MOLINA HEALTHCARE INC
Form S-3/A
May 06, 2005
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As filed with the Securities and Exchange Commission on May 6, 2005.

Registration No. 333-123783

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

AMENDMENT NO. 1

TO

FORM S-3

REGISTRATION STATEMENT

UNDER

THE SECURITIES ACT OF 1933

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware	**6324**	**13-4204626**
(State or other jurisdiction of incorporation or organization)	**(Primary Standard Industrial Classification Code Number)**	**(I.R.S. Employer Identification Number)**

One Golden Shore Drive

Long Beach, CA 90802

(562) 435-3666

(Address, including zip code, and telephone number

including area code, of registrant s principal executive offices)

J. Mario Molina, M.D.

President and Chief Executive Officer

One Golden Shore Drive

Long Beach, CA 90802

(562) 435-3666

(Name, address, including zip code, and telephone number,

including area code, of agent for service)

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Approximate date of commencement of proposed sale to the public: As soon as practicable after this Registration Statement becomes effective.

If the only securities being registered on this form are being offered pursuant to dividend or interest reinvestment plans, please check the following box. ¨

If any of the securities being registered on this form is to be offered on a delayed or continuous basis pursuant to Rule 415 under the Securities Act of 1933, other than securities offered only in connection with dividend or interest reinvestment plans, check the following box. ¨

If this form is filed to register additional securities for an offering pursuant to Rule 462(b) under the Securities Act, please check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ¨

If this form is a post-effective amendment filed pursuant to Rule 462(c) under the Securities Act, check the following box and list the Securities Act registration statement number of the earlier effective registration statement for the same offering. ¨

If delivery of the prospectus is expected to be made pursuant to Rule 434 under the Securities Act, please check the following box. ¨

The Registrant hereby amends this Registration Statement on such date or dates as may be necessary to delay its effective date until the Registrant shall file a further amendment which specifically states that this Registration Statement shall thereafter become effective in accordance with Section 8(a) of the Securities Act of 1933 or until this Registration Statement shall become effective on such date as the Commission, acting pursuant to Section 8(a), may determine.

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The information in this prospectus is not complete and may be changed. We may not sell these securities until the registration statement filed with the Securities and Exchange Commission is effective. This prospectus is not an offer to sell these securities and it is not soliciting an offer to buy these securities in any state where the offer or sale is not permitted.

SUBJECT TO COMPLETION, DATED MAY 6, 2005

PROSPECTUS

3,000,000 Shares

Molina Healthcare, Inc.

Common Stock

$ per share

We are selling 1,000,000 shares of our common stock and the selling stockholders named in this prospectus are selling 2,000,000 shares. We will not receive any proceeds from the sale of the shares by the selling stockholders. Molina Siblings Trust, a selling stockholder, has granted the underwriters an option to purchase up to 450,000 additional shares of common stock to cover over-allotments.

Our common stock is listed on the New York Stock Exchange under the symbol MOH. The last reported sale price of our common stock on the New York Stock Exchange on May 2, 2005 was $43.65 per share.

Investing in our common stock involves risks. See Risk Factors beginning on page 9.

Neither the Securities and Exchange Commission nor any state securities commission has approved or disapproved of these securities or determined if this prospectus is truthful or complete. Any representation to the contrary is a criminal offense.

	Per Share	Total
Public Offering Price	$	$
Underwriting Discount	$	$
Proceeds to Molina Healthcare, Inc. (before expenses)	$	$
Proceeds to the selling stockholders (before expenses)	$	$

The underwriters expect to deliver the shares to purchasers on or about , 2005.

Joint Book-Running Managers

Citigroup **UBS Investment Bank**

CIBC World Markets

Bear, Stearns & Co. Inc.

, 2005

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You should rely only on the information contained in or incorporated by reference in this prospectus. We have not authorized anyone to provide you with different information. We are not making an offer of these securities in any jurisdiction where the offer is not permitted. You should not assume that the information contained or incorporated by reference in this prospectus is accurate as of any date other than the date on the front of this prospectus or the date of the document incorporated by reference.

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SUMMARY

The following summary highlights selected information from, or incorporated by reference into, this prospectus and does not contain all of the information that you should consider before investing in our common stock. You should carefully read this entire prospectus, including the financial statements and related notes included or incorporated by reference in this prospectus, before making an investment decision. In this prospectus, the company, we, us or our refer to Molina Healthcare, Inc. and its subsidiaries, except where the context makes clear that the reference is only to Molina Healthcare, Inc. itself and not its subsidiaries.

Molina Healthcare, Inc.

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible to receive health care benefits through government-sponsored programs for low-income families and individuals, such as Medicaid and the State Children s Health Insurance Program, or SCHIP. We currently have health plans in California, Indiana, Michigan, New Mexico, Utah, and Washington that are administered by our health maintenance organization, or HMO, licensed subsidiaries operating in these states. We also operate 21 company-owned primary care clinics in California that are staffed by physicians, physician assistants, and nurse practitioners. We arrange health care services for members enrolled in our health plans through contracts with health care providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. As of March 31, 2005, approximately 803,000 members were enrolled in our health plans.

Our total annual revenue has increased from $185.7 million in 1999 to $1.175 billion in 2004. Over the same period, our net income grew from $9.4 million to $55.8 million. Our California HMO has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state. In Michigan, we became the state s largest Medicaid HMO in 2004 while increasing our enrollment nearly five-fold between December 31, 2003 and December 31, 2004. Our New Mexico HMO, acquired on July 1, 2004, generated over 18% of our total premium revenue during the second half of 2004. In Utah, we continue to generate substantial savings for the state Medicaid program, and we now have the largest Medicaid HMO in Washington, with approximately 50% market share.

Recent Developments

In December 2004, our Indiana subsidiary was licensed by the Indiana Department of Insurance to operate as an HMO in the State of Indiana. The license award precedes the implementation of a two-year contract, which commenced on January 1, 2005, for our Indiana subsidiary to provide Medicaid services within thirteen mandatory managed care counties.

In December 2004, our California HMO subsidiary entered into a definitive agreement with Universal Care, Inc. for the purchase of the Universal Medi-Cal (Medicaid) and Healthy Families Program (SCHIP) contracts. As part of the transaction, Universal will assign the bulk of its provider network related to its Medi-Cal and Healthy Families members to our California HMO. The proposed transfer has been approved by each of the California Department of Health Services, the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. Once effective, the transaction will add approximately 17,000 members to our California HMO s current membership.

In November 2004, our California HMO entered into a definitive agreement with Sharp Health Plan to transfer Sharp s Medi-Cal (Medicaid) and SCHIP contracts to our California HMO. As part of the transaction, Sharp will assign the bulk of its provider network to our California HMO. The proposed transfer has been approved by each of the California Department of Health Services, the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. Once effective, the transaction will add approximately 70,000 members to our California HMO s current membership.

