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

Form 10-Q

(Mark One)

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

For the quarterly period ended June 30, 2008

Or

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

For the transition period from to

Commission file number: 001-31719

Molina Healthcare, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**13-4204626**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification No.)*
200 Oceangate, Suite 100 Long Beach, California	**90802**
(Address of principal executive offices)	*(Zip Code)*

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

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 o

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

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

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

The number of shares of the issuer's Common Stock, par value $0.001 per share, outstanding as of July 25, 2008, was approximately 27,468,000.

MOLINA HEALTHCARE, INC.

Index

PART I — FINANCIAL INFORMATION

Item 1: ***Financial Statements.***

MOLINA HEALTHCARE, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

	June 30, 2008 (Unaudited)	December 31, 2007
	(Amounts in thousands, except per-share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 425,424	$ 459,064
Investments	196,268	242,855
Receivables	113,597	111,537
Deferred income taxes	11,557	8,616
Prepaid expenses and other current assets	14,484	12,521
Total current assets	761,330	834,593
Property and equipment, net	59,191	49,555
Goodwill and intangible assets, net	204,182	207,223
Investments	66,786	—
Restricted investments	29,875	29,019
Receivable for ceded life and annuity contracts	28,143	29,240
Other assets	22,247	21,675
Total assets	$ 1,171,754	$ 1,171,305
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$ 305,541	$ 311,606
Accounts payable and accrued liabilities	61,872	69,266
Deferred revenue	50,170	40,104
Income taxes payable	11,137	5,946
Total current liabilities	428,720	429,922
Long-term debt	200,000	200,000
Deferred income taxes	5,297	10,136
Liability for ceded life and annuity contracts	28,143	29,240
Other long-term liabilities	17,139	14,529
Total liabilities	679,299	680,827
Stockholders' equity:		
Common stock, $0.001 par value; 80,000 shares authorized, outstanding 27,453 shares at June 30, 2008 and 28,444 shares at December 31, 2007	29	28
Preferred stock, $0.001 par value; 20,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	191,326	185,808
Accumulated other comprehensive (loss) income	(2,975)	272
Retained earnings	354,431	324,760
Treasury stock, at cost; 2,332 shares at June 30, 2008 and 1,201 shares at December 31, 2007	(50,356)	(20,390)
Total stockholders' equity	492,455	490,478
Total liabilities and stockholders' equity	$ 1,171,754	$ 1,171,305

See accompanying notes.

CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
	(Amounts in thousands, except net income per share) (Unaudited)			
Revenue:				
Premium revenue	$ 761,153	$ 607,127	$ 1,490,791	$ 1,163,362
Investment income	5,338	6,761	12,742	13,429
Total revenue	766,491	613,888	1,503,533	1,176,791
Expenses:				
Medical care costs	640,829	516,865	1,267,176	993,342
General and administrative expenses	87,074	67,208	165,166	130,596
Depreciation and amortization	8,330	6,749	16,482	13,192
Impairment charge on purchased software	—	782	—	782
Total expenses	736,233	591,604	1,448,824	1,137,912
Operating income	30,258	22,284	54,709	38,879
Interest expense	(2,307)	(725)	(4,579)	(1,850)
Income before income taxes	27,951	21,559	50,130	37,029
Provision for income taxes	11,435	8,245	20,459	14,123
Net income	$ 16,516	$ 13,314	$ 29,671	$ 22,906
Net income per share:				
Basic	$ 0.59	$ 0.47	$ 1.05	$ 0.81
Diluted	$ 0.59	$ 0.47	$ 1.05	$ 0.81
Weighted average shares outstanding:				
Basic	27,997	28,233	28,229	28,192
Diluted	28,044	28,343	28,324	28,309

See accompanying notes.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
	(Amounts in thousands) (Unaudited)		(Amounts in thousands) (Unaudited)	
Net income	$ 16,516	$ 13,314	$ 29,671	$ 22,906
Other comprehensive (loss) income, net of tax:				
Unrealized (loss) gain on investments	(1,092)	78	(3,247)	196
Other comprehensive (loss) income	(1,092)	78	(3,247)	196
Comprehensive income	$ 15,424	$ 13,392	$ 26,424	$ 23,102

See accompanying notes.

CONSOLIDATED STATEMENTS OF CASH FLOWS

	Six Months Ended June 30,	
	2008	2007
	(Amounts in thousands) (Unaudited)	
Operating activities		
Net income	$ 29,671	$ 22,906
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	16,482	13,192
Amortization of deferred financing costs	813	475
Deferred income taxes	(5,649)	(4,763)
Stock-based compensation	3,587	3,644
Changes in operating assets and liabilities:		
Receivables	(2,060)	4,526
Prepaid expenses and other current assets	(1,963)	(1,353)
Medical claims and benefits payable	(6,065)	13,191
Deferred revenue	10,066	26,205
Accounts payable and accrued liabilities	(10,620)	4,619
Income taxes	5,191	5,232
Net cash provided by operating activities	39,453	87,874
Investing activities		
Purchases of equipment	(17,098)	(10,440)
Purchases of investments	(163,447)	(42,816)
Sales and maturities of investments	137,805	46,117
Increase in restricted cash	(856)	(3,326)
Cash paid in business purchase transaction	(1,000)	—
Increase in other assets	(2,177)	(864)
Increase in other long-term liabilities	2,610	4,484
Net cash used in investing activities	(44,163)	(6,845)
Financing activities		
Treasury stock purchases	(29,966)	—
Repayment of amounts borrowed under credit facility	—	(15,000)
Payment of credit facility fees	—	(475)
Tax (expense) benefit from employee stock compensation recorded as additional paid-in capital	(156)	642
Proceeds from exercise of stock options and employee stock purchases	1,192	1,656
Net cash used in financing activities	(28,930)	(13,177)
Net (decrease) increase in cash and cash equivalents	(33,640)	67,852
Cash and cash equivalents at beginning of period	459,064	403,650
Cash and cash equivalents at end of period	$ 425,424	$ 471,502
Supplemental cash flow information		
Cash paid during the period for:		
Income taxes	$ 20,307	$ 9,715
Interest	$ 3,892	$ 2,041
Schedule of non-cash investing and financing activities:		
Unrealized (loss) gain on investments	$ (5,443)	$ 312
Deferred taxes	2,196	(116)
Net unrealized (loss) gain on investments	$ (3,247)	$ 196
Retirement of common stock used for stock-based compensation	$ (366)	$ (117)
Accrued purchases of equipment	$ 1,595	$ 354
Cumulative effect of adoption of Financial Interpretation No. 48, *Accounting for Uncertainty in Income Taxes*	$ —	$ 445
Details of business purchase transaction:		
Fair value of assets acquired	$ 2,262	$ —
Common stock issued to seller	(1,262)	—
Net cash paid in business purchase transaction	$ 1,000	$ —
Business purchase transactions adjustments:		
Accounts payable and accrued liabilities	$ 1,265	$ —
Deferred taxes	65	873
Goodwill and intangible assets, net	$ 1,330	$ 873

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)
June 30, 2008

1. Basis of Presentation

Organization and Operations

Molina Healthcare, Inc. (the "Company") is a multi-state managed care organization participating exclusively in government-sponsored health care programs for low-income persons, such as the Medicaid program and the State Children's Health Insurance Program, or SCHIP. We also serve a small number of members who are dually eligible under both the Medicaid and the Medicare programs, and commencing in January 2007 we began to serve a small number of low-income Medicare members. We conduct our business primarily through nine licensed health plans in the states of California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those nine states, each of which is licensed as a health maintenance organization, or HMO.

Our results of operations include the results of the November 1, 2007 acquisition of Mercy CarePlus, a Medicaid managed care organization based in St. Louis, Missouri.

Consolidated and Interim Financial Information

The condensed consolidated financial statements include the accounts of the Company and all majority owned subsidiaries. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the interim periods presented, which consist solely of normal recurring adjustments, have been included. All significant intercompany balances and transactions have been eliminated in consolidation. The condensed consolidated results of income for the current interim period are not necessarily indicative of the results for the entire year ending December 31, 2008. Financial information related to subsidiaries acquired during any year is included only for the period subsequent to their acquisition.

The unaudited condensed consolidated interim financial statements have been prepared under the assumption that users of the interim financial data have either read or have access to our audited consolidated financial statements for the fiscal year ended December 31, 2007. Accordingly, certain disclosures that would substantially duplicate the disclosures contained in the December 31, 2007 audited consolidated financial statements have been omitted. These unaudited condensed consolidated interim financial statements should be read in conjunction with our December 31, 2007 audited financial statements. Certain 2007 amounts in the condensed consolidated statement of cash flows regarding stock-based compensation have been reclassified to conform to the 2008 presentation.

2. Significant Accounting Policies

Earnings Per Share

The denominators for the computation of basic and diluted earnings per share are calculated as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
Shares outstanding at the beginning of the period	28,479,000	28,199,000	28,444,000	28,119,000
Weighted average number of treasury shares purchased	(489,000)	—	(244,000)	—
Weighted average number of shares issued under employee stock plans	7,000	34,000	29,000	74,000
Denominator for basic earnings per share	27,997,000	28,233,000	28,229,000	28,193,000
Dilutive effect of employee stock options and restricted stock	47,000	110,000	95,000	116,000
Denominator for diluted earnings per share	28,044,000	28,343,000	28,324,000	28,309,000

Stock-Based Compensation

At June 30, 2008, we had employee equity incentives outstanding under two plans: (1) the 2002 Equity Incentive Plan; and (2) the 2000 Omnibus Stock and Incentive Plan (from which equity incentives are no longer awarded). Charged to general and administrative expenses, total stock-based compensation expense (net of tax) for the three and six months ended June 30, 2008 and 2007 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
	(in thousands)			
Stock options (including shares issued under our employee stock purchase plan)	$ 452	$ 567	$ 817	$ 1,086
Restricted stock awards	775	534	1,306	1,173
Total stock-based compensation expense, net of tax	$ 1,227	$ 1,101	$ 2,123	$ 2,259

As of June 30, 2008, unrecognized compensation expense related to stock options totaled $2.6 million, which we expect to recognize over a weighted-average period of 2.2 years. Also as of June 30, 2008, unrecognized compensation expense related to restricted stock awards totaled $16.9 million, which we expect to recognize over a weighted-average period of 3.2 years.

