 99.1


MOLINA HEALTHCARE
Your Extended Family.
2015B
Investor Day
September 17, 2015 / New York, New York

Cautionary Statement

Safe Harbor Statement under the Private Securities Litigation Reform Act of 1995: This slide presentation and our accompanying oral remarks contain numerous "forward-looking statements" regarding, without limitation: our growth and acquisition expectations and strategies; the closing of our announced acquisitions, the success of our integration efforts, and the projected revenues and profitability of our acquisitions; our ongoing margin improvement efforts; dual demonstration program growth and program extensions; financial reconciliations under our various government contracts; the reimbursement of the ACA health insurer fee; our projected earnings for the second half of 2015; our longer-term financial objectives; expected rate changes; the continuation of our Puerto Rico contract; and various other matters. All of our forward-looking statements are subject to numerous risks, uncertainties, and other factors that could cause our actual results to differ materially. Anyone viewing or listening to this presentation is urged to read the risk factors and cautionary statements found under Item 1A in our annual report on Form 10-K, as well as the risk factors and cautionary statements in our quarterly reports and in our other reports and filings with the Securities and Exchange Commission and available for viewing on its website at www.sec.gov. Except to the extent otherwise required by federal securities laws, we do not undertake to address or update forward-looking statements in future filings or communications regarding our business or operating results.

Investor day 2015B

Agenda

Approx. Time	Topic	Speaker
12:30pm-12:35pm	Opening Remarks	Juan José Orellana, SVP Investor Relations
12:35pm-1:20pm	Business Overview	J. Mario Molina, MD, Chief Executive Officer
1:20pm-1:35pm	Operations Review	Terry Bayer, Chief Operating Officer
1:35pm-1:55pm	Q&A	
1:55pm-2:15pm	Break	
2:15pm-2:45pm	Accounting Review	Joseph White, Chief Accounting Officer
2:45pm-3:30pm	Acquisition and Margin Improvement Review	John Molina, Chief Financial Officer
3:30pm-3:50pm	Q&A	
3:50pm	End of Program	

Key investor inquiries

How will Molina continue to grow?
What's changing in our space?
Why Providence Human Services?
What else is expected in 2015?
What progress is being made in improving margins?

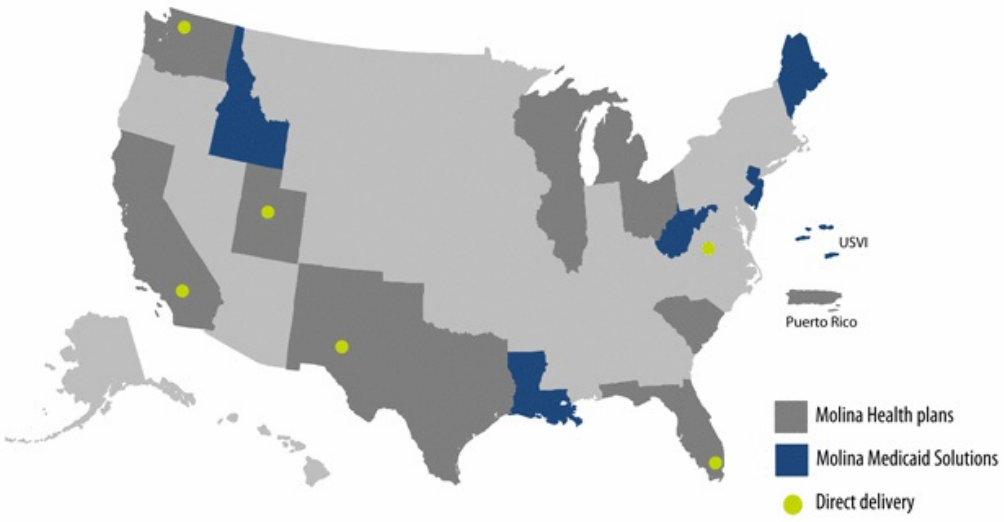

MOLINA HEALTHCARE
Your Extended Family.
2015B
Investor Day
J. Mario Molina M.D.
President & Chief Executive Officer
September 17, 2015 / New York, New York

Our mission

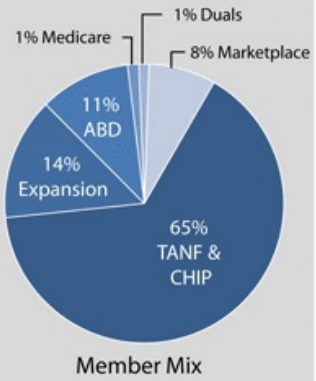
To provide quality health care to people receiving government assistance

Our footprint today

Health plan footprint includes 4 of 5 largest Medicaid markets



3.4M[1]
Members

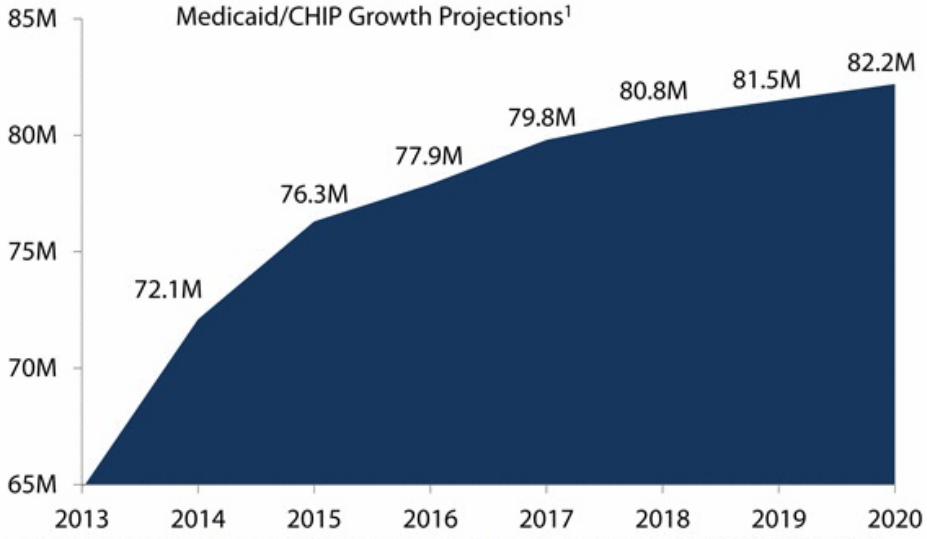


Member Mix

1. Total enrollment relates to effective membership as of June 30, 2015

Growth

While growth in the Medicaid program was significant between 2013-2015, steady organic growth is expected over the next five years.



1. CMS, Office of the Actuary, National Health Expenditure Projections 2014 - 2024, Table 17 Health Insurance Enrollment and Enrollment Growth Rates https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
2. Enrollment as of June 30, 2015

Year to Date Enrollment Growth

December31, 2014

2.6M

members

Investor Day 2015B (today)

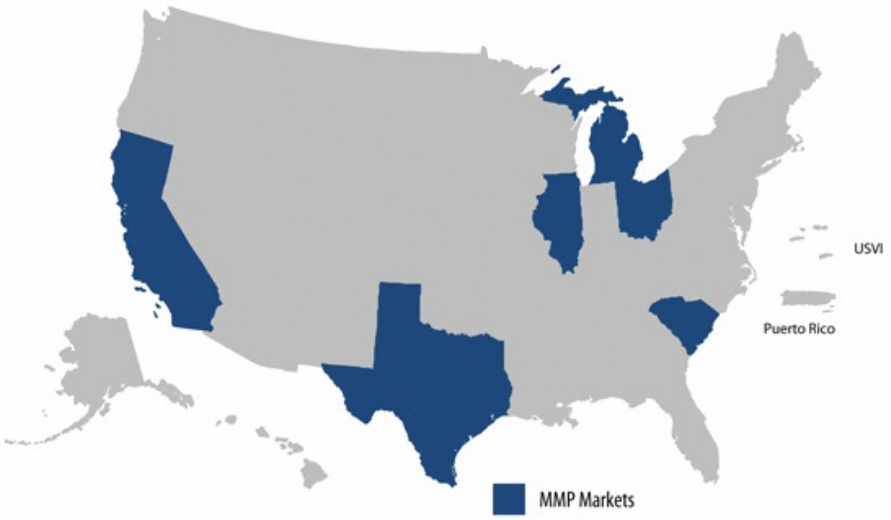
3.4M[2]

members

Where will our growth come from?

Continued organic growth in Medicare-Medicaid Plans (MMP)

Dual eligible markets



Enrollment

	December 2014	August 2015[1]
California	11K	15K
Illinois	5K	4K
Michigan	-	8K
Ohio	2K	10K
South Carolina[2]	-	<1K
Texas	-	15K
Total	**18K**	**53K**

1. CMS enrollment data as of August, 2015
2. Voluntary enrollment only as of August, 2015

In-market health plan acquisitions

MyCareChicago
The healthcare network of Accountable Care Chicago

State: Illinois
Enrollment: 60,000
Annualized Revenue: $200M

HealthPlus
The Right Plan for a Healthier You

State: Michigan
Enrollment: 85,000
Annualized Revenue: $270M

First Coast Advantage

State: Florida
Enrollment: 62,000
Annualized Revenue: $200M

Preferred medical plan medicaid

State: Florida
Enrollment: 25,000
Annualized Revenue: $80M

Integral Quality Care

State: Florida
Enrollment: 90,000
Annualized Revenue: $250M

Note: Estimated revenue based on annualized Company estimates

- Generally asset purchases
- Provide additional scale in existing areas
- Increase access into new service areas
- Accretive
- Approximately **$1.0B** total annualized revenue

Marketplace

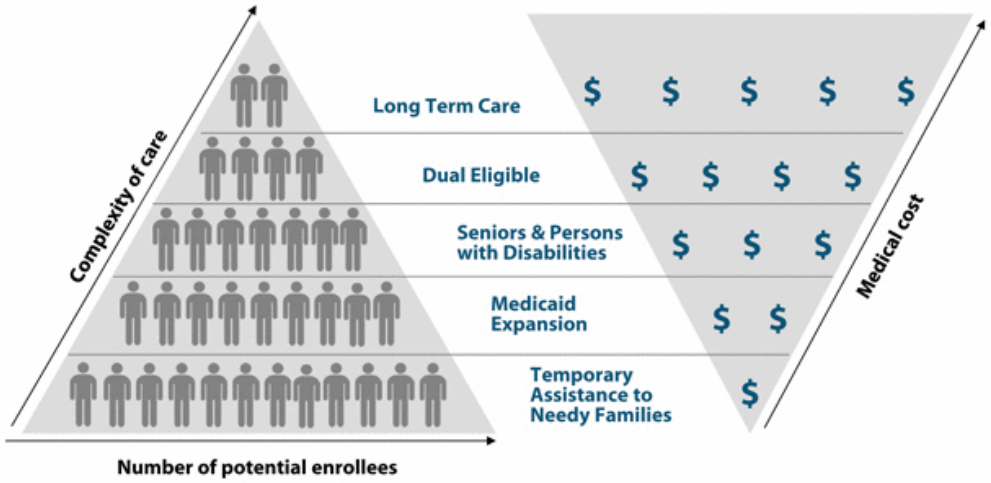
Penalty for not having coverage in 2016 is 2.5% of yearly household income or $695 per adult (half for those under 18)