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Our Industry

Medicaid and SCHIP. Medicaid provides health care coverage to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within federal guidelines. SCHIP is a program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. States have the option of administering SCHIP through their Medicaid programs.

The state and federal governments jointly finance Medicaid and SCHIP through a matching program in which the federal government pays a percentage based on the average per capita income in each state. Typically, this percentage match is at least 50%. Federal payments for Medicaid have no set dollar ceiling and are limited only by the amount states are willing to spend. State and local governments pay the share of Medicaid costs not paid by the federal government.

Characteristics of the Medicaid Population. The majority of our members have traditionally been eligible to receive Medicaid benefits as a result of their participation in the Temporary Assistance for Needy Families, or TANF, program of each state where we operate. This membership is for the most part comprised of mothers and their children, and was the first portion of the Medicaid population that states sought to move into managed care. This is a comparatively healthy population, and while it comprises the largest group of Medicaid members, Medicaid funds spent on its care are proportionally less than those spent on other segments of the Medicaid population.

Seeking to expand upon the benefits offered by Medicaid managed care, many states now wish to transition certain other segments of the Medicaid population into managed care. Chief among these groups is the Aged, Blind and Disabled, or ABD, Medicaid population. Like our TANF members, these individuals have distinct social and medical needs and are characterized by their cultural, ethnic, and linguistic diversity. Furthermore, members of this population often suffer from chronic conditions and require extensive and coordinated care spanning multiple medical and behavioral health specialties. Monthly premiums for ABD members are substantially higher than those for TANF members, as is the cost of their care.

According to the Urban Institute s Health Policy Center, based on 2003 data, annual Medicaid spending is estimated to be over five times greater for ABD members than for TANF members. We have pursued ABD membership over the past few years. At December 31, 2004, approximately 46,000 of our members were ABD enrollees, up from approximately 25,000 members in 2003.

Special Needs Plans (SNP) to Serve the Dual Eligible Population. Consistent with our intent to reach beyond the TANF population is our effort to serve the dual eligible population. This population is comprised of those Medicare beneficiaries who are also entitled to Medicaid benefits. Recent changes to the Medicare regulations allow us to offer a combined package of Medicare and Medicaid benefits to the dual eligible population, thereby integrating Medicare and Medicaid benefits to provide a single point of accountability for care and services. This integration of care is accomplished by the establishment of a Special Needs Plan, or SNP.

We have has submitted applications to operate SNPs (including a Medicare Part D prescription benefit) in California, Michigan, Utah, and Washington. In addition, we have submitted an application to service Medicare Long Term Care beneficiaries, as a subset of the Utah SNP. As is the case with our support of the ABD population, we believe our effort to establish SNPs is a natural extension of our commitment to providing quality, accessible health care to underserved populations served by government programs.

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and SCHIP, but without federal matching funds. Our Washington HMO served approximately 21,000 such members under that state s Basic Health Plan at December 31, 2004.

Medicaid Managed Care. The Medicaid members we serve generally represent diverse cultures and ethnicities. Many have had limited educational opportunities and do not speak English as their first language. Lack of adequate transportation is common.

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Under traditional Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These individuals typically have minimal access to preventive care, such as immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, providers are paid on a fee-for-service basis and lack incentive to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, most states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives a predetermined payment per enrollee for the covered health care services. The health plan, in turn, arranges for the provision of such services by contracting with a network of providers who are responsible for providing a comprehensive range of medical and hospital services. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Our Approach

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. We believe we are well positioned to capitalize on the growth opportunities in our markets. Our approach to managed care is based on the following key attributes:

Experience. For 25 years, we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. In that time we have developed and forged strong relationships with the constituents whom we serve members, providers, and government agencies.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations and the transition of members from other health plans.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions.

Cultural and Linguistic Expertise. We have a 25-year history of developing targeted health care programs for our culturally diverse membership and believe we are well-positioned to successfully serve these growing populations.

Proven Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost effectiveness of care.

Our Strategy

Our objective is to be the leading managed care organization serving Medicaid, SCHIP, and other low-income members. To achieve this objective, we intend to:

Focus on Serving Low-Income Families and Individuals. We will continue to focus on serving the beneficiaries of Medicaid and other government-sponsored programs, as our experience, infrastructure, and health care programs position us to optimally serve this population.

Increase our Membership. We will seek to grow our membership by expanding within existing markets and entering new markets.

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Manage Medical Costs. We will continue to use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members.

Leverage Operational Efficiencies. We will continue to leverage our centralized administrative infrastructure, flexible information systems and dedication to controlling administrative costs to provide economies of scale, allowing us to integrate new members and expand quickly in new and existing markets.

Our Health Plans

As of March 31, 2005, our operating health plans were located in California, Michigan, New Mexico, Utah, and Washington. We have also recently established a start-up operation in Indiana, where our HMO-licensed subsidiary began serving members in April 2005. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state in the periods presented:

	As of March 31,		As of December 31,		
State	**2005**	**2004**	**2004**	**2003**	**2002**
California	254,000	252,000	253,000	254,000	253,000
Michigan	157,000	89,000	158,000	82,000	33,000
New Mexico	61,000		65,000		
Utah	55,000	44,000	49,000	45,000	42,000
Washington	276,000	203,000	263,000	183,000	161,000
Total	803,000	588,000	788,000	564,000	489,000

Provider Networks

We arrange health care services for our members through contracts with providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table sets forth the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2004:

	California	**Michigan**	**New Mexico**	**Utah**	**Washington**	**Total**
Primary care physicians	2,201	1,249	1,488	1,250	2,714	8,902
Specialists	6,366	1,899	6,275	2,097	5,325	21,962

Hospitals	85	41	69	38	81	314

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members. Our medical management programs include specialized disease management programs that address the particular health care needs of our members, educational programs designed to increase awareness of various diseases, conditions, and methods of prevention, and pharmacy management programs that focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications.

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Best Practices

We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Health Plan Employer Data and Information Set (HEDIS) and accreditation by the National Committee on Quality Assurance, or NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Our California, Michigan, New Mexico, Utah, and Washington HMOs have each been accredited by the NCQA and we intend to seek accreditation for our Indiana HMO.

Our Company

Our principal executive offices are located at One Golden Shore Drive, Long Beach, CA 90802, and our telephone number is (562) 435-3666. Our website is located at www.molinahealthcare.com. Information contained on our website or linked to our website is not incorporated by reference into, or part of, this prospectus.