We account for stock-based compensation in accordance with Statement of Financial Accounting Standards (“SFAS”) No. 123(R), *Share-Based Payment.* Restricted stock awards are valued based on the closing market price of our common stock on the grant date. The Black-Scholes valuation model is used to estimate the fair value of stock options at grant date. The risk-free interest rate is based on the implied yield available at June 30, 2008 on U.S. treasury zero coupon issues for the expected option term. The expected volatility is based on historical volatility levels of our common stock. Beginning in the first quarter of 2008, we used an expected term for each option award based on historical experience of employee post-vesting exercise and termination behavior. Prior to 2008, the expected option term of each award granted was calculated using the “simplified method” in accordance with Staff Accounting Bulletin No. 107. This change did not produce materially different valuation results for the stock options awarded in the first half of 2008. For both restricted stock and stock option awards, the expense is recognized over the vesting period, generally straight-line over four years. The assumptions used in the Black-Scholes valuation model for options awarded in the three and six months ended June 30, 2008 and 2007 were as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
Risk-free interest rate	2.9%	4.7%	2.5%	4.5%
Expected volatility	45.7%	48.7%	45.3%	48.8%
Expected option term (in years)	4	6	4	6
Expected dividend yield	None	None	None	None
Grant date weighted-average fair value per share	$ 9.68	$ 16.96	$ 12.80	$ 16.54

Stock option activity for the six months ended June 30, 2008 was as follows:

	Options	Weighted-Average Exercise Price	Aggregate Intrinsic Value	Weighted-Average Remaining Contractual Term
			(in thousands)	(in years)
Outstanding as of December 31, 2007	733,713	$ 30.45		
Granted	12,000	33.57		
Exercised	(6,081)	28.33	$ 31	
Forfeited	(32,475)	35.43		
Outstanding as of June 30, 2008	707,157	$ 30.30	$ 344	7.2
Exercisable and expected to vest as of June 30, 2008	652,701	$ 30.17	$ 344	7.1
Exercisable as of June 30, 2008	423,110	$ 29.07	$ 344	6.5

Restricted stock activity for the six months ended June 30, 2008 was as follows:

	Shares	Weighted-Average Grant Date Fair Value	Aggregate Market Value (in thousands)
Unvested balance as of December 31, 2007	235,413	$ 34.14	
Granted	374,000	31.02	$ 11,601
Vested	(52,061)	30.92	$ 1,524
Forfeited	(29,235)	34.62	
Unvested balance as of June 30, 2008	528,117	$ 32.22	

Impairment Charge

During the six months ended June 30, 2007, an impairment charge of $782,000 was recorded related to commercial software no longer used for operations. No such charge occurred during the six months ended June 30, 2008.

New Accounting Pronouncements

In May 2008, the Financial Accounting Standards Board ("FASB") issued FASB Staff Position APB 14-1, *Accounting for Convertible Debt Instruments That May Be Settled in Cash upon Conversion (Including Partial Cash Settlement)*(the "FSP"). The FSP requires the proceeds from the issuance of such convertible debt instruments to be allocated between a liability component and an equity component. The resulting debt discount is amortized over the period the convertible debt is expected to be outstanding, as additional non-cash interest expense. The change in accounting treatment is effective for fiscal years beginning after December 15, 2008, and shall be applied retrospectively to prior periods. The FSP changes the accounting treatment for our $200.0 million 3.75% Convertible Senior Notes due 2014, which were issued in October 2007 (see Note 6 to the condensed consolidated financial statements included in this quarterly report, "Long-Term Debt"). The impact of this new accounting treatment will result in an increase to non-cash interest expense beginning in fiscal year 2009 for financial statements covering past and future periods. Assuming a 7.9% interest rate, we have estimated the incremental impact of the FSP to our results of operations in 2009 to be $3.4 million, or $0.13 per diluted share, net of tax. This estimate assumes a 38% effective tax rate and 27 million diluted shares outstanding. We estimate the retroactive adjustment for prior periods will be approximately $0.8 million, or $0.02 per diluted share, net of tax, for 2007, and $2.9 million, or $0.10 per diluted share, net of tax, for 2008.

In December 2007, the FASB issued SFAS 141(R), *Business Combinations* and SFAS 160, *Noncontrolling Interests in Consolidated Financial Statements*. The standards are intended to improve, simplify, and converge internationally the accounting for business combinations and the reporting of noncontrolling (minority) interests in consolidated financial statements. SFAS 141(R) requires the acquiring entity in a business combination to recognize all (and only) the assets acquired and liabilities assumed in the transaction; establishes the acquisition-date fair value as the measurement objective for all assets acquired and liabilities assumed; and requires the acquirer to disclose to investors and other users all of the information they need to evaluate and understand the nature and financial effect of the business combination. SFAS 141(R) is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. SFAS 141(R) applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. Earlier adoption is prohibited.

SFAS 160 is designed to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report minority interests in subsidiaries in the same way—as equity in the consolidated financial statements. Moreover, SFAS 160 eliminates the diversity that currently exists in accounting for transactions between an entity and minority interests by requiring they be treated as equity transactions. SFAS 160 is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. Earlier adoption is prohibited. In addition, SFAS 160 shall be applied prospectively as of the beginning of the fiscal year in which it is initially applied, except for the presentation and disclosure

requirements. The presentation and disclosure requirements shall be applied retrospectively for all periods presented. We do not have any material outstanding minority interests and, therefore, SFAS 160 is not applicable to us at this time.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to, have a material impact on our present or future consolidated financial statements.

3. Fair Value Measurements

As of June 30, 2008, we had cash and cash equivalents of $425.4 million, investments totaling $263.1 million, and restricted investments of $29.9 million. The cash equivalents consist of highly liquid securities with original or purchase date remaining maturities of up to three months that are readily convertible into known amounts of cash. Our investments consisted of investment grade debt securities and are designated as available-for-sale. Of the $263.1 million total, $196.3 million are classified as current assets, and $66.8 million are classified as non-current assets (see further discussion below). Our investment policies require that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates are periodically reset) and that the average maturity be four years or less. The restricted investments, classified as non-current assets and designated as held-to-maturity, consist of interest-bearing deposits and U.S. treasury securities required by the respective states in which we operate. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are reported at fair market value on the balance sheet. All restricted investments are carried at amortized cost, which approximates market value. 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. Declines in interest rates over time will reduce our investment income.

In September 2006, the FASB issued SFAS 157, *Fair Value Measurements*. SFAS 157 defines fair value, establishes a framework for measuring fair value in accordance with accounting principles generally accepted in the United States, and expands disclosures about fair value measurements. We adopted the provisions of SFAS 157 as of January 1, 2008 for our financial instruments. Although the adoption of SFAS 157 did not materially impact our financial position, results of operations, or cash flow, we are now required to provide additional disclosures as part of our financial statements.

SFAS 157 establishes a three-tier fair value hierarchy, which prioritizes the inputs used in measuring fair value. These tiers are: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

As of June 30, 2008, we held investments in auction rate securities, totaling $71.8 million, with a fair value of $66.8 million, which are required to be measured at fair value on a recurring basis. Our auction rate securities are designated as available-for-sale securities and are reflected at fair value. Prior to January 1, 2008, these securities were recorded at fair value based on quoted prices in active markets (i.e., SFAS 157 Level 1 data). Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes, and which resets the applicable interest rate at pre-determined intervals, usually every 7, 28, or 35 days. However, due to recent events in the credit markets, the auction events for some of these instruments failed during the first half of 2008. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. Therefore, the fair values of these securities were estimated using a discounted cash flow analysis or other type of valuation model as of June 30, 2008. These analyses considered, among other things, the collateral underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

As a result of the declines in fair value for our investments in auction rate securities, which we deem to be temporary and attribute to liquidity issues rather than to credit issues, we recorded net unrealized losses of $1.7

million and $5.0 million for the three and six months ended June 30, 2008, respectively, to accumulated other comprehensive income. Substantially all of the $66.8 million in auction rate security instruments held by us at June 30, 2008 were in securities collateralized by student loans, which loans are guaranteed by the U.S. government. Due to our belief that the market for these student loan collateralized instruments may take in excess of twelve months to fully recover, we have classified these investments as non-current, and have included them in investments on the unaudited condensed consolidated balance sheet at June 30, 2008. As of June 30, 2008, we continue to earn interest on our auction rate security instruments. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive (loss) income. If we determine that any future valuation adjustment was other than temporary, we would record a charge to earnings as appropriate.

Our assets measured at fair value on a recurring basis subject to the disclosure requirements of SFAS 157 at June 30, 2008, were as follows:

		Fair Value Measurements at Reporting Date Using		
	June 30, 2008	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
			(in thousands)	
Auction rate securities	$ 66,786	$ —	$ —	$ 66,786
Other available-for-sale securities	196,268	196,268	—	—
Total assets measured at fair value	$ 263,054	$ 196,268	$ —	$ 66,786

Based on market conditions which resulted in the absence of quoted prices in active markets for our auction rate securities, we changed our valuation methodology for auction rate securities to a discounted cash flow analysis during the first quarter of 2008. Accordingly, since our initial adoption of SFAS 157 on January 1, 2008, these securities changed from Level 1 to Level 3 within SFAS 157's hierarchy. The following table presents our assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) as defined in SFAS 157 at June 30, 2008:

Auction Rate Securities	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)
	(in thousands)
Balance at December 31, 2007	$ —
Transfers to Level 3	82,150
Total losses (realized or unrealized):	
Included in earnings	—
Included in other comprehensive income	(4,964)
Purchases (settlements), net	(10,400)
Balance at June 30, 2008	$ 66,786
The amount of total losses for the period included in other comprehensive income attributable to the change in unrealized losses relating to assets still held at June 30, 2008	$ (4,964)

4. Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment. As the amounts of all receivables are readily determinable and our creditors are in almost all instances state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. Accounts receivable by health plan operating subsidiary were as follows:

	June 30, 2008	December 31, 2007
	(in thousands)	
California	$ 18,773	$ 23,046
Michigan	7,892	6,419
Missouri	18,228	15,986
Ohio	30,752	28,522
Utah	23,997	23,987
Washington	8,535	8,308
Others	5,420	5,269
Total receivables	$ 113,597	$ 111,537

Substantially all receivables due our California and Missouri health plans at June 30, 2008 were collected in July 2008.

Our Utah health plan's agreement with the state of Utah calls for the reimbursement of medical costs incurred in serving our members plus an administrative fee of 9% of that medical cost amount, plus a portion of any cost savings realized as defined in the agreement. Our Utah health plan bills the state of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance from the state of Utah includes: (1) amounts billed to the state for actual paid health care claims plus administrative fees; and (2) amounts estimated for incurred but not reported claims, which, along with the related administrative fees, are not billable to the state of Utah until such claims are actually paid.