93% of Molina marketplace members receive government subsidies

1. Company's approximate enrollment as of August, 2015

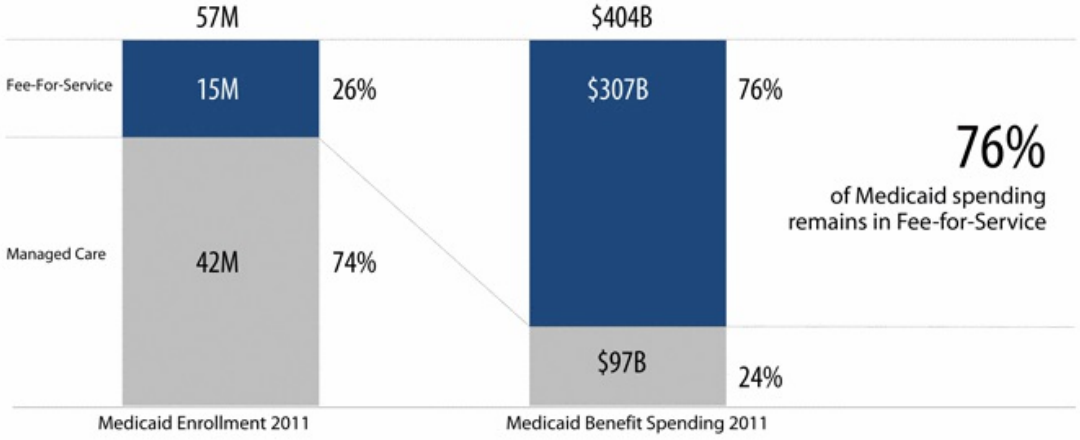
Increasing complexity drives higher spend

Complex members continue to transition into managed care



Fee for service remains significant

Managed care organizations and fee for service FY 2011

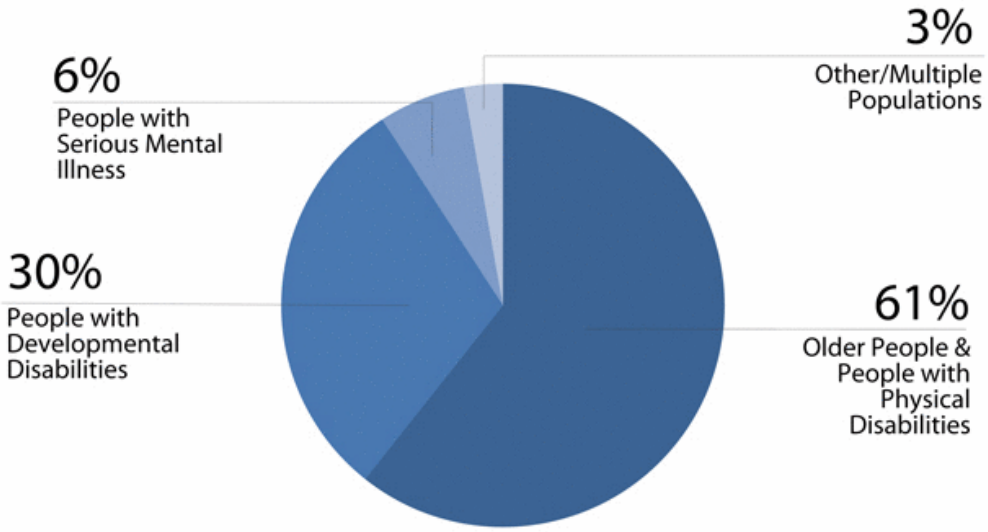


Sources:

1. Medicaid and CHIP Payment and Access Commission; Report to the Congress on Medicaid and CHIP; June 2014
2. CMS Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2011; June 1, 2012

Medicaid Long Term Services and Supports (LTSS)

LTSS is a significant portion of fee for service spend

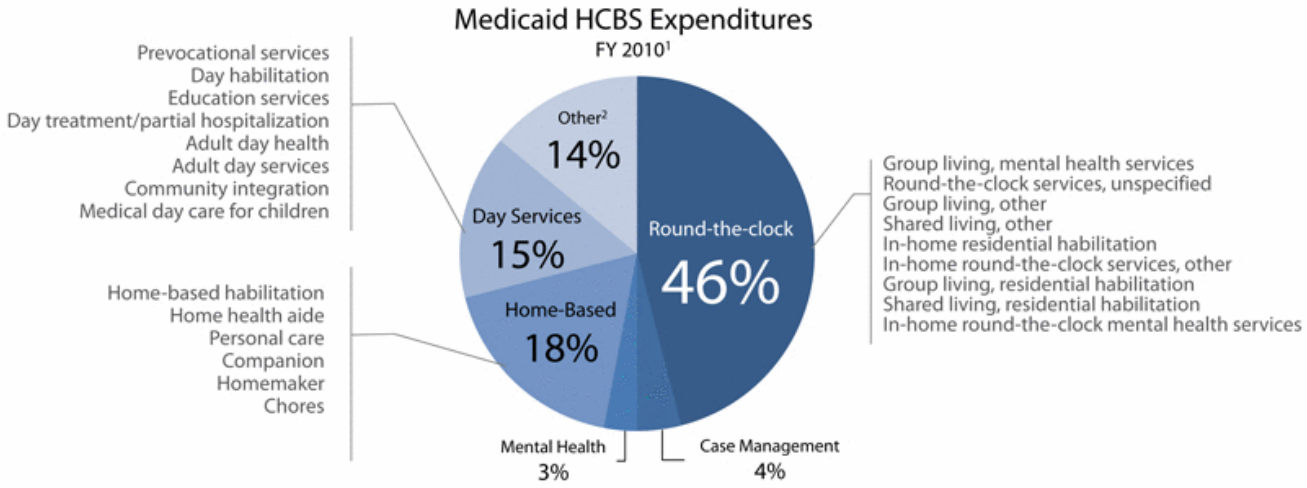


Full Medicaid LTSS Spend in 2012: $140 Billion[1]

1. Truven Health Analytics. 'Medicaid Expenditures for Long-Term Services and Supports in FFY 2012; published April 28, 2014.

Home and Community Based Services

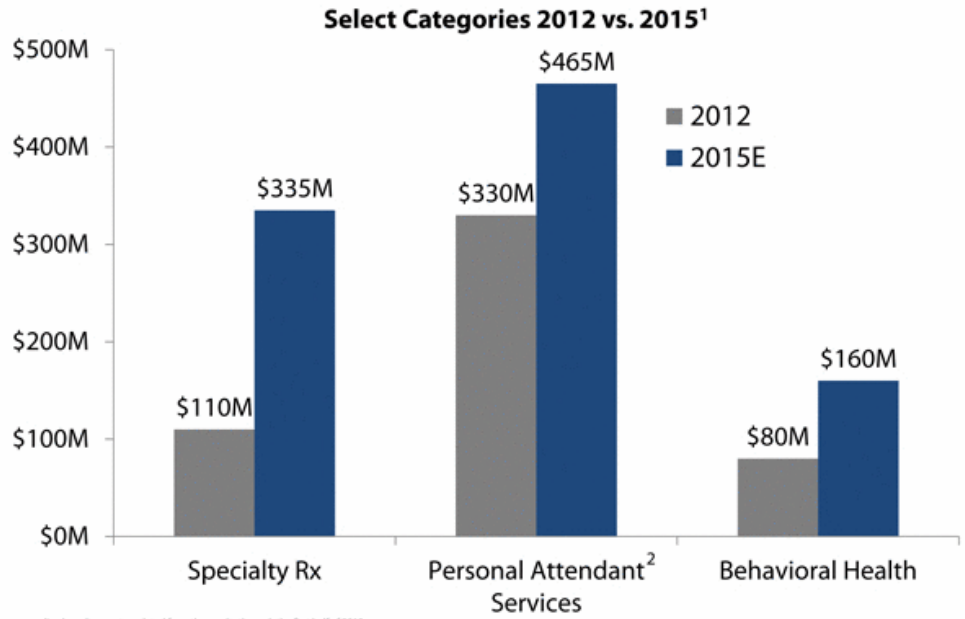
Behavioral and mental health services are significant drivers of cost



Medicaid HCBS total spend in 2012: $69B

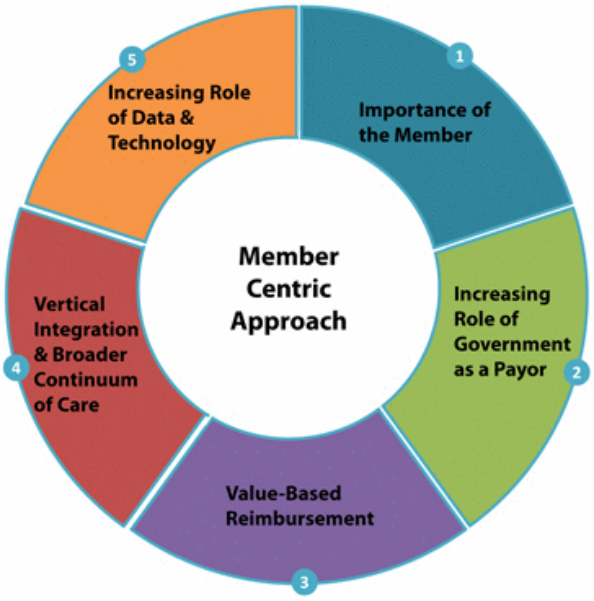
1. Mathematica Policy Research. 'The HCBS Taxonomy: A New Language for Classifying Home- and Community-Based Services', August 2013.
2. Other includes expenses related to goods and services, interpreters, housing consultation, and claims where the procedure code could not be interpreted.

Molina – changes in spend



1. 2015 estimates are based on full year annualized results as extrapolated from the results through the first half of 2015
2. Excludes amounts paid by state Medicaid agencies on Molina's behalf

Capability-based provider acquisitions – changes in delivery



1. **Importance of the Member**
   Member will pay a larger portion of medical costs through Member-Directed / High Deductible Health Plans and Health Insurance Exchanges, and will demand increased choice and access to care, more information regarding price, treatment options and information technology

2. **Increasing Role of Government as a Payor**
   Medicare, Medicaid and Exchanges represent the fastest growth areas

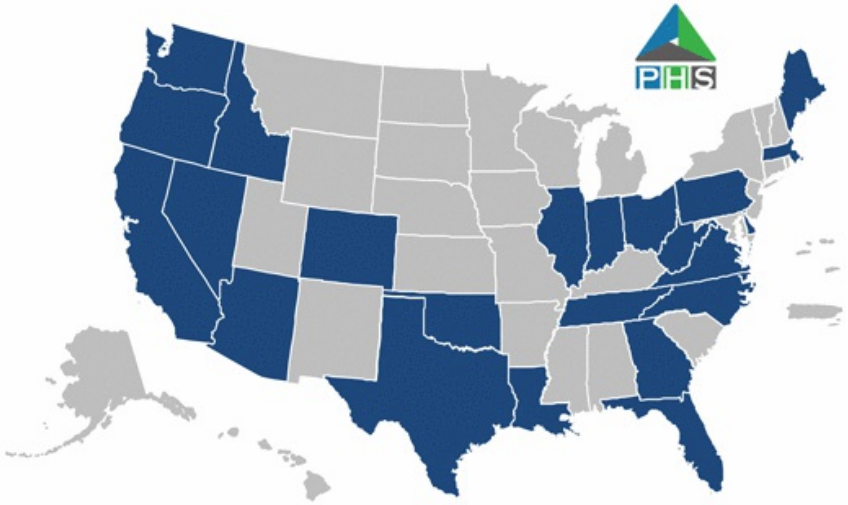
3. **Value-Based Reimbursement**
   Shifting from Fee-For-Service to risk-based capitation and bundled payments, increasing role of Accountable Care Organizations (ACOs)

4. **Vertical Integration & Broader Continuum of Care**
   Ownership of provider/care delivery assets to better manage care and medical costs, and capture "care margin"

5. **Increasing Role of Data & Technology**
   HCIT is critical to the measurement and management of medical cost and engagement with the patient

Capability-based provider acquisition – behavioral health

Providence Human Services[1], a multi-state, behavioral/mental health and social services provider

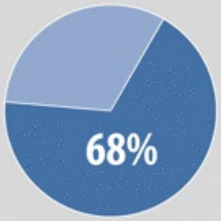


- Operations in 23 states + DC
- Medicaid focus:
  - 80% of revenue
  - Approximately 70% of all contracts are FFS
- Diverse revenue base:
  - ~100 contracts represent 70% of total revenue
- More than 6,800 employees
- Consideration ~ $200M[2]

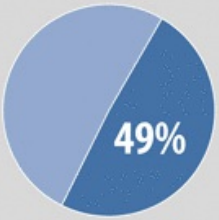
1. The PHS transaction was announced on September 3, 2015 and is subject to regulatory approvals and the satisfaction of other closing conditions
2. Subject to customary working capital and adjustments

Diagnoses of behavioral and mental health conditions are increasing

Mental and substance use disorders are expected to **surpass all physical diseases** as a major cause of worldwide disability by 2020



68% of adults with mental illness also have at least **1 chronic physical illness**.