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The Offering

Common stock offered by us	1,000,000 shares
Common stock offered by the selling stockholders	2,000,000 shares (of which 983,171 shares are being offered by the Molina Siblings Trust, 671,829 shares are being offered by the MRM GRAT 903/2 and 345,000 shares are being offered by the MRM GRAT 904/2, see Principal and Selling Stockholders)
Over-allotment option by the Molina Siblings Trust	450,000 shares
Common stock to be outstanding after this offering	28,705,448 shares
Use of proceeds	We estimate that the net proceeds to us from the offering will be approximately $40.9 million (based on an assumed offering price of $43.65 per share, the last reported sale price of our common stock on the New York Stock Exchange on May 2, 2005). We intend to use approximately $3.1 million of the net proceeds to repay amounts outstanding under our credit facility. We intend to use the balance of the net proceeds for working capital and other general corporate purposes, which may include acquisitions. We will not receive any proceeds from the sale of shares by the selling stockholders.
New York Stock Exchange symbol	MOH
Risk Factors	This offering involves risks. See Risk Factors on page 9.

The number of shares of our common stock to be outstanding immediately after this offering is based on the number of shares outstanding as of May 2, 2005. It excludes, as of May 2, 2005, 581,447 shares of common stock subject to options outstanding under our stock incentive plans with a weighted average exercise price of $16.02 per share, of which options to purchase 387,047 shares were exercisable. It also excludes 60,000 shares of restricted stock issued to employees and directors that will vest incrementally through September 27, 2007.

Unless otherwise indicated, all information contained in this prospectus assumes no exercise of the underwriters option to purchase up to 450,000 additional shares.

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Summary Consolidated Financial Data

The summary consolidated financial data presented below has been derived from our audited financial statements for the years ended December 31, 2004, 2003, 2002, 2001, and 2000 and our unaudited financial statements for the three-month periods ended March 31, 2005 and 2004. See Management s Discussion and Analysis of Financial Condition and Results of Operations, as well as our financial statements and related notes included or incorporated by reference in this prospectus.

	Three Months Ended March 31,		Year Ended December 31,				
	2005	2004	2004(1)	2003	2002	2001	2000
	(Dollars in thousands, except per share data)						
Statements of Income Data:							
Revenue:							
Premium revenue	$ 390,924	$ 217,868	$ 1,166,870	$ 789,536	$ 639,295	$ 499,471	$ 324,300
Other operating revenue	1,263	1,295	4,168	2,247	2,884	1,402	1,971
Total premium and other operating revenue	392,187	219,163	1,171,038	791,783	642,179	500,873	326,271
Investment income	1,765	863	4,230	1,761	1,982	2,982	3,161
Total revenue	393,952	220,026	1,175,268	793,544	644,161	503,855	329,432
Expenses:							
Medical care costs	333,114	184,217	984,686	657,921	530,018	408,410	264,408
Salary, general and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	33,546	17,458	94,150	61,543	61,227	42,822	38,701
Depreciation and amortization	3,198	1,599	8,869	6,333	4,112	2,407	2,085
Total expenses	369,858	203,274	1,087,705	725,797	595,357	453,639	305,194
Operating income	24,094	16,752	87,563	67,747	48,804	50,216	24,238
Total other income (expense), net	(289)	907	122	(1,334)	(405)	(561)	(197)
Income before income taxes	23,805	17,659	87,685	66,413	48,399	49,655	24,041
Provision for income taxes	9,046	6,561	31,912	23,896	17,891	19,453	9,156
Income before minority interest	14,759	11,098	55,773	42,517	30,508	30,202	14,885
Minority interest						(73)	79
Net income	$ 14,759	$ 11,098	$ 55,773	$ 42,517	$ 30,508	$ 30,129	$ 14,964
Net income per share:							
Basic	$ 0.53	$ 0.44	$ 2.07	$ 1.91	$ 1.53	$ 1.51	$ 0.75
Diluted	$ 0.53	$ 0.43	$ 2.04	$ 1.88	$ 1.48	$ 1.46	$ 0.73
Cash dividends declared per share							$ 0.05
	27,616,000	25,501,000	26,965,000	22,224,000	20,000,000	20,000,000	20,000,000

Weighted average number of common shares outstanding							
Weighted average number of common shares and potential dilutive common shares outstanding	27,964,000	25,918,000	27,342,000	22,629,000	20,609,000	20,572,000	20,376,000

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	Three Months Ended March 31,		Year Ended December 31,				
	2005	2004	2004(1)	2003	2002	2001	2000
Operating Statistics:							
Medical care ratio(2)	84.9%	84.1%	84.1%	83.1%	82.5%	81.5%	81.0%
Salary, general and administrative expense ratio(3)	8.5%	7.9%	8.0%	7.8%	9.5%	8.5%	11.7%
Members (by category)(4)							
TANF	693,000	532,000	691,000	510,000	447,000	376,000	277,000
SCHIP	36,000	25,000	30,000	24,000	20,000	14,000	9,000
Basic Health	27,000	6,000	21,000	5,000	5,000	2,000	2,000
ABD	47,000	25,000	46,000	25,000	17,000	13,000	10,000
Total Members	803,000	588,000	788,000	564,000	489,000	405,000	298,000

	As of March 31,		As of December 31,				
	2005	2004	2004(1)	2003	2002	2001	2000
			(Dollars in thousands)				
Balance Sheet Data:							
Cash and cash equivalents	$ 242,425	$ 170,138	$ 228,071	$ 141,850	$ 139,300	$ 102,750	$ 45,785
Total assets	543,107	400,555	533,859	344,585	204,966	149,620	102,012
Long-term debt (including current maturities)	4,954		1,894		3,350	3,401	3,448
Total liabilities	196,380	118,575	203,237	123,263	109,699	84,861	67,405
Stockholders equity	346,727	281,980	330,622	221,322	95,267	64,759	34,607

(1) The balance sheet and operating results of the New Mexico HMO have been included since July 1, 2004, the date of acquisition. For additional information regarding this acquisition, including pro forma financial information, see our Current Report on Form 8-K/A filed with the Securities and Exchange Commission, or SEC, on September 13, 2004, and our Current Report on Form 8-K filed with the SEC on April 4, 2005. See also, Incorporation of Documents by Reference.

(2) Medical care ratio represents medical care costs as a percentage of premium and other operating revenue. Other operating revenue includes revenues related to our California clinics and reimbursements under various risks and savings sharing programs. The medical care ratio is a key operating indicator used to measure our performance in delivering efficient and cost effective health care services. Changes in the medical care ratio from period to period result from changes in Medicaid funding by the states, our ability to effectively manage costs, and changes in accounting estimates related to incurred but not reported claims. See Management s Discussion and Analysis of Financial Condition and Results of Operations for further discussion.