As of June 30, 2008, the receivable due our Ohio health plan included approximately $8.5 million of accrued delivery payments due from the state of Ohio and approximately $21.7 million due from a capitated provider group. Our agreement with that group calls for us to pay for certain medical services incurred by the group's members, and then to deduct the amount of such payments from the monthly capitation paid to the group. This receivable also includes an estimate of our liability for claims incurred by members of this group for which we have not made payment. The offsetting liability for the amount of this receivable established for claims incurred but not paid is included in "Medical claims and benefits payable" in our condensed consolidated balance sheets. At June 30, 2008, this receivable comprised approximately $14.3 million paid on behalf of the provider group, which will be deducted from capitation payments in the months of July and August 2008. An additional $7.5 million receivable has been recorded to reflect amounts included in "Medical claims and benefits payable" in our condensed consolidated balance sheets that are the responsibility of the capitated provider group. Our Ohio health plan has withheld approximately $9.0 million from capitation payments due this provider group and placed the funds in an escrow account. The Ohio health plan is entitled to the escrow amount if the provider is unable to repay amounts owed to us. The escrow amount is included in "Restricted investments" in our condensed consolidated balance sheets. Monthly gross capitation paid to the provider group is approximately $10.5 million.

5. Other Assets

Other assets include an investment in a vision services provider (see Note 9, "Related Party Transactions"), deferred financing costs associated with our secured credit agreement, and certain investments held in connection with our deferred employee compensation program. A liability approximately equal to the assets held in connection with our deferred employee compensation program is included in other long-term liabilities.

6. Long-Term Debt

Convertible Senior Notes

In October 2007, we completed our offering of $200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds of $193.4 million. The Notes rank equally in right of payment with our existing and future senior indebtedness, and are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This represents an initial conversion price of approximately $46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the conditions noted above is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each $1,000 principal amount of Notes, as follows:

- An amount in cash equal to the sum of, for each of the 20 Volume-Weighted Average Price (the "VWAP") trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

Credit Facility

In 2005, we entered into the Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the "Credit Facility"). Effective May 2007, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit to $200.0 million, maturing in May 2012. The Credit Facility is intended to be used for working capital and general corporate purposes, and subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the Credit Facility to up to $250.0 million.

Borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America's prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for

each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of June 30, 2008 and December 31, 2007, there were no amounts outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our Michigan, New Mexico, Utah, and Washington health plan subsidiaries. The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The amended Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At June 30, 2008, we were in compliance with all financial covenants in the Credit Facility.

7. Stockholders' Equity

In April 2008, our board of directors authorized the repurchase of up to $30 million of our common stock on the open market or through privately negotiated transactions. We used working capital to fund the repurchases under this program. The timing and amount of repurchases were primarily made pursuant to a trading plan dated as of May 2, 2008. The trading plan became effective May 5, 2008, and terminated when the aggregate cost of the repurchases totaled $30 million on June 12, 2008. During the quarter ended June 30, 2008, we repurchased approximately 1.1 million shares. We did not repurchase any shares during the quarter ended March 31, 2008. See Note 10, "Subsequent Events," regarding the authorization to repurchase additional shares.

On June 30, 2008, we issued a total of 48,186 shares of our common stock in connection with our acquisition of the assets of The Game of Work, LLC.

8. Commitments and Contingencies

Legal

The health care industry is 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.

Malpractice Action. On February 1, 2007, a complaint was filed in the Superior Court of the State of California for the County of Riverside by plaintiff Staci Robyn Ward through her guardian ad litem, Case No. 465374. The complaint purports to allege claims for medical malpractice against several unaffiliated physicians, medical groups, and hospitals, including Molina Medical Centers and one of its physician employees. The plaintiff alleges that the defendants failed to properly diagnose her medical condition which has resulted in her severe and permanent disability. On July 22, 2007, the plaintiff passed away. The proceeding is in the discovery stage, and no prediction can be made as to the outcome.

Starko. Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named health maintenance organizations participating in the New Mexico Medicaid program as defendants (the "HMOs"), including Cimarron Health Plan, the predecessor of our New Mexico HMO. The plaintiffs assert that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. On July 10, 2007, the court dismissed all damages claims against Molina Healthcare of New Mexico, leaving at that time only a pending action for injunctive and declaratory relief. On August 15, 2007, the court dismissed all remaining claims against Molina Healthcare of New Mexico, including the action for injunctive and declaratory relief. The plaintiffs have filed an appeal with respect to the court's dismissal orders and the parties have submitted their respective appellate briefs and are awaiting oral argument. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to Molina Healthcare of New Mexico, an indemnification escrow account was established and funded with $6.0 million to indemnify Molina Healthcare of New Mexico against the costs of such litigation and any eventual liability or settlement costs. As of June 30, 2008, approximately $4.2 million remained in the indemnification escrow fund.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, individually or in the aggregate, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

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 consolidated financial position, results of operations, or cash flows.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our HMO subsidiaries operating in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Washington, and Utah. Our HMOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations), which may not be transferable to us in the form of cash dividends, loans, or advances, were $337.0 million at June 30, 2008 and $332.2 million at December 31, 2007. The National Association of Insurance Commissioners, or NAIC, adopted model rules effective December 31, 1998, which, if implemented by a state, set new 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, or RBC, rules. Michigan, Nevada, New Mexico, Ohio, Texas, Utah, and Washington have adopted these rules, although the rules as adopted may vary somewhat from state to state. California and Missouri have established their own minimum capitalization requirements for insurance companies.

As of June 30, 2008, our HMOs had aggregate statutory capital and surplus of approximately $349.7 million, compared with the required minimum aggregate statutory capital and surplus of approximately $207.6 million. All of our HMOs were in compliance with the minimum capital requirements at June 30, 2008. We have the ability and commitment to provide additional capital to each of our HMOs when necessary to ensure that they continue to meet statutory and regulatory capital requirements.

9. Related Party Transactions

We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee in excess of 20%. As of June 30, 2008 and 2007, our carrying amount for this investment totaled $3.6 million and $1.4 million, respectively. Effective July 1, 2007, we paid this provider a $0.9 million network access fee, which was fully amortized as of June 30, 2008. Advances outstanding to this provider totaling $315,000 were offset in full to capitation payments during the quarter ended June 30, 2008. For the three months ended June 30, 2008 and 2007, we paid $3.6 million and $3.1 million, respectively, for medical service fees to this provider. For the six months ended June 30, 2008 and 2007, we paid $7.1 million and $5.9 million, respectively, for medical service fees to this provider.

We are a party to a fee for service agreement with Pacific Hospital of Long Beach (“Pacific Hospital”). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, our Executive Vice President, Research and Development. Amounts paid under the terms of this fee for service agreement were $54,000 and $23,000 for the three months ended June 30, 2008 and 2007,

respectively, and $110,000 and $43,000 for the six months ended June 30, 2008 and 2007, respectively. We believe that the claims submitted to us by Pacific Hospital were reimbursed at prevailing market rates. In 2006, we entered into an additional agreement with Pacific Hospital as part of a capitation arrangement. Under this arrangement, we pay Pacific Hospital a fixed monthly fee based on member type. We paid Pacific Hospital for capitation services totaling approximately $818,000 and $1.0 million for the three months ended June 30, 2008 and 2007, respectively, and $1.7 million and $2.1 million for the six months ended June 30, 2008 and 2007, respectively. We believe that this agreement with Pacific Hospital is based on prevailing market rates for similar services. Also as of June 30, 2008, we had an advance outstanding to this provider totaling $0.2 million which is offsetting capitation payments in 2008.

In 2006, we assumed an office lease from Millworks Capital Ventures which at that time had a remaining term of 52 months. Millworks Capital Ventures is owned by John C. Molina, our Chief Financial Officer, and his wife. The monthly base lease payment is approximately $18,000 and is subject to an annual increase. Based on a market report prepared by an independent realtor, we believe the terms and conditions of the assumed lease were at that time at fair market value. We are currently using the office space under the lease for an office expansion. Payments made under this lease totaled $75,000 and $56,000 for the three months ended June 30, 2008 and 2007, respectively, and $132,000 and $131,000 for the six months ended June 30, 2008 and 2007, respectively.

We lease two medical clinics that are owned by the Mary R. Molina Living Trust and the Molina Marital Trust. These leases have 5 five-year renewal options. Rental expense for these leases totaled $24,000 for each of the three-month periods ended June 30, 2008 and 2007, respectively, and $49,000 for each of the six-month periods ended June 30, 2008 and 2007, respectively.

10. Subsequent Event

On July 22, 2008, our board of directors authorized the repurchase of up to one million shares of our common stock. The repurchase program will be funded using our working capital, and the timing and amount of any shares repurchased will be made pursuant to a trading plan. The repurchase program extends through December 31, 2008, but we reserve the right to suspend or discontinue the program at any time.

Item 2. ***Management's Discussion and Analysis of Financial Condition and Results of Operations.***

Forward Looking Statements

This quarterly report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, or Securities Act, and Section 21E of the Securities Exchange Act of 1934, or Securities Exchange Act. All statements, other than statements of historical facts, that we include in this quarterly report may be deemed to be forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words "anticipate(s)," "believe(s)," "estimate(s)," "expect(s)," "intend(s)," "may," "plan(s)," "project(s)," "will," "would" and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we will actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make. You should read these factors and the other cautionary statements as being applicable to all related forward-looking statements wherever they appear in this quarterly report. We caution you that we do not undertake any obligation to update forward-looking statements made by us. Forward-looking statements involve known and unknown risks and uncertainties that may cause our actual results in future periods to differ materially from those projected or contemplated as a result of, but not limited to, the following factors:

- the achievement of savings from the successful management of the medical care ratio of our health plans;
- an increase in enrollment in both our Medicaid and Medicare populations consistent with our expectations;
- our ability to reduce administrative costs in the event enrollment or revenue is lower than expected;
- increased administrative costs in support of the Company's efforts to expand Medicare membership;
- our ability to accurately estimate incurred but not reported medical costs;
- the securing of projected premium rate increases under the government contracts of our health plans, in particular in the states of Michigan and Texas and in connection with our Medicare plans;
- the January 1, 2008 increase in Michigan state taxes and the success of our efforts to mitigate the impact of that tax increase;
- the budget crisis in California and the pressure to reduce HMO rates in that state, including current PMPM rates under our existing contracts;
- the final terms as implemented of the Rogers Amendment to the Deficit Reduction Act of 2005 regarding the rates to be paid to non-contracting hospitals by our California health plan;
- changes in market interest rates and actions by the Federal Reserve Bank Board;
- the potential termination or expiration without renewal of the government contracts of our health plans;
- the imposition of fines or assessments by state or federal regulators for perceived operating deficiencies;
- our dependence upon a relatively small number of government contracts and subcontracts for our revenue;
- limitations in our ability to control our medical costs and other operating expenses;
- risks related to our new Medicare Advantage plans with prescription drug coverage, or MAPD plans, including our lack of operating experience with such plans, compliance issues, and confusion regarding the new plans among Medicare beneficiaries, providers, pharmacists, and regulators;