49% of Medicaid enrollees with disabilities **have a psychiatric illness.**

2X

Prevalence of mental illness among the **Medicaid population** is twice that of the general population

2X-3X

Treatment of chronic physical health issues for patients with behavioral health needs is 2 to 3 times more expensive than patients with physical health only needs.

Source: Annals of Internal Medicine: Crowley RA, Kirschner N, for the Health and Public Policy Committee of the American College of Physicians. The Integration of Care for Mental Health, Substance Abuse, and Other Behavioral Health Conditions into Primary Care: Executive Summary of an American College of Physicians Position Paper. Ann Intern Med. 2015;163:298-299. doi:10.7326/M15-0510

Molina members with complex conditions

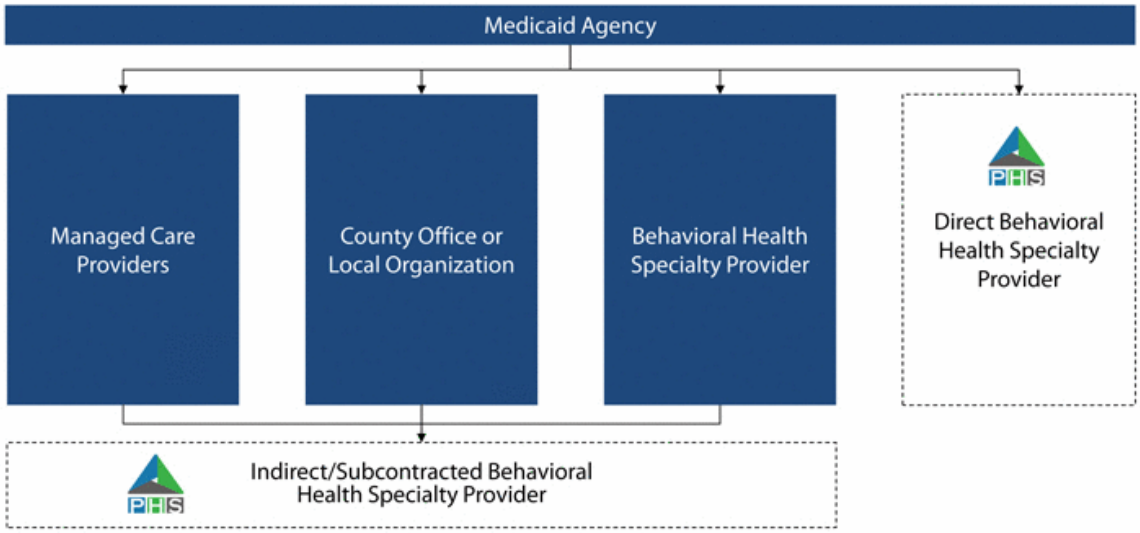
Top diagnoses by segment by number of admits/cases trailing 12 months[1]

TANF Diagnoses	ABD Diagnoses	Dual Eligibles Diagnoses
Inpatient Services		
Delivery	Septicemia	Septicemia
Complications of delivery	Schizophrenic disorders	Care involving use of rehabilitation procedures
Other maternal complications	Affective psychoses	Schizophrenic disorders
Prolonged pregnancy	Other diseases of lung	Pneumonia
Affective psychoses	Chronic bronchitis	Diabetes
Outpatient Services		
Well Child care	Renal failure	Renal failure
Acute upper respiratory infection	Schizophrenic disorders	Schizophrenic disorders
Normal Pregnancy	Hypertension	Affective psychoses
Other maternal complications	Diabetes	Diabetes
General symptoms	Affective psychoses	Hypertension

1. Based on Company data ending June 30, 2015

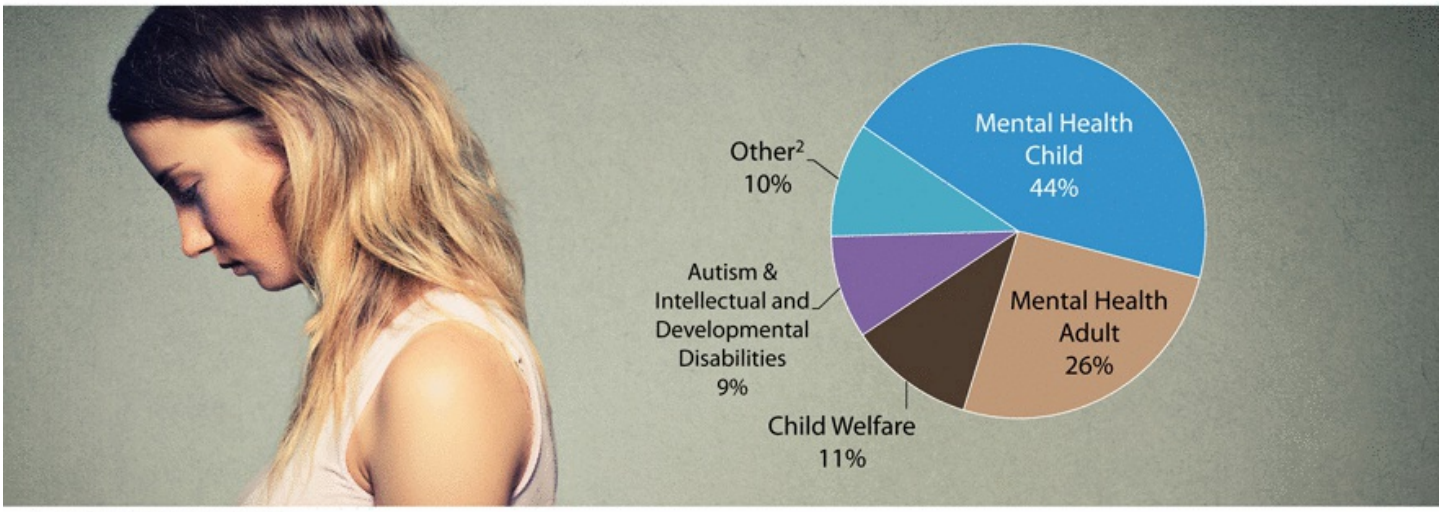
PHS – Adaptable contracting options

Different regulations/reimbursement policies dictate which services are offered in a particular geography



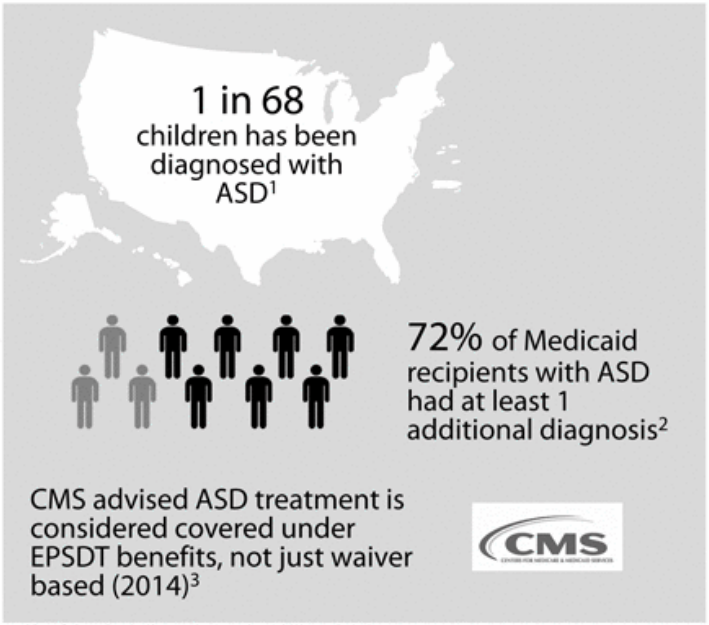
What services does PHS provide?

More than 80% of revenues are related to services focused on Mental Health[1]



1. Based on Net Adjusted Revenues through 2014
2. Other includes Educational, Probational, and Substance Abuse

Autism spectrum disorders (ASD) and Medicaid



Increasingly being included in new state RFPs and Federal Regulations.

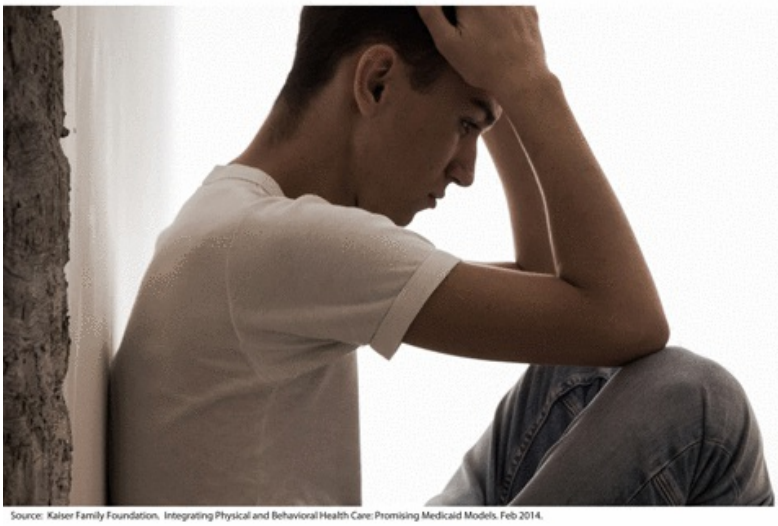
- 2013 Virginia Medicaid
- Puerto Rico
  - Care coordination
- 2015 Washington Foster Care
  - Care coordination
- 2015 Iowa Medicaid
- 2015 Wisconsin rate build

1. US Centers for Disease Control and Prevention. http://www.cdc.gov/ncbddd/autism/data.html
2. Milliman Medicaid Issues Briefing Paper . http://us.milliman.com/uploadedFiles/insight/2015/expansion-asd-treatment.pdf
3. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. CMS CMCS Information Bulletin, July 7, 2014. http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

A growing need in Medicaid

Source: Kaiser Family Foundation. Integrating Physical and Behavioral Health Care: Promising Medicaid Models. Feb 2014.