(3) Salary, general and administrative expense ratio represents such expenses as a percentage of total operating revenue.

(4) Number of members at end of period.

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RISK FACTORS

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully consider the risk factors set forth herein, as well as other information we include or incorporate by reference in this prospectus.

Risks Related To Our Business

Reductions in Medicaid funding could substantially reduce our profitability.

Substantially all of our revenues come from state Medicaid premiums. The premium rates paid by each state to health plans like ours differ depending on a combination of factors, such as upper payment limits established by the federal and state governments, a member s health status, age, gender, county or region, benefit mix, and member eligibility categories. Future Medicaid premium rate levels may be affected by continued government efforts to contain medical costs, or federal and state budgetary constraints. Changes in Medicaid funding could, for example, reduce the number of persons enrolled in or eligible for Medicaid, reduce the amount of reimbursement or payment levels by the federal or state governments or increase our administrative or health benefit costs. Additionally, changes could eliminate coverage for certain benefits such as our pharmacy, behavioral health, vision, or other benefits. In some cases, changes in funding could be made retroactive. The federal government and all of the states in which we operate are presently considering proposals and legislation that would implement certain Medicaid reforms or redesigns, reduce reimbursement or payment levels, or reduce the number of persons eligible for Medicaid. Reductions in Medicaid payments at either the federal or state level could reduce our profitability if we are unable to reduce our expenses.

As part of President Bush s 2006 Budget submission to Congress, there are a number of proposals related to federal funding of Medicaid. The Administration proposes to reduce federal funding to states for Medicaid by $60 billion over a ten-year period. This $60 billion reduction would be partially offset by $15 billion in proposed new Medicaid-related initiatives. The President s 2006 Budget contains little detail on these Medicaid proposals, and it is expected that more discussion of these proposals will occur throughout the year. It is uncertain whether any of these proposals, or a variation thereof, will be enacted. If the President s proposals are ultimately adopted and states are required to reduce or change funding mechanisms, our operations and financial performance could be adversely affected.

If our government contracts or our subcontracts with government contractors are not renewed or are terminated, our business will suffer.

All of our contracts are terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are subject to cancellation by the state in the event of unavailability of state or federal funding. In some jurisdictions, such cancellation may be immediate and in other jurisdictions a notice period is required. In addition, most contracts are terminable without cause. Most contracts are for a specified period and are subject to non-renewal. Our other contracts are also eligible for termination or non-renewal through annual competitive bids. We may face increased competition as other plans attempt to enter our markets through the contracting process. If we are unable to renew, successfully rebid, or compete for any of our government contracts, or if any of our contracts are terminated, our business will suffer.

If we are unable to effectively manage medical costs, our profitability could be reduced.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage medical costs. Historically, our medical care costs as a percentage of premium and other operating revenue have fluctuated. Relatively small changes in these medical care ratios can create significant changes in our financial results. Changes in health care laws, regulations and practices, level of use of health care services, hospital costs, pharmaceutical costs, major epidemics, terrorism or bioterrorism, new medical technologies, and other external factors, including general economic conditions such as inflation levels, could reduce our ability to predict and effectively control the costs of providing health care services. Although we have been able to manage medical care costs through a variety of techniques, including various payment methods to primary care physicians and

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other providers, advance approval for hospital services and referral requirements, medical management and quality management programs, our information systems, and reinsurance arrangements, we may not be able to continue to effectively manage medical care costs in the future. If our medical care costs increase, our profits could be reduced or we may not remain profitable.

A failure to accurately estimate incurred but not reported medical care costs may hamper our operations.

Our medical care costs include estimates of claims incurred but not reported. We, together with our independent actuaries, estimate our medical claims liabilities using actuarial methods based on historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services and other relevant factors. The estimation methods and the resulting reserves are continually reviewed and updated, and adjustments, if necessary, are reflected in the period known. Our estimates of claims incurred but not reported may be inadequate in the future, which would negatively affect our results of operations. Further, our inability to accurately estimate claims incurred but not reported may also affect our ability to take timely corrective actions, further exacerbating the extent of the negative impact on our results.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or the interpretation and enforcement of those laws or regulations, could cause us to modify our operations and could negatively impact our operating results.

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than stockholders. The government agencies administering these laws and regulations have broad latitude to enforce them. These laws and regulations along with the terms of our government contracts regulate how we do business, what services we offer, and how we interact with members and the public. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations could reduce our profitability by:

- imposing additional capital requirements,
- increasing our liability,
- increasing our administrative and other costs,
- increasing or decreasing mandated benefits,
- forcing us to restructure our relationships with providers, or
- requiring us to implement additional or different programs and systems.

For example, Congress enacted the Health Insurance Portability and Accountability Act of 1996 which mandates that health plans enhance privacy protections for member protected health information. This requires health plans to add, at significant cost, new administrative, information, and security systems to prevent inappropriate release of protected member health information. The requirements for compliance with this law are uncertain and will continue to affect our profitability. The regulations enacting this law also establish significant criminal

penalties and civil sanctions for non-compliance, including fines for violations of the regulations by our business associates. Individual states periodically consider adding operational requirements applicable to health plans, often without identifying funding for these requirements. California recently required all health plans to make available to members independent medical review of their claims. This requirement is costly to implement and could affect our profitability.

We are subject to various routine and non-routine governmental reviews, audits, and investigation. Violation of the laws governing our operations, or changes in interpretations of those laws, could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide managed care services, the suspension or revocation of our licenses, and exclusion from participation in government sponsored health programs, including Medicaid and SCHIP. If we become subject to material fines or if other sanctions or other corrective actions were imposed upon us, we might suffer a substantial reduction in profitability, and might also lose one or more of our government contracts and as a result lose significant numbers of members and amounts of revenue.

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

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

Our business is dependent on effective and secure information systems that assist us in, among other things, monitoring utilization and other cost factors, supporting our health care management techniques, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status, and other information. If we experience a reduction in the performance, reliability, or availability of our information systems, our operations and ability to produce timely and accurate reports could be adversely affected. In addition, our information system software is leased from a third party. If the owner of the software were to become insolvent and fail to support the software, our operations could be negatively affected.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our operational needs. Moreover, our acquisition activity requires transitions to or from, and the integration of, various information systems. We regularly upgrade and expand our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security systems and client data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network, and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be negatively impacted by cancellation of contracts and loss of members if they are not prevented.

Difficulties in executing our acquisition strategy could adversely affect our business.