- the successful and cost-effective integration of Mercy CarePlus, including risks related to our lack of prior operating experience in Missouri;
- risks related to our lack of experience with members in Ohio, Texas, and Missouri;
- the availability of adequate financing to fund and/or capitalize our acquisitions and start-up activities;
- membership eligibility processes and methodologies;
- unexpected changes in demographics, member utilization patterns, healthcare practices, or healthcare technologies;
- high dollar claims related to catastrophic illness or conditions, increases in respiratory illnesses, or increases in the number of premature infants among our plans' members;
- risks related to the continued solvency of our major providers and provider groups;
- failure to maintain effective, efficient, and secure information systems and claims processing technology;
- the unfavorable resolution of pending litigation or arbitration;
- risks associated with the potential negative perception among regulators, governmental representatives, and the public of abuses occurring within the Medicaid or Medicare managed care sectors and the association or general attribution of such negative perceptions to us;
- funding decreases in the Medicaid, SCHIP, or Medicare programs or the failure to timely renew the SCHIP program;
- risks associated with our $200 million 3.75% Convertible Senior Notes due 2014;
- epidemics such as the avian flu; and
- changes to government laws and regulations or in the interpretation and enforcement of those laws and regulations, including the recently enacted citizenship certification requirements.

Investors should refer to Part II, Item 1A of this Quarterly Report, and to Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2007, for a discussion of certain risk factors which could materially affect our business, financial condition, or future results. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution investors not to place undue reliance on these statements.

This document and the following discussion of our financial condition and results of operations should be read in conjunction with the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report and the audited financial statements and Management's Discussion and Analysis appearing in our Annual Report on Form 10-K for the year ended December 31, 2007.

Overview

Our financial performance for the three and six months ended June 30, 2008 compared with the same prior year periods is briefly summarized as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
	(Dollar amounts in thousands, except per-share data)			
Earnings per diluted share	$ 0.59	$ 0.47	$ 1.05	$ 0.81
Premium revenue	$ 761,153	$ 607,127	$ 1,490,791	$ 1,163,362
Operating income	$ 30,258	$ 22,284	$ 54,709	$ 38,879
Net income	$ 16,516	$ 13,314	$ 29,671	$ 22,906
Medical care ratio	84.2%	85.1%	85.0%	85.4%
G&A expenses as a percentage of total revenue	11.4%	10.9%	11.0%	11.1%
Total ending membership			1,234,000	1,076,000

Revenue

Premium revenue is fixed in advance of the periods covered and, except as described below, is not generally subject to significant accounting estimates. For the six months ended June 30, 2008, we received approximately 92% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies and other managed care organizations for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs periodically adjust premium rates.

The amount of these premiums may vary substantially between states and among various government programs. PMPM premiums for members of the State Children's Health Insurance Program, or SCHIP, are generally among our lowest, with rates as low as approximately $80 PMPM in California and Utah. Premium revenues for Medicaid members are generally higher. Among the Temporary Aid for Needy Families (TANF) Medicaid population — the Medicaid group that includes most mothers and children — PMPM premiums range between approximately $100 in California to $300 in New Mexico and Utah. Among our Medicaid Aged, Blind or Disabled (ABD) membership, PMPM premiums range from approximately $450 in California to over $1,000 in New Mexico and Ohio. Medicare revenue is approximately $1,200 PMPM. Approximately 3% of our premium revenue for the six months ended June 30, 2008 was realized under a Medicaid cost-plus reimbursement agreement that our Utah plan has with that state. For the six months ended June 30, 2008, we also received approximately 4% of our premium revenue in the form of "birth income" — a one-time payment for the delivery of a child — from the Medicaid programs in Michigan, Ohio, Texas, and Washington. Such payments are recognized as revenue in the month the birth occurs. Our premium revenue also included premiums generated from Medicare, totaling approximately $44.4 million and $19.5 million for the six months ended June 30, 2008 and 2007, respectively. All of our Medicare revenue is paid to us as a fixed PMPM amount.

Certain components of premium revenue are subject to accounting estimates. Chief among these are (1) that portion of premium revenue paid to our New Mexico health plan by the state of New Mexico that may be refunded to the state if certain minimum amounts are not expended on defined medical care costs, (2) the additional premium revenue our Utah health plan is entitled to receive from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid, and (3) the profit-sharing agreement between our Texas health plan and the state of Texas, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income above a certain specified percentage, according to a tiered rebate schedule.

Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs. Our contract is for a three-year period, and the minimum percentage is based on premiums and medical care costs over the entire contract period. Year to date, we have recorded adjustments totaling $12.9 million to increase premium revenue associated with this requirement. The revenue resulted from a reversal of previously recorded amounts due the state of New Mexico because we exceeded the minimum percentage in the first half of 2008. At June 30, 2008, there is no remaining liability recorded under our interpretation of the existing terms of this contract provision. Any change to the terms of this provision, including revisions to the definitions of premium revenue or medical care costs, the period of time over which the minimum

percentage is measured or the manner of its measurement, or the percentage of revenue required to be spent on the defined medical care costs, may trigger a change in this amount. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to this amount may occur.

In prior years, we estimated amounts we believed were recoverable under our savings sharing agreement with the state of Utah based on available information and our interpretation of our contract with the state. The state may not agree with our interpretation or our application of the contract language, and it may also not agree with the manner in which we have processed and analyzed our member claims and encounter records. Thus, the ultimate amount of savings sharing revenue that we realize may be subject to negotiation with the state. During 2007, as a result of an ongoing disagreement with the state of Utah, we wrote off the entire receivable, totaling $4.7 million. Our Utah health plan continues to work with the state to assure an appropriate determination of amounts due under the savings share agreement. When additional information is known, or agreement is reached with the state regarding the appropriate savings sharing payment amount, we will adjust the amount of savings sharing revenue recorded in our financial statements as appropriate in light of such new information or agreement.

As of June 30, 2008, we had a liability of approximately $9.0 million accrued pursuant to our profit-sharing agreement with the state of Texas, for the 2007 and 2008 contract years ending August 31. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimate.

Historically, membership growth has been the primary reason for our increasing revenues, although more recently our revenues have also grown due to the more care intensive benefits associated with our ABD and Medicare members. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate total number of members by state as of the dates indicated:

Total Ending Membership by Health Plan:	As of June 30, 2008	As of December 31, 2007	As of June 30, 2007
California	310,000	296,000	291,000
Michigan	212,000	209,000	217,000
Missouri (1)	76,000	68,000	—
Nevada (2)	—	—	—
New Mexico	81,000	73,000	66,000
Ohio	173,000	136,000	138,000
Texas	29,000	29,000	30,000
Utah	57,000	55,000	47,000
Washington	296,000	283,000	287,000
Total	1,234,000	1,149,000	1,076,000
Total Ending Membership by State for the Medicare Advantage Plans:			
California	1,452	1,115	724
Michigan	1,469	1,090	459
Nevada	680	520	9
New Mexico	149	—	—
Texas	430	—	—
Utah	2,056	1,860	1,646
Washington	911	507	413
Total	7,147	5,092	3,251
Total Ending Membership by State for the Aged, Blind or Disabled Population:			
California	12,092	11,837	10,728
Michigan	30,896	31,399	31,940
New Mexico	6,716	6,792	6,822
Ohio	15,355	14,887	15,117
Texas	15,999	16,018	16,603
Utah	6,993	6,795	6,876
Washington	3,049	2,814	2,693
Total	91,100	90,542	90,779

(1) We acquired our Missouri health plan effective as of November 1, 2007.

(2) Less than 1,000 members.

The following table provides details of total member months (defined as the aggregation of each month's ending membership for the period) by state for the periods indicated:

	Three Months Ended June 30,		
	2008	2007	% of Increase (Decrease)
California	921,000	874,000	5.4%
Michigan	639,000	658,000	(2.9)
Missouri (1)	227,000	—	—
Nevada	2,000	—	—
New Mexico	239,000	197,000	21.3
Ohio	522,000	399,000	30.8
Texas	85,000	91,000	(6.6)
Utah	164,000	145,000	13.1
Washington	879,000	860,000	2.2
Total	3,678,000	3,224,000	14.1%

	Six Months Ended June 30,		
	2008	2007	% of Increase (Decrease)
California	1,829,000	1,760,000	3.9%
Michigan	1,277,000	1,327,000	(3.8)
Missouri	450,000	—	—
Nevada (2)	4,000	—	—
New Mexico	467,000	389,000	20.1
Ohio	935,000	739,000	26.5
Texas	170,000	157,000	8.3
Utah	321,000	296,000	8.4
Washington	1,738,000	1,716,000	1.3
Total	7,191,000	6,384,000	12.6%

(1) We acquired our Missouri health plan effective November 1, 2007.

(2) Our Nevada health plan became operational on June 1, 2007, serving only Medicare members.

Expenses

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, expenses. Our results of operations are impacted by our ability to effectively manage expenses related to health care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals in a variety of ways, including per diem amounts, diagnostic-related groups, or DRGs, percent of billed charges, case rates, and capitation. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts 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 managers are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitation basis. Under capitation contracts, we typically pay a fixed PMPM payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated

contracts, we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. 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.

- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the six months ended June 30, 2008 and 2007, medically related administrative costs were approximately $36.9 million and $30.8 million, respectively.

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

	Three Months Ended June 30,					
	2008			2007		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 410,619	$ 111.65	64.1%	$ 336,654	$ 104.41	65.1%
Capitation	117,707	32.00	18.4	92,931	28.82	18.0
Pharmacy	88,676	24.11	13.8	65,930	20.45	12.8
Other	23,827	6.48	3.7	21,350	6.62	4.1
Total	$ 640,829	$ 174.24	100.0%	$ 516,865	$ 160.30	100.0%

	Six Months Ended June 30,					
	2008			2007		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Fee for service	$ 822,628	$ 114.40	64.9%	$ 644,534	$ 100.96	64.9%
Capitation	221,498	30.80	17.5	180,864	28.33	18.2
Pharmacy	174,958	24.33	13.8	126,509	19.82	12.7
Other	48,092	6.70	3.8	41,435	6.49	4.2
Total	$ 1,267,176	$ 176.23	100.0%	$ 993,342	$ 155.60	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. See “Critical Accounting Policies” below for a comprehensive discussion of how we estimate such liabilities.