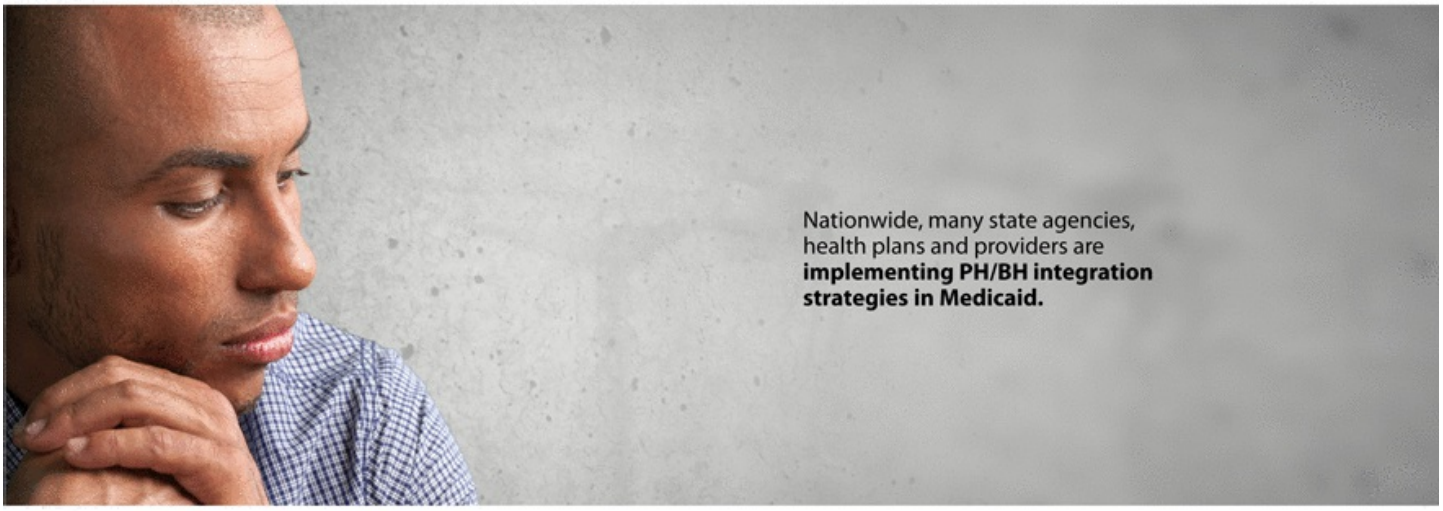
An essential benefit



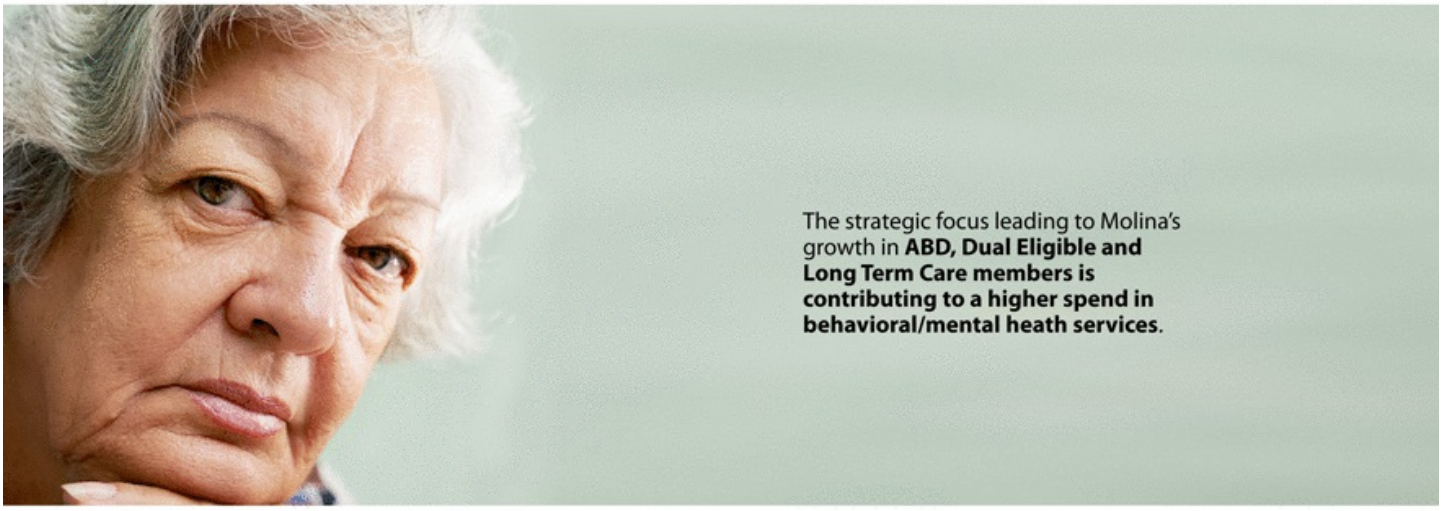
The **ACA specifically includes mental health and substance use disorder services as one of the ten categories of required "essential health benefits,"** and the law requires parity between the mental and physical health benefits covered by health plans.

Source: Kaiser Family Foundation. Integrating Physical and Behavioral Health Care: Promising Medicaid Models. Feb 2014.

Integration



A strategic focus identifies greater needs



The strategic focus leading to Molina's growth in **ABD, Dual Eligible and Long Term Care members is contributing to a higher spend in behavioral/mental heath services.**

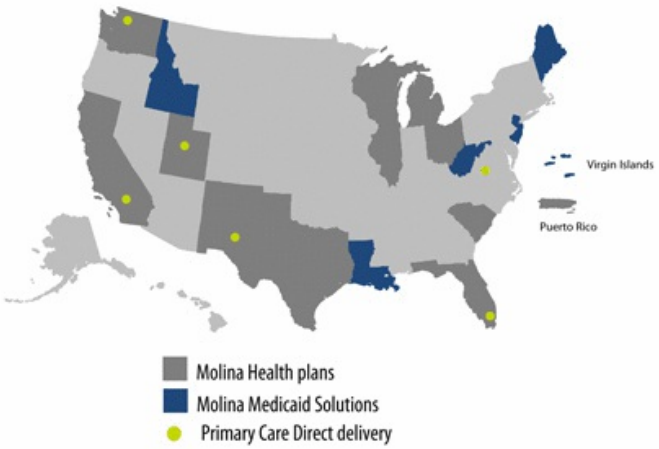
A new provider capability

PHS revenue is generated **by 5,700 client-facing social workers, behavioral/mental health workers, case managers, licensed clinicians, psychologists, nurses and psychiatrists.**

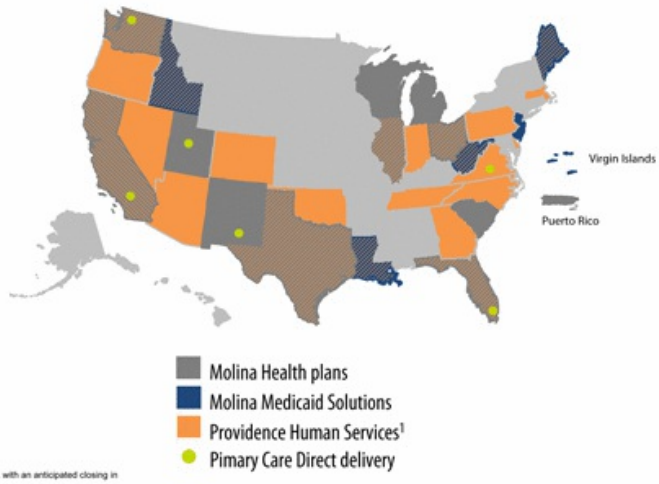
Providence acquisition pro-forma footprint

Molina will have a presence in 28 states 2 Commonwealths + Washington D.C.
Please refer to the Company's cautionary statement on page 2 of this presentation

Today



Post Close



1. Behavioral/Mental health and social services capabilities added through the acquisition of Providence Human Services (PHS) and Providence Community Services (PCS), with an anticipated closing in 4Q2015, pending regulatory approvals and the satisfaction of other closing conditions.

One of a kind

Flexible health services portfolio (health plans, direct delivery, MMIS)

Focused on people receiving government assistance

Scalable administrative infrastructure

Consistent national brand

Seasoned management team

Unique culture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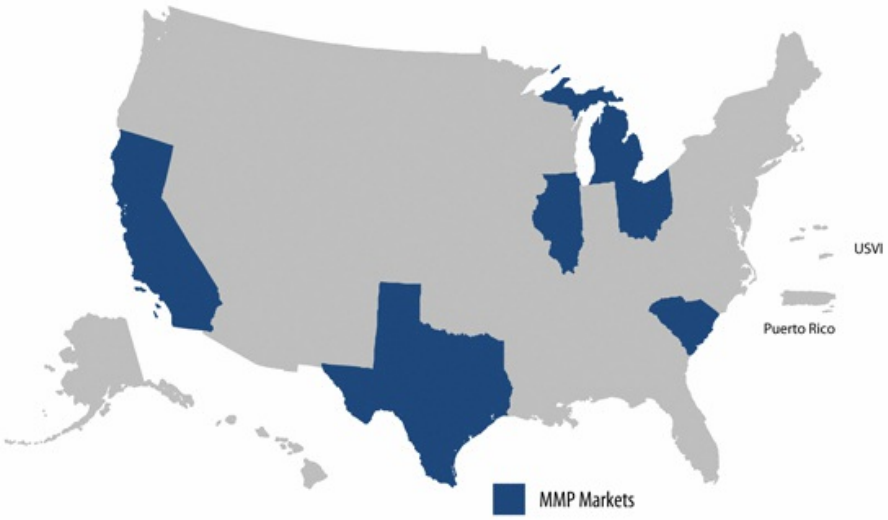
Terry Bayer
Chief Operating Officer
September 17, 2015 / New York, New York

Medicare-Medicaid Plans (MMP)

Dual eligible markets



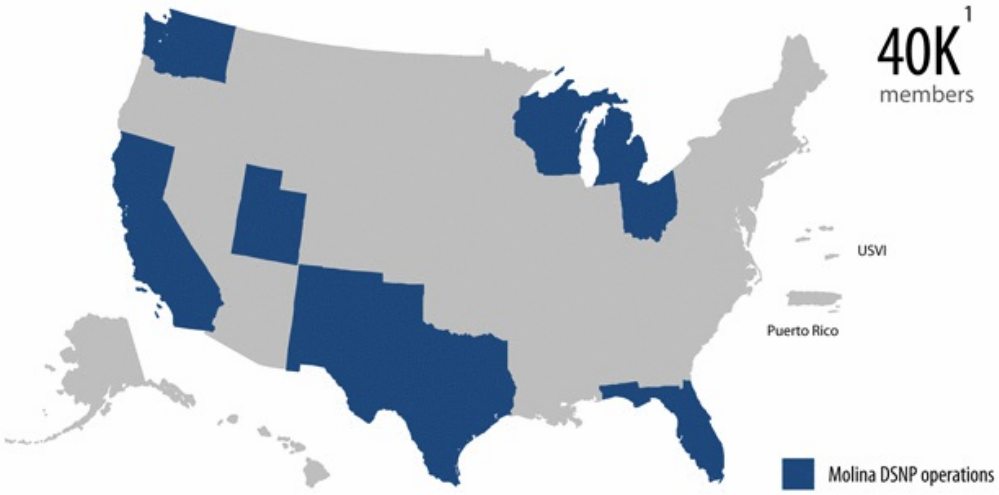
Enrollment

	December 2014	August 2015[1]
California	11K	15K
Illinois	5K	4K
Michigan	-	8K
Ohio	2K	10K
South Carolina[2]	-	<1K
Texas	-	15K
Total	**18K**	**53K**

1. CMS enrollment data as of August, 2015
2. Voluntary enrollment only as of August, 2015

Medicare – Dual Eligible Special Needs Plan

Our DSNP enrollment extends our dual eligible reach beyond just the Medicare Medicaid Plans



1. CMS enrollment data as of August, 2015

What's new with the duals?