The acquisitions of Medicaid contract rights and other health plans have accounted for a significant amount of our growth. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that acquisitions similar in nature to those we have historically executed will be important to our future growth strategy. Many of the other potential purchasers of these assets have greater financial resources than we have. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include the integration of:

additional employees who are not familiar with our operations,

new provider networks, which may operate on terms different from our existing networks,

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additional members, who may decide to transfer to other health care providers or health plans,

disparate information, claims processing, and record keeping systems, and

internal controls and accounting policies, including those which require judgmental and complex estimation processes, such as estimates of claims incurred but not reported, accounting for goodwill, intangible assets, stock-based compensation, and income tax matters.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. For example, the previously announced agreements to transfer to the company the Medi-Cal (Medicaid) and Healthy Families Program (California s SCHIP) contracts of both Sharp Health Plan and Universal Care in San Diego County require four separate governmental agency approvals. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we will be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of the state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or to comply with these regulatory requirements for an acquisition in a timely manner, or at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced or to sustain our pattern of growth.

Ineffective management of our growth may negatively affect our results of operations, financial condition, and business.

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In 1998, we had total revenue of $135.9 million. In 2004, we had total revenue of $1.175 billion. Continued rapid growth could place a significant strain on our management and on other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

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

We operate in a highly competitive environment and in an industry that is currently subject to significant changes from business consolidations, new strategic alliances, and aggressive marketing practices by other managed care organizations. We compete for members principally on the basis of size, location, and quality of provider network, benefits supplied, quality of service, and reputation. A number of these competitive elements are partially dependent upon and can be positively affected by financial resources available to a health plan. Many other organizations with which we compete have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership.

Restrictions and covenants in our credit facility may limit our ability to make certain acquisitions and declare dividends.

We have a credit facility that imposes various restrictions and covenants, including prescribed debt coverage ratios, net worth requirements, and acquisition limitations, that restrict our financial and operating flexibility, including our ability to make certain acquisitions above specified

values and declare dividends without lender approval. Our growth strategy may be negatively impacted by our inability to act with complete flexibility.

We are dependent on our executive officers and other key employees.

Our operations are highly dependent on the efforts of our President and Chief Executive Officer and our Executive Vice Presidents, some of whom have entered into employment agreements with us. These employment

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agreements may not provide sufficient incentives for those employees to continue their employment with us. While we believe that we could find replacements, the loss of their leadership, knowledge, and experience could negatively impact our operations. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the managed care industry have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. Our success is also dependent on our ability to hire and retain qualified management, technical, and medical personnel. We may be unsuccessful in recruiting and retaining such personnel which could negatively impact our operations.

Claims relating to medical malpractice and other litigation could cause us to incur significant expenses.

Our providers involved in medical care decisions may be exposed to the risk of medical malpractice claims. Providers at the primary care clinics we operate in California are employees of our California subsidiary. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our subsidiary may experience increased exposure to liability for acts or omissions by our employees and for acts or injuries occurring on our premises. We maintain errors and omissions insurance in the amount of $5 million per occurrence and in aggregate for each policy year, medical malpractice insurance for our clinics in the amount of $1 million per occurrence, and an annual aggregate limit of $3 million, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, this insurance may not be sufficient or available at a reasonable cost to protect us from damage awards or other liabilities. Even if any claims brought against us were unsuccessful or without merit, we would have to defend ourselves against such claims. The defense of any such actions may be time-consuming and costly, and may distract our management s attention. As a result, we may incur significant expenses and may be unable to effectively operate our business.

In addition, claimants often sue managed care organizations for improper denials or delay of care. Also, Congress, as well as several states, are considering legislation that would permit managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. If this or similar legislation were enacted, claims of this nature could result in substantial damage awards against us and our providers that could exceed the limits of any applicable medical malpractice insurance coverage. Successful malpractice or tort claims asserted against us, our providers, or our employees could adversely affect our financial condition and profitability.

The results of our operations could be negatively impacted by both upturns and downturns in general economic conditions.

The number of persons eligible to receive Medicaid benefits has historically increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. However, during such economic downturns, state and federal budgets could decrease, causing states to attempt to cut health care programs, benefits, and rates. If federal or state funding were decreased while our membership was increasing, our results of operations would be negatively affected. Conversely, the number of persons eligible to receive Medicaid benefits may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels and profitability to decrease, which could lead to decreases in our operating income.

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

We principally operate through our health plan subsidiaries. These subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In Michigan, New Mexico, Utah and Washington, our health plans must give thirty days

advance notice and the opportunity to disapprove extraordinary dividends to the respective state departments of insurance for amounts over the lesser of (a) ten percent of surplus or net worth at the prior year

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end or (b) the net income for the prior year. The discretion of the state regulators, if any, in approving or disapproving a dividend is not clearly defined. Health plans that declare non-extraordinary dividends must usually provide notice to the regulators ten or fifteen days in advance of the intended distribution date of the non-extraordinary dividend. The aggregate amounts our health plan subsidiaries could have paid us at December 31, 2004, 2003, and 2002 without approval of the regulatory authorities were approximately $27.9 million, $29.0 million, and $28.9 million, respectively, assuming no dividends had been paid during the respective calendar years. If the regulators were to deny or significantly restrict our subsidiaries requests to pay dividends to us, the funds available to our company as a whole would be limited, which could harm our ability to implement our business strategy. For example, we could be hindered in our ability to make debt service payments on amounts drawn from our credit facility.

Unforeseen changes in regulations or pharmaceutical market conditions may impact our revenues and adversely affect our results of operations.

A significant category of our health care costs relate to pharmaceutical products and services. Evolving regulations and state and federal mandates regarding coverage may impact the ability of our HMOs to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, the price of pharmaceuticals, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. The unpredictable nature of these factors may have an adverse effect on our financial condition and results of operations.

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. As permitted by SEC guidance, our internal control evaluation and testing, and the attestation of our independent registered public accounting firm, included in our Annual Report on Form 10-K for the year ended December 31, 2004 did not cover the internal controls of Health Care Horizons, Inc., which we acquired on July 1, 2004.

We will, however, have to assess the internal controls of that business no later than June 30, 2005, and we are in the process of transitioning its internal controls over to our systems. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Risks Associated With This Offering

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the closing sales price of our common stock has ranged from a low of $20.15 to a high of $53.23. A number of factors will continue to influence the market price of our common stock, including:

state and federal budget decreases,

adverse publicity regarding health maintenance organizations and other managed care organizations,

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- government action regarding eligibility,
- changes in government payment levels,
- changes in state mandatory programs,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies,
- the termination of our Medicaid or SCHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including inflation and unemployment rates.

In addition, the stock market in general has been highly volatile recently. During this period of market volatility, the stocks of health care companies also have been highly volatile and have recorded lows well below their historical highs. Our stock may not trade at the same levels as the stock of other health care companies and the market in general may not sustain its current prices. Also, if the trading market for our stock does not continue to develop, securities analysts may not initiate or maintain research coverage of our company and our shares, and this could further depress the market for our shares.