G&A expenses largely consist of wage and benefit costs for our employees, premium taxes, and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The primary centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally provided functions include member services, plan administration, and provider relations. G&A expenses include premium taxes for each of our health plans in California, Michigan, New Mexico, Ohio, Texas, and Washington.

Results of Operations

The following table sets forth selected operating ratios. All ratios with the exception of the medical care ratio are shown as a percentage of total revenue. The medical care ratio is shown as a percentage of premium revenue because there is a direct relationship between the premium revenue earned and the cost of health care.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2008	2007	2008	2007
Premium revenue	99.3%	98.9%	99.2%	98.9%
Investment income	0.7	1.1	0.8	1.1
Total revenue	100.0%	100.0%	100.0%	100.0%
Ratio of direct medical care costs to premium revenue	81.9%	82.5%	82.5%	82.7%
Ratio of administrative costs included in medical care costs to premium revenue	2.3	2.6	2.5	2.7
Medical care ratio	84.2%	85.1%	85.0%	85.4%
General and administrative expense ratio, excluding premium taxes	8.2%	7.7%	8.0%	7.8%
Premium taxes included in general and administrative expenses	3.2	3.2	3.0	3.3
Total general and administrative expense ratio	11.4%	10.9%	11.0%	11.1%
Depreciation and amortization expense ratio	1.1%	1.1%	1.1%	1.1%
Effective tax rate	40.9%	38.2%	40.8%	38.1%
Operating income	3.9%	3.6%	3.6%	3.3%
Income before income taxes	3.6%	3.5%	3.3%	3.1%
Net income	2.2%	2.2%	2.0%	1.9%

Three Months Ended June 30, 2008 Compared with Three Months Ended June 30, 2007

The following summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the three months ended June 30, 2008 and June 30, 2007 (dollars in thousands except PMPM amounts):

	Three Months Ended June 30, 2008					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 104,136	$ 113.00	$ 88,449	$ 95.98	84.9%	$ 3,242
Michigan	125,382	196.37	100,273	157.05	80.0	6,625
Missouri	54,250	238.84	45,050	198.34	83.0	—
Nevada	2,243	1,303.04	2,506	1,456.25	111.8	—
New Mexico	89,279	374.58	69,593	291.99	78.0	4,184
Ohio	147,114	281.73	133,816	256.26	91.0	6,672
Texas	25,742	303.09	19,669	231.58	76.4	460
Utah	35,385	214.89	31,932	193.92	90.2	—
Washington	177,619	202.11	145,840	165.95	82.1	2,993
Other (1)	3	—	3,701	—	—	(5)
Total	$ 761,153	$ 206.96	$ 640,829	$ 174.24	84.2%	$ 24,171

	Three Months Ended June 30, 2007					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 94,710	$ 108.43	$ 76,185	$ 87.22	80.4%	$ 3,202
Michigan	121,427	184.43	101,184	153.68	83.3	7,364
New Mexico	61,337	312.44	52,949	269.71	86.3	1,394
Ohio	111,457	279.18	101,515	254.28	91.1	5,016
Texas	24,953	273.48	22,774	249.59	91.3	433
Utah	30,033	206.15	26,535	182.14	88.4	—
Washington	162,905	189.45	130,726	152.02	80.2	2,685
Other (1)	305	—	4,997	—	—	(19)
Total	$ 607,127	$ 188.30	$ 516,865	$ 160.30	85.1%	$ 20,075

(1) "Other" medical care costs represent medically related administrative costs at the parent company.

Net Income

Net income for the quarter ended June 30, 2008, increased to $16.5 million, or $0.59 per diluted share, compared with net income of $13.3 million, or $0.47 per diluted share, for the quarter ended June 30, 2007.

Premium Revenue

Premium revenue for the second quarter of 2008 was $761.1 million, an increase of $154.0 million, or 25.4%, over the $607.1 million of premium revenue for the second quarter of 2007. Medicare premium revenue for the second quarter of 2008 was $23.1 million compared with $10.5 million in the second quarter of 2007. Excluding the impact of the November 1, 2007 acquisition of our Missouri health plan, consolidated membership increased 7.6% between June 30, 2008 and June 30, 2007. Significant contributors to the $154.0 million increase in quarterly premium revenues included the following:

- A $54.3 million increase as a result of the acquisition of Mercy CarePlus in Missouri on November 1, 2007.
- A $35.7 million increase at the Ohio health plan due to higher enrollment, particularly in the Covered Families and Children (CFC) population.
- A $27.9 million increase at the New Mexico health plan due to higher enrollment, higher premium rates, and the recognition of $6.2 million in revenues associated with a minimum medical care ratio contract provision.

- A $14.7 million increase at the Washington health plan due to higher premium rates and slightly higher membership.

Investment Income

Investment income during the second quarter of 2008 totaled $5.3 million compared with $6.7 million in the second quarter of 2007, a decrease of $1.4 million, primarily due to declining interest rates and slightly lower invested balances as a result of cash used in the treasury share repurchase program.

Medical Care Costs

Medical care costs as a percentage of premium revenue (the medical care ratio) decreased to 84.2% in the second quarter of 2008 from 85.1% in the second quarter of 2007. Sequentially, the medical care ratio decreased from 85.8% for the quarter ended March 31, 2008, a change of 160 basis points. Excluding Medicare, our medical care ratio was 84.2% in the second quarter of 2008, 85.4% in the second quarter of 2007, and 85.8% in the first quarter of 2008.

- The medical care ratio of the Michigan health plan decreased 330 basis points to 80.0% in the second quarter of 2008, from 83.3% in the second quarter of 2007. This decrease was due primarily to lower hospital fee-for-service costs.
- The medical care ratio of the Missouri health plan was 83.0% for the quarter, down from 89.7% in the first quarter of 2008. The sequential decrease was due primarily to lower hospital fee-for-service costs.
- The medical care ratio of the California health plan increased as a result of an increase in PMPM medical costs of approximately 10%, chiefly in pharmacy costs and specialist fee-for-service costs. The California medical care ratio rose to 84.9% in the second quarter of 2008 from 80.4% in the second quarter of 2007.
- The medical care ratio of the New Mexico health plan decreased 830 basis points to 78.0% in the second quarter of 2008, from 86.3% in the second quarter of 2007. This decrease was due to higher premium rates, particularly under the State Coverage Initiative (SCI) contract, which offset higher medical costs. The medical care ratio decrease also included the impact of the recognition of $6.2 million in revenue associated with a minimum medical care ratio contract provision. Absent the adjustments made to premium revenue in the second quarter of 2008 and 2007 under this provision, the medical care ratio in New Mexico would have been 83.8% in the second quarter of 2008 and 82.1% in the second quarter of 2007.
- The medical care ratios of the Ohio health plan, by line of business, were as follows:

	Three Months Ended		
	June 30, 2008	March 31, 2008	June 30, 2007
Covered Families and Children (CFC)	90.7%	88.9%	90.6%
Aged, Blind or Disabled (ABD)	91.5	92.7	92.3
Aggregate	91.0%	90.3%	91.1%

In total, the medical care ratio decreased 10 basis points year over year and increased 70 basis points sequentially. The sequential increase was due primarily to increased expense due a sub-capitated behavioral health provider under a risk-sharing arrangement with that provider. These amounts added approximately 70 basis points to the aggregate medical care ratio in Ohio when compared with the first quarter of 2008. We are in the process of terminating our contract with this provider and will bring behavioral health care in-house beginning September 1, 2008.

- The medical care ratio of the Texas health plan decreased from 91.5% in the second quarter of 2007 to 76.4% in the second quarter of 2008 primarily due to low medical costs for the Star Plus membership. During the second quarter of 2008, the Texas health plan reduced revenue $2.3 million to record amounts due back to the state under a profit-sharing agreement.

- The medical care ratio of the Utah health plan increased 180 basis points to 90.2% in the second quarter of 2008, from 88.4% in the second quarter of 2007. This increase was primarily the result of higher medical care ratios in the Utah plan's SCHIP and Medicare lines of business. The Utah health plan serves the majority of its Medicaid membership under a cost-plus contract with the state of Utah. The Utah health plan's SCHIP and Medicare lines of business are conducted under "at risk" prepaid capitation contracts.
- The medical care ratio reported at the Washington health plan increased to 82.1% in the second quarter of 2008 from 80.2% in the second quarter of 2007, primarily due to higher fee-for-service hospital and specialist costs. The higher fee-for-service costs were driven by increases to the Medicaid in-patient fee schedule that took effect on each of August 1, 2007 and January 1, 2008.

Days in medical claims and benefits payable were 47 days at June 30, 2008, 50 days at March 31, 2008, and 54 days at June 30, 2007. Our reserving methodology is applied consistently across all periods presented. As of June 30, 2008, medical claims inventory (measured as the total billed charges of all claims received but not paid as of the reporting date) has decreased approximately 20% since June 30, 2007, and 4% since March 31, 2008. Additionally, increased capitation and pharmacy expenses (measured as a percentage of total medical costs) reduced days in medical claims payable by approximately one day between June 30, 2008 and March 31, 2008.

General and Administrative Expenses

General and administrative expenses were $87.1 million, or 11.4% of total revenue, for the second quarter of 2008 compared with $67.2 million, or 10.9% of total revenue, for the second quarter of 2007.

Core G&A expenses (defined as G&A expenses less premium taxes) were 8.2% of revenue in the second quarter of 2008 compared with 7.7% in the second quarter of 2007 and 7.8% in the first quarter of 2008. The increase in core G&A compared with the second quarter of 2007 was primarily due to our continued investment in the administrative infrastructure necessary to support our Medicare product line, and also due to an increase in the accrual for employee incentive compensation, as indicated in the table below.

	Three Months Ended June 30,			
	2008		2007	
	Amount (in thousands)	% of Total Revenue	Amount (in thousands)	% of Total Revenue
Medicare-related administrative costs	$ 4,118	0.5%	$ 2,043	0.3%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	48,656	6.3	38,120	6.2
All other administrative expense	10,129	1.4	6,970	1.2
Core G&A expenses	$ 62,903	8.2%	$ 47,133	7.7%

Depreciation and Amortization

Depreciation and amortization expense increased $1.6 million in the second quarter of 2008 compared with the second quarter of 2007, including a $0.9 million increase in depreciation expense due to investments in infrastructure, and a $0.7 million increase in amortization expense primarily due to intangible assets associated with the 2007 Mercy CarePlus acquisition in Missouri.