2 year extension

From CMS for existing dual demonstration programs. **All 6** of Molina's states submitted letters of intent before the September 1st deadline

- CA, IL, OH extended until December 2019
- MI, SC, TX extended until December 2020

Opportunities for continued growth

- Age-ins
- Part D re-assignees
- Other passive enrollment opportunities at the state level

Retention

Reaching out to members that have opted out resulted in more than **2K** members returning to Molina.

More than **7K** dual members enrolled voluntarily, and have a **50%** lower rate of disenrollment.

Marketplace

Penalty for not having coverage in 2016 is 2.5% of yearly household income or $695 per adult (half for those under 18)

230K[1] members

- 81% of our Marketplace revenue is in the form of subsidies
- Nationally 84% of Marketplace enrollees receive the advanced premium tax credit subsidys[2]
- 75% of Molina Marketplace membership are in a silver plan

93% of Molina marketplace members receive government subsidies

1. Company's approximate enrollment as of August, 2015
2. CMS June 30, 2015 Effectuated Enrollment Snapshot, released September 8, 2015; https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-09-08.html

Marketplace – staying true to the strategy

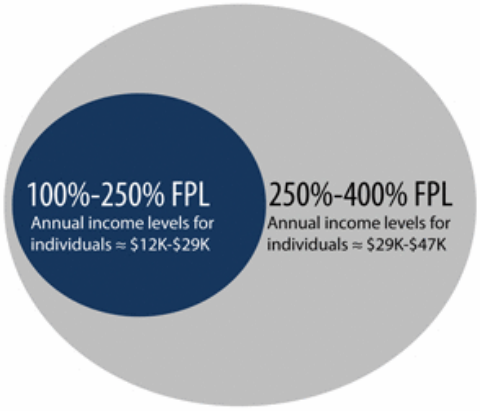
Priority segment: 100%-250% FPL

Medicaid transitioners; parents of CHIP members; ex-Medicaid members; low-income uninsured

Heavily subsidized

Used to getting care from safety net providers

Require enhanced services



Ensuring continuity of care to those transitioning from Medicaid

Marketplace – staying true to the strategy

Example: CA Minimum Wage

$9.00 per hour

$18,720 annualized

Premium assistance for marketplace is calculated based on the federal poverty scale. Individuals who earn **<138%** of the FPL **qualify for Medicaid.**

FEDERAL POVERTY LEVELS & INCOME[1,2]					
Size of Household	**133%**	**138%**	**150%**	**200%**	**250%**
1	$ 15,654	$ 16,243	$ 17,655	$ 23,540	$ 29,425
2	$ 21,187	$ 21,983	$ 23,895	$ 31,860	$ 39,825
3	$ 26,720	$ 27,724	$ 30,135	$ 40,180	$ 50,225
4	$ 32,253	$ 33,465	$ 36,375	$ 48,500	$ 60,625
5	$ 37,785	$ 39,206	$ 42,615	$ 56,820	$ 71,025

Hourly rate $12.85

Hourly rate $14.49

Small hourly rate increases can affect Medicaid eligibility and marketplace subsidies

1. Office of the Assistant Secretary for Planning and Evaluation. http://aspe.hhs.gov/2015-poverty-guidelines
2. All dollar amounts are for the 48 contiguous states and DC

Puerto Rico

Molina was awarded Medicaid contracts in two regions in late 2014

Commenced operations on **April 1, 2015**

361,000 members as of 2Q2015

Estimated annualized revenue of **$750M**

Commonwealth continues to pay us weekly and is current

Q&A


MOLINA HEALTHCARE
Your Extended Family.
2015B
Investor Day
Joseph White
Chief Accounting Officer
September 17, 2015 / New York, New York

2015 income statement (unaudited)

Please refer to the Company's cautionary statement on page 2 of this presentation

Dollars (in millions)

	YTD June 2015 Actual	FY 2015 Outlook[1]	Remaining Outlook[2]
Premium Revenue	$6.3B	$13.5B	$7.2B
Health Insurer Fee Revenue	$122M	$260M	$138M
Premium Tax Revenue	$190M	$400M	$210M
Service Revenue	$99M	$180M	$81M
Investment and Other Income	$10M	$17M	$7M
Total Revenue	**$6.7B**	**$14.3B**	**$7.6B**
Total Medical Care Cost	**$5.6B**	**$12.1B**	**$6.5B**
Medical Care Ratio[3]	*88.7%*	*89.5%*	*n/a*
Total Cost of Service Revenue	$69M	$145M	$76M
General & Administrative Expenses	**$0.5B**	**$1.1B**	**$0.6B**
G&A Ratio[4]	*8.1%*	*7.6%*	*n/a*
Premium Tax Expense	$190M	$400M	$210M
Health Insurer Fee Expense	$81M	$165M	$84M
Depreciation & Amortization	$50M	$105M	$55M
Interest & Other Expense	$30M	$60M	$30M
Income before Taxes	$168M	$300M	$132M
Net Income	**$67M**	**$132M**	**$65M**
EBITDA[5]	**$256M**	**$485M**	**$229M**
Effective Tax Rate	*60.1%*	*56.0%*	*n/a*
Net Income Per Diluted Share	**$1.29**	**$2.35**	**$1.06**
Adjusted Net Income Per Diluted Share[5]	**$1.57**	**$2.90**	**$1.33**

Amounts are estimates – actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings

1. Reflects fiscal year 2015 outlook as provided on June 1, 2015
2. Remaining outlook is the result of FYI 2015 outlook less YTD June 2015 actual only
3. Medical Care Ratio represents medical care costs as a percent of premium revenue
4. G&A ratio computed as a percentage of total revenue
5. See reconciliation of unaudited non-GAAP financial measures

Reconciliation of non-GAAP financial measures

EBITDA and adjusted net income

Please refer to the Company's cautionary statement on page 2 of this presentation.

EBITDA	YTD June 2015 Actual	FY 2015 Outlook[1]	Remaining Outlook[2]
Net income	$67M	$132M	$65M
Adjustments:			
Depreciation, and amortization of intangible assets and capitalized software	$58M	$125M	$67M
Interest expense	$30M	$60M	$30M
Income tax expense	$101M	$168M	$67M
EBITDA	**$256M**	**$485M**	**$229M**

Adjusted net income per diluted share	YTD June 2015 Actual	FY 2015 Outlook	Remaining Outlook
Net income per diluted share	$1.29	$2.35	$1.06
Adjustments, net of tax:			
Amortization of convertible senior notes and lease financing obligations	$0.18	$0.35	$0.17
Amortization of intangible assets	$0.10	$0.20	$0.10
Adjusted net income per diluted share	**$1.57**	**$2.90**	**$1.33**

Amounts are estimates – actual results may differ materially. See our risk factors as discussed in our Form 10-K and other periodic filings

1. Reflects fiscal year 2015 outlook as provided on June 1, 2015
2. Remaining outlook is the result of FYI 2015 outlook less YTD June 2015 actual only

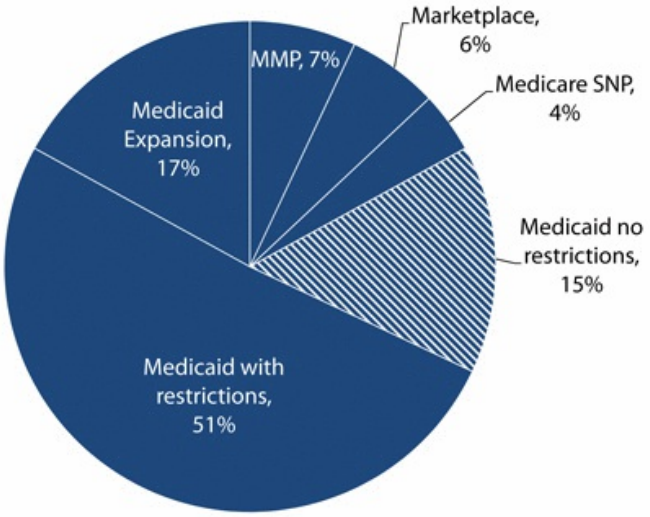
Uncertainties relating to 2nd half earnings

Please refer to the Company's cautionary statement on page 2 of this presentation

Issues	State
MCR floor reconciliation	CA, NM, WA
Cost plus reconciliation	NM
Quality revenue	TX
HIF reimbursement	MI
MCR	PR / MI MMP/ TX MMP / Acquisitions / FL Rates

Profit restrictions are significant

85% of Premium revenue earned YTD 6/30/2015 is subject to profit restrictions



% of revenue subject to profit restrictions:

Medicaid: 75%

Medicaid Expansion: 100%

MMP Duals: 100%

Marketplace: 100%

Medicare SNP: 100%

Payables due to profit restrictions

Please refer to the Company's cautionary statement on page 2 of this presentation

	Dec-14	Jun-15
Medicaid Expansion:		
California	~$120M	~$130M
New Mexico	~$25M	~$50M
Washington	~$240M	~$270M
Others	-	~$15M
Medicaid Expansion Subtotal	~$385M	~$465M
Marketplace	-	~$40M
Others	~$15M	~$35M
Total	~$400M	~$540M

Marketplace medical care ratio

How do we report a Marketplace MCR <80%?

	Six Months Ended June 30, 2015[1]						
		Premium Revenue		Medical Care Costs			
	Member Months[2]	Total	PMPM	Total	PMPM	MCR[3]	Medical Margin
TANF and CHIP	12,035	$2,141,316	$177.93	$1,960,315	$162.89	91.5%	$181,001
Medicaid Expansion	2,661	1,089,339	409.29	867,229	325.84	79.6	222,110
ABD	2,120	1,993,366	940.23	1,809,613	853.56	90.8	183,753
Marketplace	1,371	354,725	258.66	245,682	179.15	69.3	109,043
Medicare	264	273,472	1,036.95	269,005	1,020.01	98.4	4,467
MMP	213	422,806	1,986.04	413,474	1,942.20	97.8	9,332
	18,664	$6,275,024	$336.21	$5,565,318	$298.18	88.7%	$709,706

(1) Six months ended June 30, 2014 data not presented due to lack of comparability.