You will experience immediate and significant dilution in the book value per share and will experience further dilution with the future exercise of stock options.

If you purchase common stock in this offering, you will incur immediate dilution, which means that you will pay a price per share that exceeds by $33.53 the per share net tangible book value of our assets immediately following the offering (on an as adjusted basis as of March 31, 2005 based on an assumed offering price of $43.65 per share, the last reported sale price of our common stock on the New York Stock Exchange on May 2, 2005).

As of May 2, 2005, we had outstanding options to purchase 581,447 shares of our common stock, of which options to purchase 387,047 shares were exercisable. From time to time, we may issue additional options to employees and non-employee directors pursuant to our equity incentive plans. These options generally vest commencing one year from the date of grant and continue vesting over a three year period. Once these options vest, our stockholders will experience further dilution as these stock options are exercised by their holders.

Future sales, or the availability for sale, of our common stock may cause our stock price to decline.

In connection with this offering, we, along with our executive officers, directors and certain stockholders who beneficially own 5% or more of our common stock, will have agreed prior to the commencement of this offering, subject to limited exceptions, not to sell or transfer any shares of common stock for 90 days after the date of this prospectus without the underwriters consent. However, Citigroup Global Markets Inc. and UBS Securities LLC, as representatives of the underwriters, may release these shares from these restrictions at any time. In evaluating whether to grant such a request, Citigroup Global Markets Inc. and UBS Securities LLC may consider a number of factors with a view toward maintaining an orderly market for, and minimizing volatility in the market price of, our common stock. These factors include, among others, the number of shares involved, recent trading volume and prices of the stock, the length of time before the lock-up expires and the reasons for, and the timing of, the request. We cannot predict what effect, if any, market sales of shares held by any stockholder or the availability of these shares for future sale will have on the market price of our common stock.

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Approximately 14,690,437 restricted shares of common stock held by our officers, directors and certain stockholders who beneficially own more than 5% of our common stock may be sold in the public market 91 days after the date of this prospectus, subject to applicable volume and other limitations imposed under federal securities laws. Sales of substantial amounts of our common stock in the public market after the completion of this offering, or the perception that such sales could occur, could adversely affect the market price of our common stock and could materially impair our future ability to raise capital through offerings of our common stock. See Shares Eligible for Future Sale below for a more detailed description of the restrictions on selling shares of our common stock after this offering.

Our directors and officers and members of the Molina family own a majority of our capital stock, decreasing the influence of other stockholders on stockholder decisions.

Following this offering, our executive officers and directors, in the aggregate, will beneficially own approximately 17.7% of our capital stock, or 16.1% if the underwriters over-allotment option is exercised in full. Following this offering, members of the Molina family (some of whom are also officers or directors), in the aggregate, will beneficially own approximately 50.1% of our capital stock, or 48.5% if the underwriters over-allotment option is exercised in full, either directly or in trusts of which members of the Molina family are beneficiaries. In some cases, members of the Molina family are trustees of the trusts. As a result, Molina family members, acting by themselves or together with our officers and directors, will have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of substantially all of our assets. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of ownership in our company could delay, defer, or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of our controlling stockholders may be different from those of our company or our other stockholders, and our controlling stockholders may vote their common stock in a manner that may adversely affect our other stockholders.

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

We are subject to the Delaware anti-takeover laws regulating corporate takeovers. These provisions may prohibit stockholders owning 15% or more of our outstanding voting stock from merging or combining with us.

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

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

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

Our forecasts and other forward-looking statements are based on a variety of assumptions that are subject to significant uncertainties. Our performance may not be consistent with these forecasts and forward-looking statements.

From time to time in press releases and otherwise, we may publish forecasts or other forward-looking statements regarding our future results, including estimated revenues, net earnings, and other operating and

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financial metrics. Any forecast of our future performance reflects various assumptions. These assumptions are subject to significant uncertainties, and as a matter of course, any number of them may prove to be incorrect. Further, the achievement of any forecast depends on numerous risks and other factors, including those described in this prospectus, many of which are beyond our control. As a result, we cannot assure that our performance will be consistent with any management forecasts or that the variation from such forecasts will not be material and adverse. You are cautioned not to base your entire analysis of our business and prospects upon isolated predictions, but instead are encouraged to utilize the entire publicly available mix of historical and forward-looking information, as well as other available information affecting us and our services, when evaluating our prospective results of operations.

SPECIAL NOTE REGARDING FORWARD-LOOKING INFORMATION

This prospectus and the documents we incorporate by reference in this prospectus contain 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 prospectus and in the documents we incorporate by reference in this prospectus, may be deemed forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words anticipate, believe, estimate, expect, intend, may, plan, project, will, would and similar expressions to identify forward statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we actually will 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, including the factors included in the documents we incorporate by reference in this prospectus. You should read these factors and the other cautionary statements made in the documents we incorporate by reference as being applicable to all related forward-looking statements wherever they appear in this prospectus and any document incorporated by reference. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

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USE OF PROCEEDS

We estimate that the net proceeds to us from the sale of the 1,000,000 shares of common stock that we are offering will be approximately $40.9 million, after deducting an underwriting discount and estimated offering expenses (based on an assumed offering price of $43.65 per share, the last reported sale price of our common stock on the New York Stock Exchange on May 2, 2005). We will not receive any proceeds from the sale of shares by the selling stockholders or upon any exercise of the underwriters over-allotment option. We intend to use approximately $3.1 million of the net proceeds to repay amounts outstanding under our credit facility, which has a maturity date of March 8, 2010 and bears interest at a floating rate which was 6.0% as of March 31, 2005. The borrowings under this credit facility were used to pay fees and expenses associated with the amendment and restatement of the credit facility in March 2005. We intend to use the balance of the net proceeds for working capital and other general corporate purposes. We may apply proceeds to fund working capital to, among other things:

- increase market penetration within our current service areas;
- pursue opportunities for the development of new markets;
- expand services and products available to our members;
- strengthen our capital base by increasing the statutory capital of our health plan subsidiaries; and
- acquire businesses, assets, and technologies that are complementary to our business.

In particular, we may use proceeds to acquire Medicaid and SCHIP businesses, specialty services businesses, and contract rights in order to increase our membership and to expand our business into new service areas.

Except for the repayment of amounts outstanding under our credit facility, we have not determined the amount of net proceeds to be used specifically for the foregoing purposes. As a result, our management will have broad discretion to allocate our net proceeds. Pending application of our net proceeds, we intend to invest the net proceeds in investment-grade, interest-bearing instruments.