Impairment Charge on Purchased Software

During the second quarter of 2007, an impairment charge of $782,000 was recorded related to commercial software no longer used for operations. No such charge occurred in the second quarter of 2008.

Interest Expense

Interest expense in the second quarter of 2008 increased $1.6 million compared with the second quarter of 2007, principally due to the issuance of our $200 million 3.75% Convertible Senior Notes in October 2007.

Income Taxes

Income taxes were recorded at an effective rate of 40.9% in the second quarter of 2008 compared with 38.2% in the second quarter of 2007. The increase in our effective tax rate was primarily the result of a change in Michigan state taxes effective January 1, 2008. Prior to January 1, 2008, Michigan state taxes were calculated as a percentage of net income at a rate of 1.9%. As of January 1, 2008, the state income tax was changed to comprise three components on a combined filing basis: a gross receipts tax calculated at 0.8% of modified gross receipts; an income tax calculated at 4.95% of income before taxes; and a surtax of 21.99% of the total of the previous two items.

Six Months Ended June 30, 2008 Compared to Six Months Ended June 30, 2007

The following summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the six months ended June 30, 2008 and June 30, 2007 (dollars in thousands except PMPM amounts):

	Six Months Ended June 30, 2008					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 205,756	$ 112.49	$ 178,103	$ 97.37	86.6%	$ 6,201
Michigan	250,134	195.89	203,173	159.12	81.2	13,565
Missouri	106,286	236.29	91,732	203.93	86.3	—
Nevada	4,187	1,267.13	4,133	1,250.76	98.7	—
New Mexico	177,928	381.45	141,518	303.40	79.5	5,686
Ohio	271,720	290.54	246,354	263.42	90.7	12,277
Texas	49,174	288.81	37,499	220.24	76.3	936
Utah	72,731	226.40	64,923	202.10	89.3	—
Washington	352,817	202.97	290,353	167.03	82.3	5,838
Other (1)	58	—	9,388	—	—	20
Total	$ 1,490,791	$ 207.33	$ 1,267,176	$ 176.23	85.0%	$ 44,523

	Six Months Ended June 30, 2007					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	$ 187,642	$ 106.64	$ 152,509	$ 86.68	81.3%	$ 6,232
Michigan	245,193	184.75	205,785	155.05	83.9%	14,873
New Mexico	118,530	305.11	102,168	262.99	86.2%	3,610
Ohio	186,401	252.13	170,777	231.00	91.6%	8,388
Texas	39,409	250.35	36,122	229.47	91.7%	690
Utah	60,960	205.88	55,001	185.76	90.2%	—
Washington	324,887	189.33	261,985	152.67	80.6%	5,369
Other (1)	340	—	8,995	—	—	14
Total	$ 1,163,362	$ 182.23	$ 993,342	$ 155.60	85.4%	$ 39,176

(1) "Other" medical care costs represent medically related administrative costs at the parent company.

Net Income

Net income for the six months ended June 30, 2008, increased to $29.7 million, or $1.05 per diluted share, compared with net income of $22.9 million, or $0.81 per diluted share, for the six months ended June 30, 2007.

Premium Revenue

Premium revenue for the six months ended June 30, 2008, was $1,490.8 million, an increase of $327.4 million, or 28.1%, over $1,163.4 million of premium revenue for the six months ended June 30, 2007. Medicare premium revenue for the first half of 2008 was $44.4 million compared with $19.5 million in the same period of 2007. Significant contributors to this $327.4 million increase in premium revenues included the following:

- A $106.3 million increase as a result of the acquisition of Mercy CarePlus in Missouri on November 1, 2007.
- An $85.3 million increase at the Ohio health plan due to higher enrollment.
- A $59.4 million increase at the New Mexico health plan due to higher enrollment, higher premium rates, and the recognition of $12.9 million in revenues associated with a minimum medical care ratio contract provision.
- A $27.9 million increase at the Washington health plan due to higher premium rates and slightly higher membership.

Investment Income

Investment income for the six months ended June 30, 2008 totaled $12.7 million compared with $13.4 million earned in the same period of 2007. The $0.7 million decrease was primarily due to declining interest rates.

Medical Care Costs

The medical care ratio decreased to 85.0% in the first half of 2008, compared with 85.4% for the first half of 2007. Excluding Medicare, the Company's medical care ratio was 85.0% in the first half 2008 compared with 85.7% in the first half of 2007.

- The medical care ratio of the Michigan health plan decreased 270 basis points to 81.2% in the first half of 2008, from 83.9% in the first half of 2007. This decrease was due primarily to lower hospital fee-for-service costs.
- The medical care ratio of the Missouri health plan was 86.3% for the first half of 2008.
- The medical care ratio of the California health plan increased as a result of an increase in PMPM medical costs of approximately 12%, chiefly in pharmacy costs and hospital and specialist fee-for-service costs. The California medical care ratio rose to 86.6% in the first half of 2008 from 81.3% in the first half of 2007.
- The medical care ratio of the New Mexico health plan decreased 670 basis points to 79.5% in the first half of 2008, from 86.2% in the first half of 2007. This decrease was due to higher premium rates, particularly under the State Coverage Initiative (SCI) contract, which more than offset higher medical costs. The MCR decrease also included the impact of the recognition of $12.9 million in revenue associated with a minimum medical care ratio contract provision. Absent the adjustments made to premium revenue in the first half of 2008 and 2007, the medical care ratio in New Mexico would have been 85.8% in the first half of 2008 and 81.0% in the first half of 2007.
- The medical care ratios of the Ohio health plan, by line of business, were as follows:

	Six Months Ended	
	June 30, 2008	June 30, 2007
Covered Families and Children (CFC)	89.9%	91.4%
Aged, Blind or Disabled (ABD)	92.1	92.4
Aggregate	90.7%	91.6%

In total, the medical care ratio decreased 90 basis points year over year. This decrease was due primarily to lower fee-for-service hospital costs, offset slightly by higher capitation rates.

- The medical care ratio of the Texas health plan decreased from 91.7% in the first half of 2007 to 76.3% in the first half of 2008 primarily due to low medical costs for the Star Plus membership. During the first half of 2008, the Texas health plan reduced revenue by $6.8 million to record amounts due the state under a profit-sharing agreement.
- The medical care ratio of the Utah health plan decreased 90 basis points to 89.3% in the first half of 2008, from 90.2% in the first half of 2007. This decrease was primarily the result of lower medical care ratios in the Utah health plan's SCHIP and Medicare lines of business. The Utah health plan serves the majority of its Medicaid membership under a cost-plus contract with the state of Utah. The Utah health plan's SCHIP and Medicare lines of business are conducted under "at risk" prepaid capitation contracts.
- The medical care ratio of the Washington health plan increased to 82.3% in the first half of 2008 from 80.6% in the first half of 2007. Fee-for-service hospital and specialist costs as a percentage of premium revenue were higher in the first half of 2008 than in the first half of 2007. The higher fee-for-service costs were driven by increases to the Medicaid fee schedule that took effect on each of August 1, 2007 and January 1, 2008.

General and Administrative Expenses

General and administrative expenses were $165.2 million, or 11.0% of total revenue, for the first half of 2008 compared with $130.6 million, or 11.1% of total revenue, for the first half of 2007. This decrease was due primarily to a reduction in premium taxes in Michigan from 6.0% of premium revenue to 5.5% of premium revenue effective January 1, 2008, and increased credits taken against premium taxes in New Mexico during the first half of 2008.

Core G&A expenses increased to 8.0% of revenue in the first half of 2008 compared with 7.8% in the first half of 2007. The increase in core G&A compared with the first half of 2007 was primarily due to our continued investment in the administrative infrastructure necessary to support our Medicare product line as indicated in the table below.

	Six Months Ended June 30,			
	2008		2007	
	Amount (in thousands)	% of Total Revenue	Amount (in thousands)	% of Total Revenue
Medicare-related administrative costs	$ 9,410	0.6%	$ 3,679	0.3%
Non Medicare-related administrative costs:				
Administrative payroll, including employee incentive compensation	92,603	6.2	74,901	6.4
All other administrative expense	18,630	1.2	12,840	1.1
Core G&A expenses	$ 120,643	8.0%	$ 91,420	7.8%

Depreciation and Amortization

Depreciation and amortization expense increased $3.3 million in the first half of 2008 compared with the first half of 2007, including a $1.9 million increase in depreciation expense due to investments in infrastructure, and a $1.4 million increase in amortization expense, primarily due to intangible assets associated with the 2007 Mercy CarePlus acquisition in Missouri.

Interest Expense

Interest expense in the first half of 2008 increased $2.7 million compared with the first half of 2007, principally due to the issuance of our $200 million 3.75% Convertible Senior Notes in October 2007.

Income Taxes

Income taxes were recorded at an effective rate of 40.8% in the first half of 2008 compared with 38.1% in the first half of 2007. The increase in our effective tax rate was primarily the result of a change in Michigan state taxes effective January 1, 2008. Prior to January 1, 2008 Michigan state taxes were calculated as a percentage of net income at a rate of 1.9%. As of January 1, 2008, the state income tax was changed to comprise three components on a combined filing basis: a gross receipts tax calculated at 0.8% of modified gross receipts; an income tax calculated at 4.95% of income before taxes; and a surtax of 21.99% of the total of the previous two items.

Liquidity and Capital Resources

We generate cash from premium revenue and investment income. Our primary uses of cash include the payment of expenses related to medical care services and G&A expenses. We generally receive premium revenue in advance of payment of claims for related health care services.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets. As of June 30, 2008, we had cash and cash equivalents of $425.4 million, investments totaling $263.1 million, and restricted investments of $29.9 million. The cash equivalents consist of highly liquid securities with original or purchase date remaining maturities of up to three months that are readily convertible into known amounts of cash. Our investments consisted of investment grade debt securities and are designated as available-for-sale. Of the $263.1 million total, $196.3 million are classified as current assets, and $66.8 million are classified as non-current assets (see further discussion below). Our investment policies require that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates are periodically reset) and that the average maturity be four years or less. The restricted investments, classified as non-current assets and designated as held-to-maturity, consist of interest-bearing deposits and U.S. treasury securities required by the respective states in which we operate. These states also prescribe the types of instruments in which our subsidiaries may invest their funds. Professional portfolio managers operating under documented investment guidelines manage our investments. The average annualized portfolio yield for the six months ended June 30, 2008 and 2007 was approximately 3.5% and 5.1%, respectively.