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

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

Different calculations of Marketplace MCR

MOH GAAP MCR

MOH 10K MCR

$$MCR = \frac{\text{Medical Care Cost}}{\text{Premium Revenue}}$$

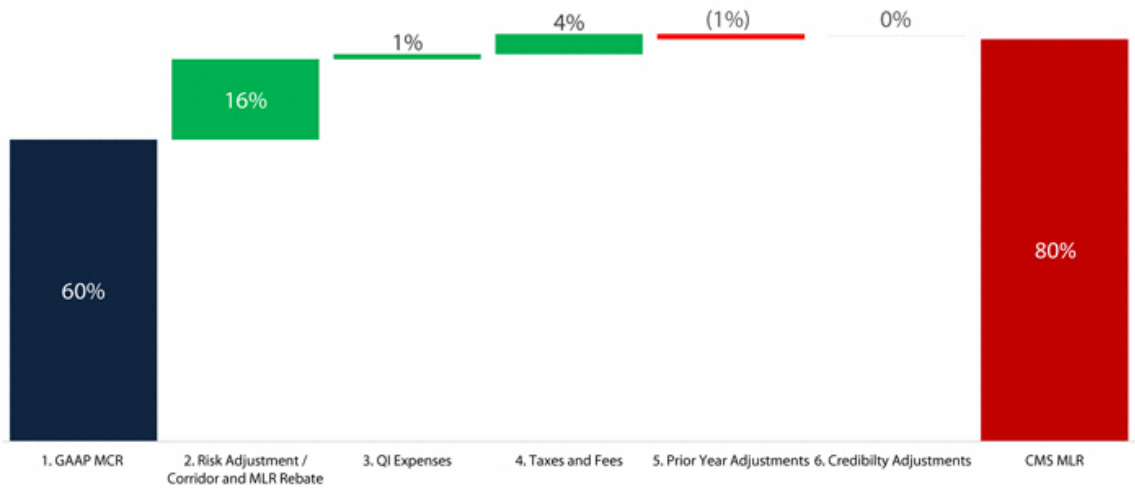
Min MCR Calculation

Federal Register Vol 78 No. 47; Monday March 11, 2013, Part II, HHS Notice of Benefit and Payment Parameters for 2014, Page 15,505

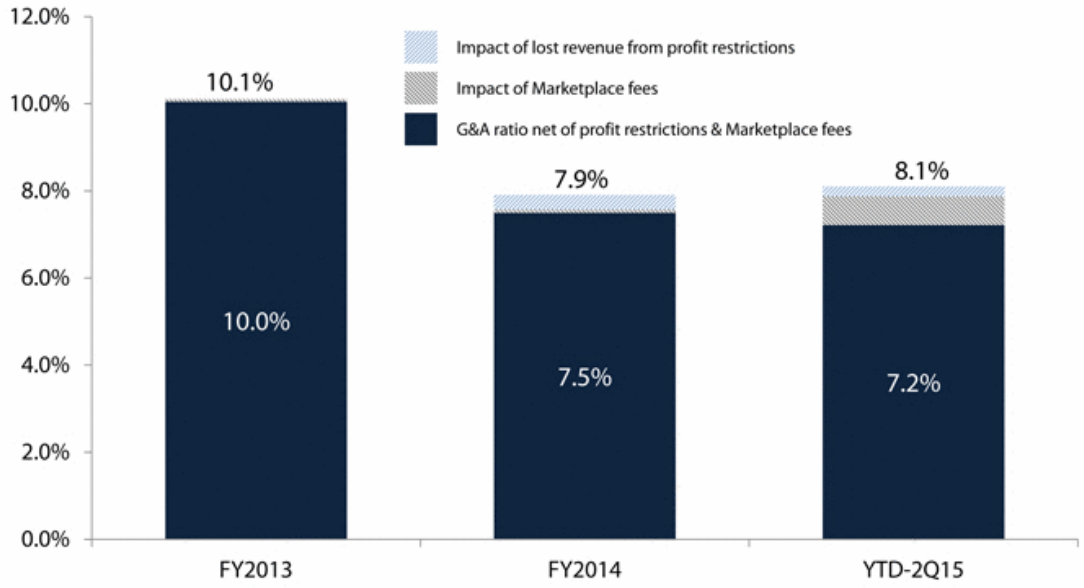
$$MCR = [(i + q - s + n - r)/\{(p + s - n + r) - t - f - (s - n + r)\}] + c$$

i = incurred claims
q = expenditures on quality improving activities
p = earned premiums
t = Federal and State taxes and assessments
f = licensing and regulatory fees, including transitional reinsurance contributions
s = issuer's transitional reinsurance receipts
n = issuer's risk corridors and risk adjustment related payments
r=issuer's risk corridors and risk adjustment related receipts
c = credibility adjustment, if any

Marketplace example - GAAP vs. CMS minimum MCR

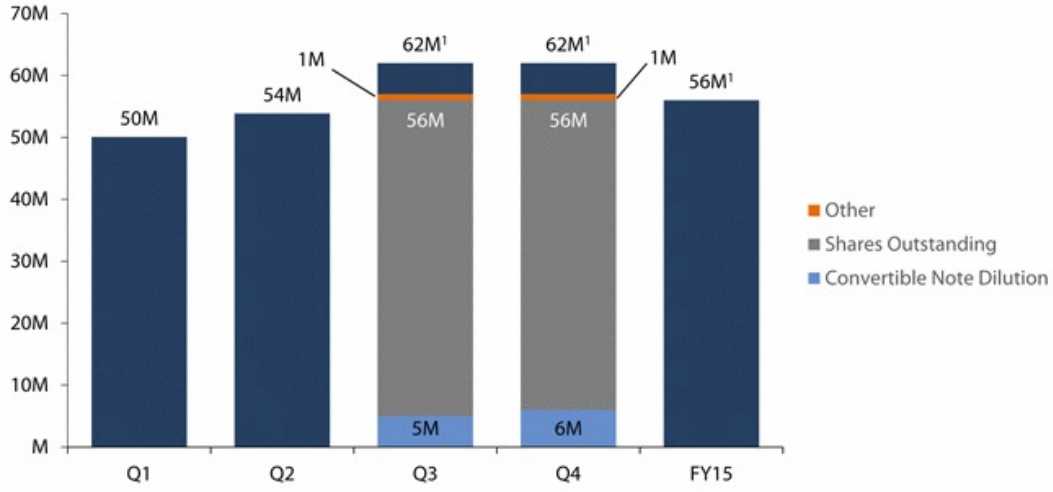


Admin ratio – market place and profit restriction impact



Diluted Shares outstanding 2015 (unaudited)

Please refer to the Company's cautionary statement on page 2 of this presentation



Totals may not add due to rounding

1. Q3, Q4 and FY 15 are estimates


MOLINA HEALTHCARE
Your Extended Family.
2015B
Investor Day
John C. Molina
Chief Financial Officer
September 17, 2015 / New York, New York

Acquisition strategy

How do the pieces fit together?

New Managed Care State	Existing Managed Care State	Provider / Capability
Rationale		
Diversification – revenue, risk, contracts	Fortify competitive position	Enhance provider alignment
Administrative cost leverage – long term	Administrative leverage – short term	Medical cost improvement – medium term
Criteria		
Competitive provider environment	Competitive provider environment	Increased member care oversite / management
Sizeable Medicaid population	Attractive price	Complementary to Molina care model
Favorable regulatory environment	Favorable regulatory environment	Difficult /expensive / timely to develop internally
		Valuable talent

A closer look at our health plan acquisitions

Recent health plan M&A

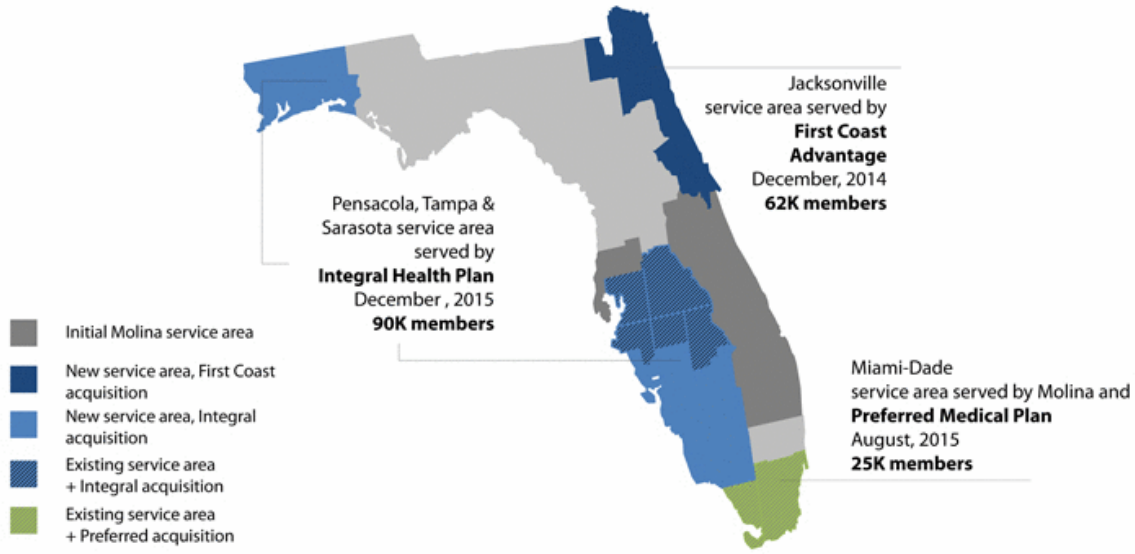
Please refer to the Company's cautionary statement on page 2 of this presentation

Transaction	Status	Membership[1]	Annualized Revenue[1]
MyCare Chicago	Close pending	60,000	$200M
Integral Health Plan	Close pending	90,000	$250M
HealthPlus	Closed	85,000	$270M
Preferred Medical Plan	Closed	25,000	$80M
Subtotal		**260,000**	**$800M**

1. Membership and annualized revenue reflect estimates as of the transaction announcement date for transaction that are pending close. For closed transactions membership reflects actual members transferred to Molina and estimated revenues associated with those members.

Florida Medicaid footprint expansion

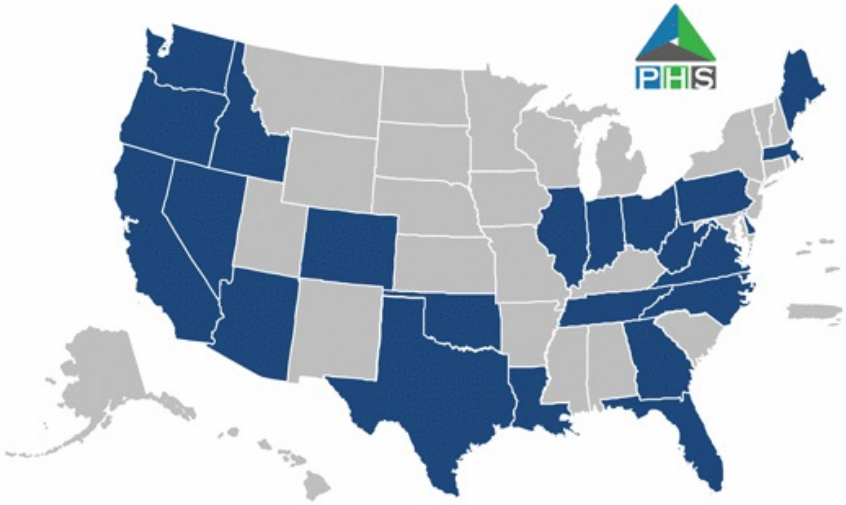
Recent Florida acquisition summary[1,2]



1. Transactions for Integral Health Plan & Preferred Medical have yet to close.
2. Enrollment numbers are estimates, based on the publically announced press release

Capability-based provider acquisition – behavioral health

Providence Human Services[1], a multi-state, behavioral/mental health and social services provider



- Operations in 23 states + DC
- Medicaid focus:
  - 80% of revenue
  - Approximately 70% of all contracts are FFS
- Diverse revenue base:
  - ~100 contracts represent 70% of total revenue
- More than 6,800 employees
- Consideration ~ $200M[2]

1. The PHS transaction was announced on September 3, 2015 and is subject to regulatory approvals and the satisfaction of other closing conditions
2. Subject to customary working capital and adjustments

Providence Human Services strategic rationale

Why Molina?