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PRICE RANGE OF COMMON STOCK AND DIVIDEND POLICY

Our common stock became listed on the New York Stock Exchange on July 2, 2003 under the symbol MOH. Prior to that time, there was no established public trading market for any class of our common equity. As of May 2, 2005, there were approximately 51 holders of record of our common stock. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2003		
Third Quarter (beginning July 2, 2003)	$ 27.75	$ 20.15
Fourth Quarter	29.00	21.75
2004		
First Quarter	$ 33.45	$ 23.25
Second Quarter	39.74	29.21
Third Quarter	38.18	29.79
Fourth Quarter	49.45	34.90
2005		
First Quarter	$ 53.23	$ 42.15
Second Quarter (through May 2, 2005)	47.25	40.88

We currently anticipate that we will retain any future earnings for the development and operation of our business. Accordingly, we do not anticipate declaring or paying any cash dividends in the foreseeable future. Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Laws of the states in which we operate or may operate, as well as requirements of the government sponsored health programs in which we participate, limit the ability of our subsidiaries to pay dividends to us. In addition, the terms of our credit facility limit our ability to pay dividends.

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CAPITALIZATION

The table below sets forth the following as of March 31, 2005:

- our historical cash, cash equivalents and investments and capitalization; and
- our cash and capitalization as adjusted to give effect to the sale by us of 1,000,000 shares of common stock, after deducting the underwriting discount and estimated offering expenses (based on an assumed public offering price of $43.65 per share, the last reported sale price of our common stock on the New York Stock Exchange on May 2, 2005).

Actual common stock data are as of March 31, 2005 and excludes 581,447 shares issuable upon the exercise of options to purchase shares of common stock issued under our equity incentive plans at a weighted average price of $16.02 per share, of which options to purchase 387,047 shares were exercisable, as well as 60,000 shares of restricted stock issued to employees and directors that will vest incrementally through September 27, 2007.

You should read the following table in conjunction with Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and related notes included or incorporated by reference in this prospectus.

	March 31, 2005	
	Actual	As Adjusted
	(Dollars in thousands)	
Cash, cash equivalents and investments	$ 315,607	$ 356,495
Long-term debt (including current maturities)	4,954	4,954
Stockholders equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 27,602,443 shares actual; 28,602,443 shares as adjusted	28	29
Preferred stock, $0.001 par value; 20,000,000 shares authorized; no shares issued and outstanding, actual or as adjusted		
Paid-in capital	159,247	200,134
Accumulated other comprehensive income (loss)	(469)	(469)
Retained earnings	208,311	208,311
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders equity	346,727	387,615
Total capitalization	$ 351,681	$ 392,569

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MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion of our financial condition and results of operations should be read in conjunction with Summary Consolidated Financial Data included elsewhere in this prospectus and the consolidated financial statements and the notes to those statements included or incorporated by reference in this prospectus.

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. Our objective is to become the leading managed care organization in the United States focused primarily on serving people who receive health care benefits through state-sponsored programs for low income populations.

We generate revenues primarily from premiums we receive from the states in which we operate. Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. For the three months ended March 31, 2005 and the year ended December 31, 2004, we received approximately 87.4% and 85.8%, respectively, of our premium revenue as a fixed amount per member per month pursuant to our contracts with state Medicaid agencies and other managed care organizations with which we operate as a subcontractor. These premium revenues are recognized in the month members are entitled to receive health care services. Approximately 6.4% and 7.9% of our premium revenue in the three months ended March 31, 2005 and the year ended December 31, 2004, respectively, was realized under a cost plus reimbursement agreement that our Utah subsidiary has with that state. We also received approximately 6.2% and 6.3% of our premium revenue for the three months ended March 31, 2005 and the year ended December 31, 2004, respectively, in the form of birth payments (one-time payments for the delivery of children) from the Medicaid programs in Michigan, New Mexico, and Washington. Such payments are recognized as revenue in the month the birth occurs. The state Medicaid programs periodically adjust premium rates.

Membership growth has been the primary reason for our increasing revenues. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state in the periods presented:

	As of March 31,		As of December 31,		
State	**2005**	**2004**	**2004**	**2003**	**2002**
California	254,000	252,000	253,000	254,000	253,000
Michigan	157,000	89,000	158,000	82,000	33,000
New Mexico	61,000		65,000		
Utah	55,000	44,000	49,000	45,000	42,000
Washington	276,000	203,000	263,000	183,000	161,000
Total	803,000	588,000	788,000	564,000	489,000

The following table details member months (defined as the aggregation of each month s membership for the period) by state for the periods presented:

State	Three Months Ended March 31,		Year Ended December 31,		
	2005	2004	2004	2003	2002
California	753,000	761,000	2,989,000	3,063,000	2,953,000
Michigan	471,000	256,000	1,272,000	585,000	352,000
New Mexico	187,000		391,000		
Utah	159,000	132,000	576,000	537,000	341,000
Washington	823,000	590,000	2,851,000	2,142,000	1,802,000
Total	2,393,000	1,739,000	8,079,000	6,327,000	5,448,000

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Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California; savings sharing revenues in California and Utah, where we receive additional incentive payments from the states if inpatient medical costs are less than prescribed amounts (the savings sharing provisions of our contract with the state of Michigan are no longer in effect, and we recognized our last savings sharing revenue in that state in the second quarter of 2003); and certain ancillary revenues in New Mexico.

Our operating expenses include expenses related to the provision of medical care services and salary, general and administrative, or SG&A, costs. Our results of operations depend on our ability to effectively manage expenses related to health benefits and accurately predict costs incurred.

Expenses related to medical care services include two components: direct medical expenses and medically related administrative costs. Direct medical expenses include payments to physicians, hospitals, and providers of ancillary medical services, such as pharmacy, laboratory, and radiology services. Medically-related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, member services, and compliance. In general, primary care physicians are paid on a capitation basis (a fixed amount per member per month regardless of actual utilization of medical services), while specialists and hospitals are paid on a fee-for-service basis. For the three months ended March 31, 2005 and the year ended December 31, 2004, approximately 86.0% and 82.7%, respectively, of our direct medical expenses were related to fees paid to providers on a fee-for-service basis, with the balance paid on a capitation basis. Physician providers not paid on a capitated basis are paid on a fee schedule set by the state or by our contracts with these providers. We pay hospitals in a variety of ways, including fee-for-service, per diems, diagnostic-related groups, and case rates.

Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. Fee-for-service payments are expensed in the period services are provided to our members. Medical care costs include actual historical claims experience and estimates of medical expenses incurred but not reported, or IBNR. Monthly, we estimate our IBNR based on a number of factors, including prior claims experience, inpatient hospital utilization data, and prior authorization of medical services. As part of this review, we also consider estimates of amounts to cover uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership, and medical cost trends. These estimates are adjusted monthly as more information becomes available. We employ our own actuary. We believe that our process for estimating IBNR is adequate, but there can be no assurance that medical care costs will not exceed such estimates.