Cash provided by operating activities for the six months ended June 30, 2008, was $39.5 million compared with $87.9 million for the same period in 2007, a decrease of $48.4 million. The decline was due primarily to the following: timing of the receipt of premiums recorded as deferred revenue in Ohio and Washington netting to a $16.1 million decline year over year; the reversal of $12.9 accrued costs relating to the minimum medical care ratio contract provision in New Mexico in the first half of 2008; and the maturation of our operations in Texas and Ohio during the first half of 2008. As enrollment grew at these health plans during 2007, medical expense outpaced claims payments, leading to increased claims liabilities. In the first half of 2008 enrollment has stabilized and medical expenses are no longer outpacing claims payments.

We have a $200 million credit facility. Borrowings under this credit facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. As of June 30, 2008, there were no amounts outstanding under this credit facility. See Note 6 to the condensed consolidated financial statements included in this quarterly report for more information regarding our credit facility.

In April 2008, our board of directors authorized the repurchase of up to $30 million of our common stock on the open market or through privately negotiated transactions. We used working capital to fund the repurchases under this program. The timing and amount of repurchases (up to an aggregate repurchase amount of $30 million) were primarily made pursuant to a trading plan dated as of May 2, 2008. The trading plan became effective May 5, 2008, and terminated when the aggregate cost of the repurchases totaled $30 million on June 12, 2008. During the quarter ended June 30, 2008, we repurchased 1.1 million shares. We did not repurchase any shares during the quarter ended March 31, 2008.

On July 22, 2008, our board of directors authorized the repurchase of up to one million shares of our common stock. The repurchase program will be funded using our working capital, and the timing and amount of any shares repurchased will be made pursuant to a trading plan. The repurchase program extends through December 31, 2008, but we reserve the right to suspend or discontinue the program at any time.

At June 30, 2008, we had working capital of $332.6 million compared with $404.7 million at December 31, 2007. At June 30, 2008, the parent company (Molina Healthcare, Inc.) had cash and investments of approximately $76.1 million, including $19.6 million in auction rate securities. 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.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our nine HMO subsidiaries operating in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The HMOs are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our HMOs.

The National Association of Insurance Commissioners, or NAIC, has established model rules which, if adopted by a particular state, set minimum capitalization requirements for HMOs and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. California and Missouri have not adopted RBC rules, but have established their own minimum capitalization requirements.

At June 30, 2008, our HMOs had aggregate statutory capital and surplus of approximately $349.7 million, compared with the required minimum aggregate statutory capital and surplus of approximately $207.6 million. All of our HMOs were in compliance with the minimum capital requirements at June 30, 2008. We have the ability and commitment to provide additional capital to each of our HMOs when necessary to ensure that they continue to meet statutory and regulatory capital requirements.

Contractual Obligations

In our Annual Report on Form 10-K for the year ended December 31, 2007, we reported on our contractual obligations as of that date. There have been no material changes to our contractual obligations since that report.

Critical Accounting Policies

When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. The determination of our liability for claims and medical benefits payable is particularly important to the determination of our financial position and results of operations in any given period. This determination of our liability requires the application of a significant degree of judgment by our management. As a result, the determination of our liability for claims and medical benefits 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 liabilities include, among other items, 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 Reported,” or IBNR. Our IBNR liability, 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 IBNR monthly using actuarial methods based on a number of factors. Our estimated IBNR liability represented $248.7 million of our total medical claims and benefits payable of $305.5 million as of June 30, 2008. Excluding IBNR related to our Utah health plan, where we are primarily reimbursed on a cost-plus basis, our IBNR liability at June 30, 2008 was $231.9 million.

The factors we consider when estimating our IBNR 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, the incidence of high dollar or catastrophic claims, entry into new geographic markets, and modifications and upgrades to our claims processing systems and practices. Our assessment of these factors is then translated into an estimate of our IBNR liability at the relevant measuring point through the calculation of a base estimate IBNR, a further reserve for adverse claims development, and an estimate of the administrative costs of

settling all claims incurred through the reporting date. The base estimate of IBNR is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

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

The following table reflects the change in our estimate of claims liability as of June 30, 2008 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding June 30, 2008 by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Our Utah health plan is excluded from these calculations, because the majority of the Utah business is conducted under a cost-plus reimbursement contract.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable (in thousands)
(6)%	$ 50,315
(4)%	33,543
(2)%	16,772
2%	(16,772)
4%	(33,543)
6%	(50,315)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of June 30, 2008 that would have resulted had we altered our trended PMPM factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Our Utah HMO is excluded from these calculations, because the majority of the Utah business is conducted under a cost-plus reimbursement contract.

(Decrease) Increase in Trended Per Member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable (in thousands)
(6)%	$(26,877)
(4)%	(17,918)
(2)%	(8,959)
2%	8,959
4%	17,918
6%	26,877

Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNR at June 30, 2008, net income for the six months ended June 30, 2008 would increase or decrease by approximately $8.4 million pretax, or $0.18 per diluted share, net of tax. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNR at June 30, 2008, net income for the six months ended June 30, 2008 would increase or decrease by approximately $4.5 million pretax, or $0.09 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be $41.9 million pretax, or $0.88 per diluted share, net of tax, and $22.4 million pretax, or $0.47 per diluted share, net of tax, respectively.

It is important to note that any error in the estimate of either completion factors or trended PMPM costs would usually be accompanied by an error in the estimate of the other component, and that an error in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement

of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities and medical care costs in the same direction. For example, if completion factors were overestimated by 1%, resulting in an overstatement of net income by $5.0 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 IBNR reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, which also uses actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNR. It is intended to capture the adverse development of factors such as known outbreaks of disease such as influenza, our entry into new geographic markets, our provision of services to new populations such as the aged, blind or disabled (ABD), claims receipt and payment experience, changes in membership, cost trends, changes to Medicaid fee schedules, incidence of high dollar or catastrophic claims, changes in provider billing practices, health care service utilization trends, and modifications and upgrades to our claims processing systems and practices. 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 IBNR after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNR liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNR 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 to establish IBNR.

On a monthly basis, we review and update our estimated IBNR liability 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, the incidence of high dollar or catastrophic claims, changes in membership, entry into new geographic markets, and modifications and upgrades to our claims processing systems and practices. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results in 2007 when the amounts ultimately paid out were less than the amount of our established reserves by approximately 19%. As of June 30, 2008, we estimate that the total payout in satisfaction of the liability established for claims and medical benefits payable at December 31, 2007 will be approximately 15% less than the amount originally recorded. This estimate may change during the course of the year as more information becomes available.

The apparent overestimation of our liability for claims and medical benefits payable at December 31, 2007 led to the recognition of a benefit from prior period claims development in the first half of 2008. The overestimation of

the claims liability at our Michigan and Washington health plans was principally the cause of the recognition of a benefit from prior period claims development. This was partially offset by the underestimation of our claims liability at December 31, 2007 at our Missouri health plan:

- In Michigan, we overestimated the upward trend in medical costs in the second half of 2007, principally due to claims processing difficulties during the third quarter of 2007 that exaggerated the upward trend in medical costs.
- In Washington, we did not fully account for reduced utilization of medical services in the fourth quarter of 2007, thus overestimating our liability at December 31, 2007.
- In Missouri, we underestimated the upward trend in medical costs during the latter half of 2007 that was driven by an increase in the Medicaid fee schedule effective July 1, 2007. Additionally, we underestimated the impact of the underpayment of certain hospital claims in the second half of 2007. Additional payments were made on many of those claims in the first quarter of 2008.

The recognition of a benefit from prior period claims development did not have a material impact on our consolidated results of operations in the first half of 2008.

In estimating our claims liability at June 30, 2008, we adjusted our base calculation to take account of the impact of the following factors which we believe are reasonably likely to change our final claims liability amount (some of the factors listed below were also factors impacting our final claims liability amount at December 31, 2007):

- Our assessment regarding the impact of some overpayments made to certain Ohio providers in 2007 and 2006 and the impact of those overpayments on estimated medical cost trends.
- The impact of the increased incidence of respiratory illness in the first quarter of 2008 as compared to previous years.
- Costs associated with our newly acquired membership in Missouri, as well as the impact of any difference between our claims payment policies and those used by the prior management of our Missouri health plan.
- Increases in claims inventory at our California and Michigan health plans during the second quarter of 2008.
- Decreases in claims inventory at our New Mexico, Ohio, and Washington health plans during the second quarter of 2008.
- The addition, effective April 1, 2008, of approximately 35,000 members to our Ohio health plan.

Any absence of adverse claims development (as well as the expensing of the costs, through general and administrative expense, 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. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability.

We seek to maintain a consistent claims reserving methodology across all periods. Accordingly, any prior period benefit from an un-utilized reserve for adverse claims development would likely be offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) in the current period, and thus the impact on earnings for the current period would likely be minimal.

The following table presents the components of the change in our medical claims and benefits payable for the periods indicated. The negative amounts displayed for "*components of medical care costs related to prior years*" represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The benefit of this prior period development may be offset by the addition of a

reserve for adverse claims development when estimating the liability at the end of the period (captured as a "*component of medical care costs related to current year*").

	As of and for the Six Months Ended June 30,		As of and for the Year Ended December 31,
	2008	2007	2007
	(dollar amounts in thousands)		
Balances at beginning of period	$ 311,606	$ 290,048	$ 290,048
Medical claims and benefits payable from business acquired	—	—	14,876
Components of medical care costs related to:			
Current year	1,315,469	1,036,378	2,136,381
Prior years	(48,293)	(43,036)	(56,298)
Total medical care costs	1,267,176	993,342	2,080,083
Payments for medical care costs related to:			
Current year	1,043,522	764,638	1,851,035
Prior years	229,719	215,513	222,366
Total paid	1,273,241	980,151	2,073,401
Balances at end of period	$ 305,541	$ 303,239	$ 311,606
Benefit from prior period as a percentage of balance at beginning of period	15.5%	14.8%	19.4%
Benefit from prior period as a percentage of premium revenue	3.2%	3.7%	2.3%
Benefit from prior period as a percentage of total medical care costs	3.8%	4.3%	2.7%
Days in claims payable	47	54	52
Number of members at end of period	1,234,000	1,076,000	1,149,000
Number of claims in inventory at end of period	151,500	254,800	161,400
Billed charges of claims in inventory at end of period	$ 209,100	$ 260,100	$ 212,000
Claims in inventory per member at end of period	0.12	0.24	0.14

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.