Medicaid focus

Significantly advances our behavioral/mental health capabilities

Builds upon our direct delivery infrastructure

Creates market presence in new states relevant to these patients

Why PHS?

Medicaid focus

A viable stand alone business that brings new capabilities and overall margin improvement to our health plans

Large behavioral/mental health provider with flexible model and adaptable services offering

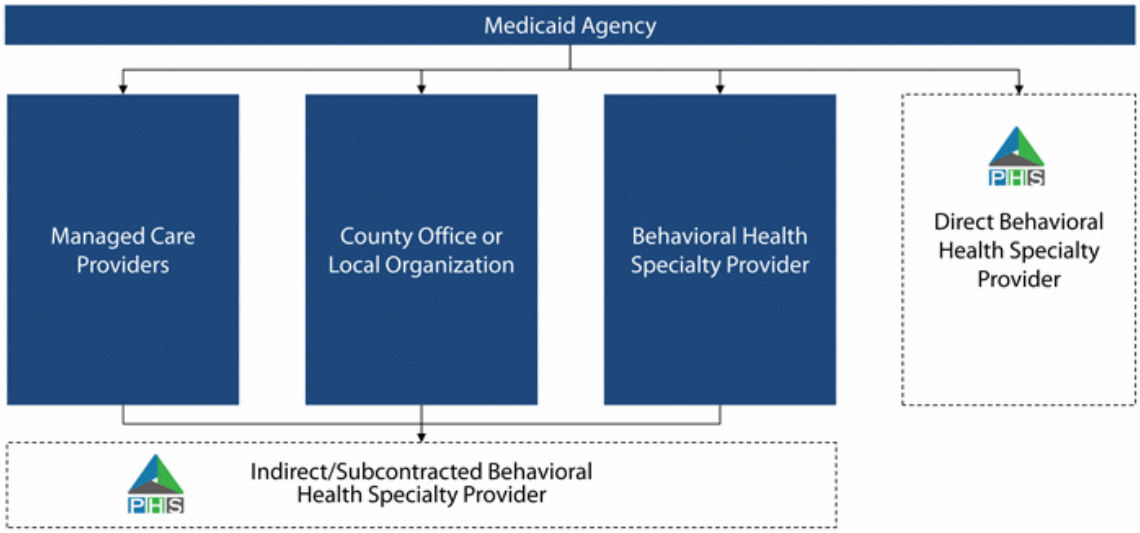
Cross expansion opportunities to Molina geographies

Cultural fit, mission and philosophy

2016+
FORTIFY
Consistent with our long term objectives of improving the model of care, enhancing our systems and improving our margins.

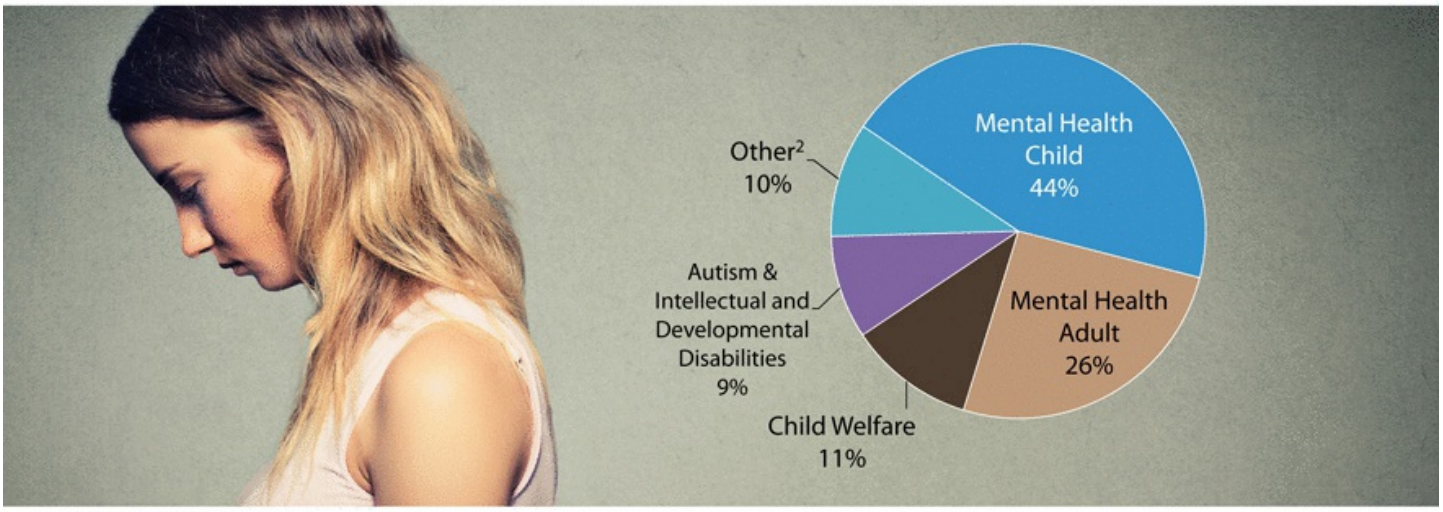
PHS – Adaptable contracting options

Different regulations/reimbursement policies dictate which services are offered in a particular geography



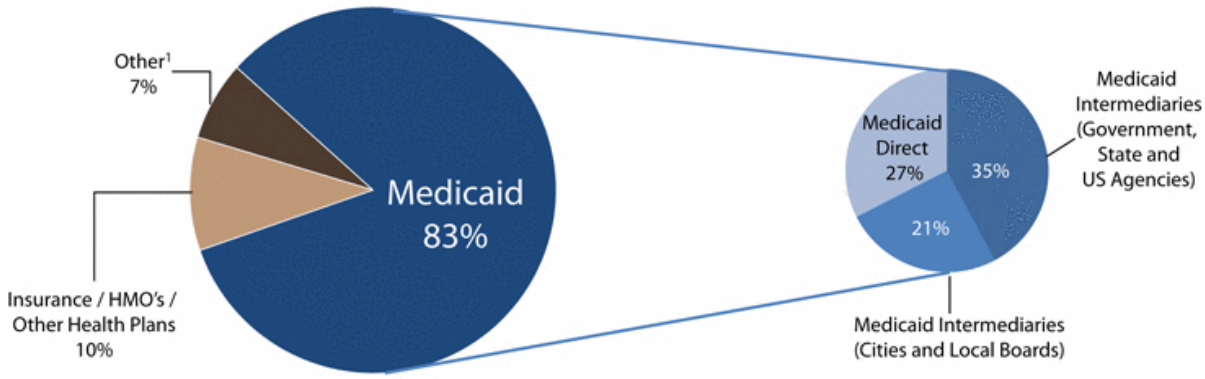
What services does PHS provide?

More than 80% of revenues are related to services focused on Mental Health[1]



1. Based on Net Adjusted Revenues through 2014
2. Other includes Educational, Probational, and Substance Abuse

PHS – net revenue breakdown by payor



1. Other includes Educational, Probational, Workforce Development and Substance Abuse

2015 and beyond

MOLINA HEALTHCARE

2013 INCUBATE	2014 TRANSITION & GROW	2015 DEVELOP & GROW	2016+ FORTIFY
			
▪ Acquire new business ▪ Design systems ▪ Test readiness ▪ Invest in infrastructure ▪ New business: SC, Duals, Marketplace, Medicaid Expansion, NM & FL re-procurements, WI Medicare	▪ Transition members into model of care ▪ Address pent-up demand ▪ Adjust premiums ▪ Process transition issues ▪ Begin leveraging infrastructure ▪ Invest to prepare for 2015 revenue	▪ Transition members into model of care ▪ Address pent-up demand ▪ Adjust premiums ▪ Improve systems ▪ Ensure equitable rates ▪ Leverage administrative costs	▪ Improve model of care ▪ Enhance systems ▪ Improve margins

2017 Financial objectives

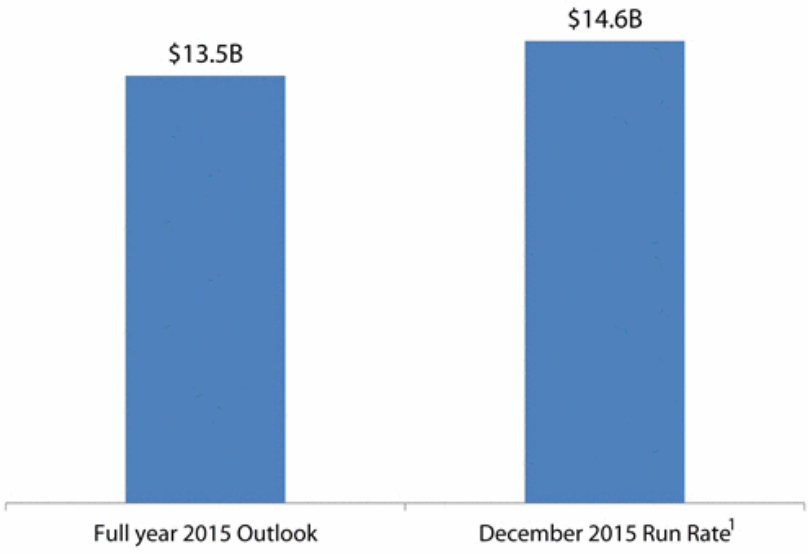
Please refer to the Company's cautionary statement on page 2 of this presentation

	How will we get there?
Revenue growth	Actuarially sound premium rates
~0.5%-1.5% decline in medical cost ratio	Manage inpatient costs
~0.5% - 1.0% decline in G&A ratio	Network alignment
Target: ~1.5% - 2.0% after tax margin	Retention of members

Premium revenue

We expect 2016 premium revenue to be at least $1.0B higher than in 2015

Please refer to the Company's cautionary statement on page 2 of this presentation

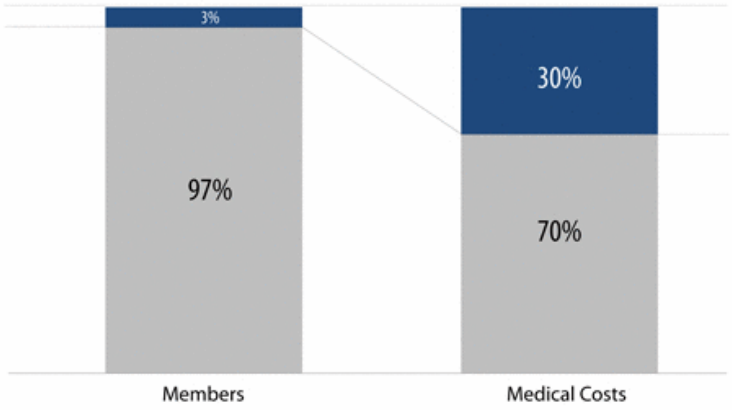


Both numbers are Company estimates

1. Month of December 2015 Annualized

High cost member intervention

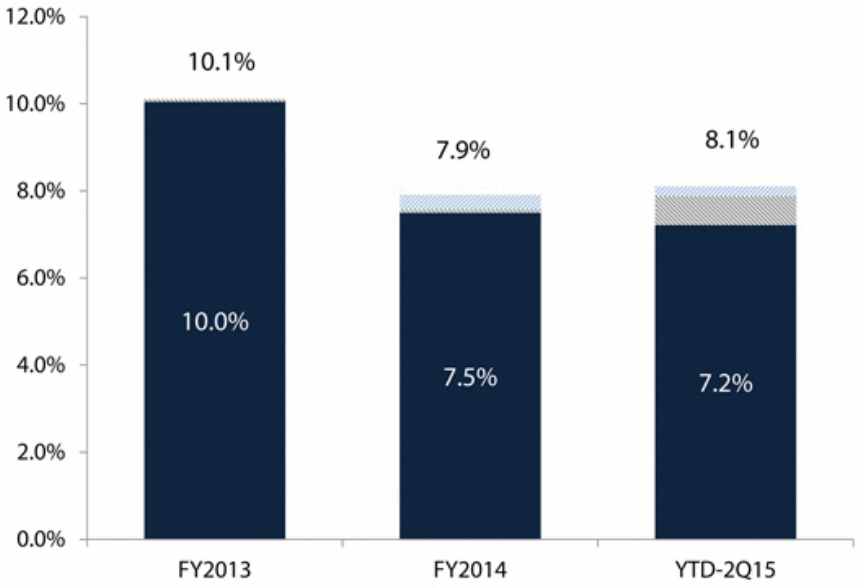
A look at dual eligibles and ABDs



3% of our dual eligible members and 3% of our ABD members account for 30% of our medical costs under each line of business.

Admin ratio – market place and profit restriction impact

Please refer to the Company's cautionary statement on page 2 of this presentation



Admin ratio sensitivity

- Every $1 billion of incremental revenue:
  - requires between $43 million and $50 million of new G&A spend
  - G&A ratio declines between 10 to 20 bps
- 40 bps decrease in G&A ratio increases after tax margins by 25 bps

Impact of Profit Restrictions on G&A Ratio

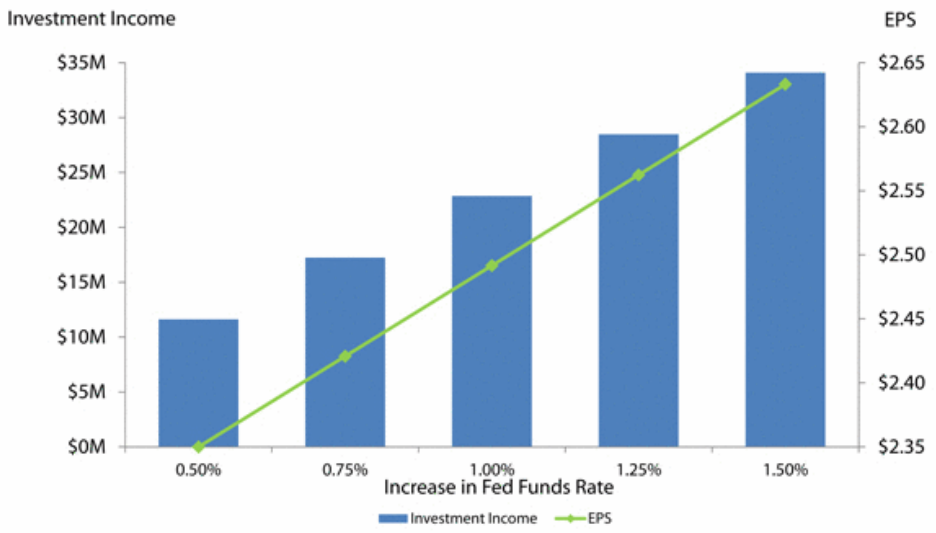
Impact of Marketplace Fees

G&A Ratio Net Profit Restrictions & Marketplace Fees

Investment income

Interest rate sensitivity on investment income

Please refer to the Company's cautionary statement on page 2 of this presentation

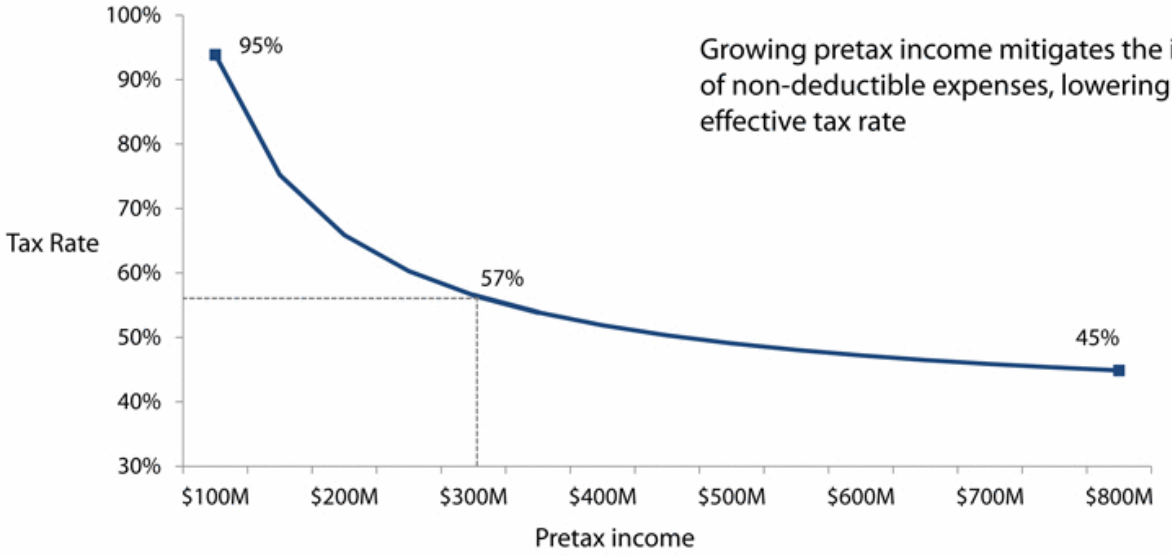


Each 25bp increase in rates results in $5M to $6M more of annualized investment income

Effective tax rate

ETR sensitivity to pretax income[1]

Please refer to the Company's cautionary statement on page 2 of this presentation



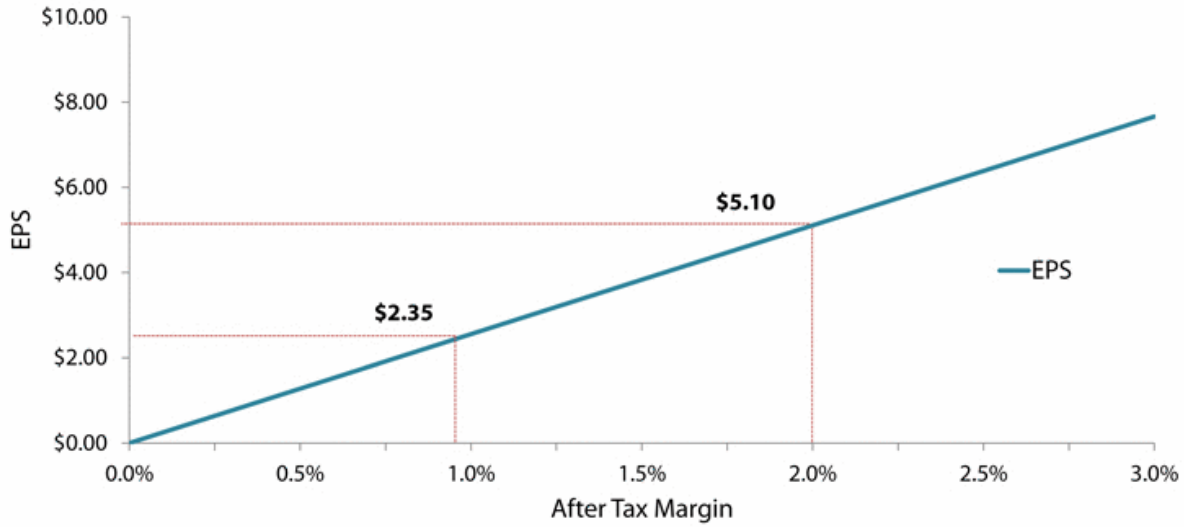
Growing pretax income mitigates the impact of non-deductible expenses, lowering the effective tax rate

1. ETR includes estimated 2015 non deductible expenses

After tax margin sensitivity

Each 25bps increase in after tax margin increases EPS by $0.65

Please refer to the Company's cautionary statement on page 2 of this presentation

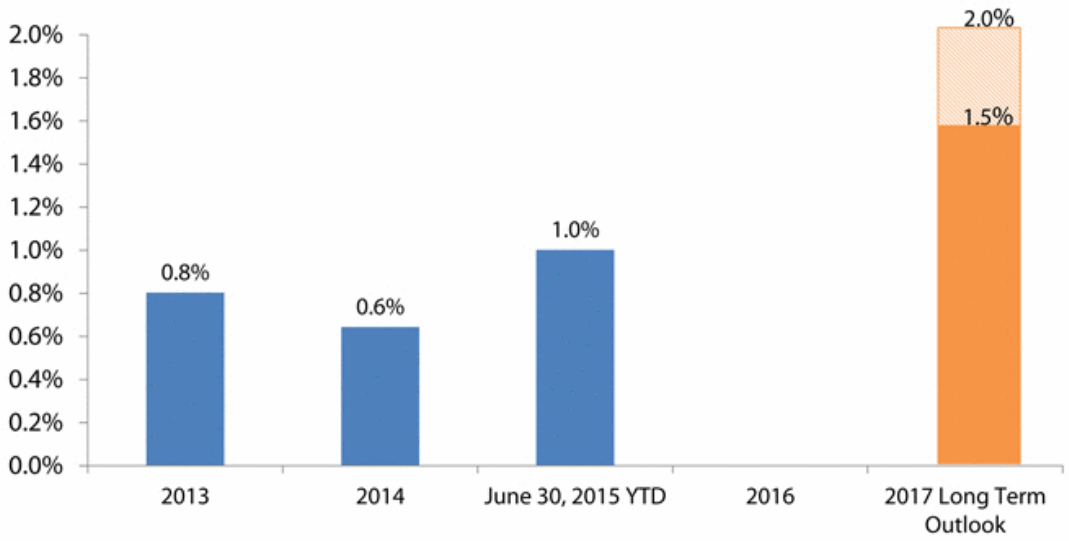


Based on 2015 Outlook

After tax margin

Historical and outlook

Please refer to the Company's cautionary statement on page 2 of this presentation



Rate changes revisited

Please refer to the Company's cautionary statement on page 2 of this presentation

State	Baseline Outlook [1]	
	Effective Date	Rate Change
California	Jul-15	+2%
Florida	Sep-15	+4%
Illinois	Jul-15	TBD
Michigan (8% LTC)	Oct-15	TBD
New Mexico	Jan-15	+3%
Ohio	Jan-15	+1%
South Carolina	Jul-15	(3%)
Texas	Jul-15[3]/Sep-15	+3% /+2%
Utah	Jan-15[4]/Jul-15	+3% / TBD
Washington (11% ABD)	Jan-15	+3%
Wisconsin	Jan-15	+0.5%

State	Medicaid Expansion	
	Effective Date	Rate Change
California	Jan-15[2]/Jul-15	(16%) / (12%)
Illinois	Jul-15	TBD
Michigan	Oct-15	TBD
New Mexico	Jan-15	+4%
Ohio	Jan-15	(3%)
Washington	Jan-15/Jul-15	(41%) / (8%)

Note:

1. Base business denotes rate change for TANF, CHIP, and ABD Estimate
2. CA fiscal year begins 7/1/15, but Expansion included a rate update 1/1/15
3. TX fiscal year begins 9/1/15, but includes rate update CFC (Community First Choice) on 6/1/15
4. UT fiscal year begins 7/1/15, but includes rate update on 1/1/15

Q&A