Item 3. *Quantitative and Qualitative Disclosures About Market Risk.*

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. We invest a substantial portion of our cash in the CADRE Liquid Asset Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. Professional portfolio managers operating under documented investment guidelines manage our investments. Restricted investments are invested principally in certificates of deposit and U.S. treasury

securities. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of June 30, 2008, we held investments in auction rate securities, totaling $71.8 million, with a fair value of $66.8 million, which are required to be measured at fair value on a recurring basis. Our auction rate securities are designated as available-for-sale securities and are reflected at fair value. Prior to January 1, 2008, these securities were recorded at fair value based on quoted prices in active markets (i.e., SFAS 157 Level 1 data). Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes, and which resets the applicable interest rate at pre-determined intervals, usually every 7, 28, or 35 days. However, due to recent events in the credit markets, the auction events for some of these instruments failed during the first half of 2008. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. Therefore, the fair values of these securities were estimated using a discounted cash flow analysis or other type of valuation model as of June 30, 2008. These analyses considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows, and the expectation of the next time the security would be expected to have a successful auction. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

As a result of the declines in fair value for our investments in auction rate securities, which we deem to be temporary and attribute to liquidity issues rather than to credit issues, we have recorded an unrealized loss of $5.0 million to accumulated other comprehensive income for the six months ended June 30, 2008. Substantially all of the $66.8 million in auction rate security instruments held by us at June 30, 2008 were in securities collateralized by student loans, which loans are guaranteed by the U.S. government. Due to our belief that the market for these student loan collateralized instruments may take in excess of twelve months to fully recover, we have classified these investments as non-current, and have included them in investments on the unaudited condensed consolidated balance sheet at June 30, 2008. As of June 30, 2008, we continue to earn interest on our auction rate security instruments. Any future fluctuation in fair value related to these instruments that we deem to be temporary, including any recoveries of previous write-downs, would be recorded to accumulated other comprehensive (loss) income. If we determine that any future valuation adjustment was other than temporary, we would record a charge to earnings as appropriate.

Item 4. ***Controls and Procedures***

Evaluation of Disclosure Controls and Procedures: Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, has concluded, based upon its evaluation as of the end of the period covered by this report, that the Company's "disclosure controls and procedures" (as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (the "Exchange Act")) are effective to ensure that information required to be disclosed in the reports that we file or submit under the Exchange Act is recorded, processed, summarized, and reported within the time periods specified in the Securities and Exchange Commission's rules and forms.

Changes in Internal Control Over Financial Reporting: There has been no change in our internal control over financial reporting during the three months ended June 30, 2008 that has materially affected, or is reasonably likely to materially affect, our internal controls over financial reporting.

PART II — OTHER INFORMATION

Item 1. ***Legal Proceedings***

The health care industry is 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.

Malpractice Action. On February 1, 2007, a complaint was filed in the Superior Court of the State of California for the County of Riverside by plaintiff Staci Robyn Ward through her guardian ad litem, Case No. 465374. The complaint purports to allege claims for medical malpractice against several unaffiliated physicians, medical groups, and hospitals, including Molina Medical Centers and one of its physician employees. The plaintiff alleges that the defendants failed to properly diagnose her medical condition which has resulted in her severe and permanent disability. On July 22, 2007, the plaintiff passed away. The proceeding is in the discovery stage, and no prediction can be made as to the outcome.

Starko. Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named health maintenance organizations participating in the New Mexico Medicaid program as defendants (the "HMOs"), including Cimarron Health Plan, the predecessor of our New Mexico HMO. The plaintiffs assert that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. On July 10, 2007, the court dismissed all damages claims against Molina Healthcare of New Mexico, leaving at that time only a pending action for injunctive and declaratory relief. On August 15, 2007, the court dismissed all remaining claims against Molina Healthcare of New Mexico, including the action for injunctive and declaratory relief. The plaintiffs have filed an appeal with respect to the court's dismissal orders, and the parties have submitted their respective appellate briefs and are awaiting oral argument. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the Molina Healthcare of New Mexico, an indemnification escrow account was established and funded with $6.0 million to indemnify Molina Healthcare of New Mexico against the costs of such litigation and any eventual liability or settlement costs. As of June 30, 2008, approximately $4.2 million remained in the indemnification escrow fund.

We are involved in other legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. These actions, individually or in the aggregate, when finally concluded and determined, are not likely, in our opinion, to have a material adverse effect on our consolidated financial position, results of operations, or cash flows.

Item 1A. ***Risk Factors***

Our investment portfolio may suffer losses from reductions in market interest rates and fluctuations in fixed income securities which could materially and adversely affect our results of operations or liquidity.

As of June 30, 2008, our portfolio of fixed income securities totaled $263.1 million, our cash and cash equivalents totaled $425.4 million, and restricted investments held as collateral totaled $29.9 million. This portfolio of holdings generated investment income totaling approximately 25% and 36% of our pretax income for the six months ended June 30, 2008 and 2007, respectively. The performance of our portfolio is interest rate driven. Therefore, volatility in interest rates, such as the recent actions by the Federal Reserve Bank Board, affects our returns on and the market value of our portfolio. This and any future reductions in the federal funds interest rate or other disruptions in the credit markets could materially and adversely affect our results of operations and liquidity.

A mandated retroactive change to the inpatient per diem rates paid by our California health plan to non-contracted hospitals could have a materially adverse effect on our results of operations.

Under the so-called Rogers Amendment to the Medicaid provisions of the Deficit Reduction Act of 2005, 42 U.S.C. § 1396u-2(b)(2)(D), a Medicaid provider which does not have a contract with a Medicaid managed care entity must accept as payment the amount otherwise applicable outside of managed care minus any payments for indirect costs of medical education and direct costs of graduate medical education. For purposes of a state where rates paid to hospitals are negotiated by contract and not publicly released, such as in California, the amount applicable under this requirement is the "average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals."

There is a disagreement among health plans and hospitals over how this payment language regarding average contract rates should be applied to the Medicaid program in California, known as Medi-Cal. The California Department of Health Care Services, known as DHCS, has convened a collaborative workgroup of health plans, hospitals, industry associations, and government representatives to discuss the appropriate application of the Rogers Amendment to non-contracted providers of emergency services in California. A recent DHCS proposal to the workgroup provides for the creation of weighted average per diem rates for both tertiary and non-tertiary hospitals, and for the retroactive application of these per diem rates to January 1, 2007, the effective date of the Rogers Amendment. Because the proposed per diem rates are materially greater than the existing average contract rates paid by our California health plan to non-contracting hospitals, if this proposal were to become effective, the resulting additional cost to the Company's California health plan could have a materially adverse effect on our results of operations.

In addition to the other information and risk factors set forth in this report, you should carefully consider the risk factors discussed in Part I, Item 1A — Risk Factors, in our Annual Report on Form 10-K for the year ended December 31, 2007. The risks described herein and in our Annual Report on Form 10-K are not the only risks facing our Company. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial may also materially adversely affect our business, financial condition, and/or operating results.

Item 2. ***Unregistered Sales of Equity Securities and Use of Proceeds***

On June 30, 2008, we issued a total of 48,186 shares of our common stock in reliance upon the exemption from securities registration provided by Section 4(2) of the Securities Act of 1933. The shares were issued to a single accredited investor for investment purposes in connection with our acquisition of all of the assets of The Game of Work, LLC, a Utah limited liability company. The total agreed-upon consideration for the assets, including both the unregistered shares issued and cash, was approximately $2.3 million.

Issuer Purchases of Equity Securities

As publicly announced on April 29, 2008, our board of directors authorized the repurchase of up to $30 million of our common stock on the open market or through privately negotiated transactions. We used working capital to fund the repurchases under this program. The timing and amount of repurchases (up to an aggregate repurchase amount of $30 million) were primarily made pursuant to a Rule 10b5-1 trading plan dated as of May 2, 2008. The Rule 10b5-1 plan became effective May 5, 2008, and terminated when the aggregate cost of the repurchases totaled $30 million on June 12, 2008. Purchases of common stock made by or on behalf of the Company during the quarter ended June 30, 2008 are set forth below:

	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number (or Approximate Dollar Value) of Shares That May Yet Be Purchased Under the Plans or Programs
April 1 — April 30, 2008	—	—	—	$30,000,000
May 1 — May 31, 2008	731,000	$25.3953	731,000	$11,414,000
June 1 — June 30, 2008	399,789	$28.5203	399,789	—
Total	1,130,789	$26.5001	1,130,789	—

Item 4. ***Submission of Matters to a Vote of Security Holders***

At our 2008 Annual Meeting of Stockholders held on May 15, 2008, our stockholders elected three Class III directors as follows:

Director	Votes For	Votes Withheld
J. Mario Molina	26,166,849	66,103
Steven J. Orlando	26,067,885	165,067
Ronna E. Romney	26,067,470	165,482

The three directors' terms as Class III directors shall continue until the 2011 Annual Meeting of Stockholders. There were no additional matters voted upon at the Annual Meeting.

Item 5. ***Other Information.***

None.

Item 6. ***Exhibits***

A list of exhibits required to be filed as part of this Quarterly Report on Form 10-Q is set forth in the Index to Exhibits, which immediately precedes such exhibits, and is incorporated herein by this reference.

SIGNATURES

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 thereunto duly authorized.

MOLINA HEALTHCARE, INC.
(Registrant)

/s/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President
(Principal Executive Officer)

Dated: July 30, 2008

/s/ JOHN C. MOLINA, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer
(Principal Financial Officer)

Dated: July 30, 2008

EXHIBIT INDEX

Exhibit No.	Title
31.1	Certification of Chief Executive Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Chief Financial Officer pursuant to Rules 13a-14(a)/15d-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification 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.
32.2	Certification 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.

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. Molina, M.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended June 30, 2008 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 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.

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

Dated: July 30, 2008

EXHIBIT 31.2

CERTIFICATION PURSUANT TO
RULES 13a-14(a)/15d-14(a)
UNDER THE SECURITIES EXCHANGE
ACT OF 1934, AS AMENDED

I, John C. Molina, J.D., certify that:

1. I have reviewed the report on Form 10-Q for the quarter ended June 30, 2008 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 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.

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

Dated: July 30, 2008

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-Q for the period ended June 30, 2008 (the "Report"), I, Joseph M. Molina, M.D., 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.

/s/ Joseph M. Molina, M.D.
Joseph M. Molina, M.D.
Chairman of the Board,
Chief Executive Officer and President

Dated: July 30, 2008

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-Q for the period ended June 30, 2008 (the "Report"), I, John C. Molina, J.D., 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.

/s/ John C. Molina, J.D.
John C. Molina, J.D.
Chief Financial Officer and Treasurer

Dated: July 30, 2008