SG&A costs are largely comprised of wage and benefit costs related to our employee base and other administrative expenses. Some SG&A services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally-provided functions include marketing (to the extent permitted by law and regulation), plan administration, and provider relations. Included in SG&A expenses are premium taxes for the Michigan HMO (beginning in the second quarter of 2003), the New Mexico HMO (beginning with its acquisition on July 1, 2004) and the Washington HMO.

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 and other operating revenue because there is a direct relationship between the premiums and other operating revenue earned and the cost of health care.

Year Ended December 31,

	Three Months Ended March 31,				
	2005	2004	2004	2003	2002
Premium revenue	99.2%	99.0%	99.3%	99.5%	99.2%
Other operating revenue	0.3%	0.6%	0.3%	0.3%	0.5%
Investment income	0.5%	0.4%	0.4%	0.2%	0.3%
Total revenue	100.0%	100.0%	100.0%	100.0%	100.0%

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	Three Months Ended March 31,		Year Ended December 31,		
	2005	2004	2004	2003	2002
Medical care ratio	84.9%	84.1%	84.1%	83.1%	82.5%
Salary, general and administrative expenses	8.5%	7.9%	8.0%	7.8%	9.5%
Operating income	6.1%	7.6%	7.5%	8.5%	7.6%
Net income	3.7%	5.0%	4.7%	5.4%	4.7%

Three Months Ended March 31, 2005 Compared to Three Months Ended March 31, 2004

Premium Revenue

Premium revenue for the first quarter of 2005 was $390.9 million, representing an increase of $173.0 million, or 79.4%, over premium revenue of $217.9 million for the same period of 2004.

Membership growth contributed $106.7 million to the increase in premium revenue. Enrollment was significantly higher in Washington and Michigan, principally due to the transfer of members from other health plans in the second and fourth quarters of 2004, respectively, in those states. Additionally, the first quarter of 2005 benefited from our New Mexico acquisition, which closed on July 1, 2004.

Higher premium rates contributed the remaining $66.3 million to the increase premium revenue. Blended premium increases were most pronounced at our Michigan and Washington HMOs. Additionally, premium rates at our New Mexico HMO are considerably higher than the average for our company as a whole.

Other Operating Revenue

Other operating revenue was $1.3 million for the three months ended March 31, 2005 and March 31, 2004. Other operating revenue primarily includes fee-for-service revenue generated by our clinics in California; savings sharing revenues in Utah and California, where we receive additional incentive payments from those states if medical costs are less than prescribed amounts; and certain ancillary revenues in New Mexico.

Investment Income

Investment income for the three months ended March 31, 2005 increased to $1.8 million from $0.9 million for the same period of 2004, principally as a result of larger invested balances as well as higher investment yields.

Medical Care Costs

Medical care costs as a percentage of premium and other operating revenue (the medical care ratio) increased to 84.9% in the first quarter of 2005 from 84.1% in the first quarter of 2004. Medical care costs increased in absolute terms to $333.1 million in the first quarter of 2005 from $184.2 million in the first quarter of 2004.

The primary source of the increase in the medical care ratio was the acquisition of the New Mexico HMO, which has traditionally experienced a higher medical care ratio than our other HMOs. Excluding our New Mexico HMO, our medical care ratio for the first quarter of 2005 was 84.2%, essentially flat when compared to the 84.1% medical care ratio experienced in the first quarter of 2004.

Our medical margin (defined as the difference between the total of premium and other operating revenue and medical costs) grew substantially in the first quarter of 2005 when compared with the first quarter of 2004. Medical margin increased to $24.69 per member per month in 2005 from $20.10 per member per month in 2004, an increase of approximately 23%.

Salary, General and Administrative Expenses

SG&A expenses were $33.5 million for the first quarter of 2005, representing 8.5% of total revenue, as compared with $17.5 million, or 7.9% of total revenue, for the first quarter of 2004. Excluding premium taxes,

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SG&A expenses decreased to 5.9% of total revenue in the first quarter of 2005, as compared with 6.6% in the first quarter of 2004.

Depreciation and Amortization

Depreciation and amortization expense for the three months ended March 31, 2005 increased to $3.2 million from $1.6 million for the same period of the prior year. The increase was primarily due to the amortization of identifiable intangible assets acquired in the Washington (Premera) and New Mexico acquisitions, as well as increased capital expenditures.

Provision for Income Taxes

Income tax expense increased to $9.0 million in the first quarter of 2005 from $6.6 million in the first quarter of 2004. The effective tax rate for the first quarter of 2005 was 38.0% as compared with an effective tax rate of 37.2% for the first quarter of 2004.

Year Ended December 31, 2004 Compared to Year Ended December 31, 2003

Premium Revenue

Premium revenue for 2004 was $1.167 billion, up $377.3 million (47.8%) from $789.5 million for 2003.

Membership growth contributed $253.1 million to the increase in revenue. Year-end enrollment increased 39.7% to 788,000 members at December 31, 2004, from 564,000 members at the same date of the prior year. Member months for the year ended December 31, 2004 increased by 27.7% to 8,079,000 from 6,327,000 for the year ended December 31, 2003. Year-end enrollment increased by 92.7% at our Michigan HMO and 43.7% at our Washington HMO between 2003 and 2004. The transfer of membership from other managed care companies was the primary source of enrollment growth in both states. Our New Mexico acquisition (effective July 1, 2004) added 65,000 members to our total year-end 2004 enrollment

The remaining $124.2 million increase in premium revenue was attributable to increases in premium rates and proportionally greater increases in membership in those states and those aid categories with higher premium rates than our overall premium base. Premium revenue on a per member per month basis is substantially higher at our New Mexico HMO than at our other HMOs. The percentage of our membership classified as ABD increased to 5.8% at December 31, 2004 from 4.4% at December 31, 2003. Premiums for ABD members are substantially higher than for our overall membership. At our Michigan HMO, which had approximately 55% of our ABD membership at December 31, 2004, per member per month revenue for the ABD population was approximately $473, as compared to a TANF per member per month premium rate of approximately $101 for the Michigan HMO in 2004.

Other Operating Revenue

Other operating revenue increased to $4.2 million for 2004 from $2.2 million for 2003. Other operating revenue for 2004 included $2.1 million of savings sharing income recognized by our Utah HMO. Our Utah HMO recognized no savings sharing income prior to 2004. For 2003, our Michigan HMO recognized approximately $0.7 million in savings sharing income. Our Michigan HMO s contract with the state no longer contains risk sharing provisions.

Other than the amounts recognized by our Utah and Michigan HMOs for savings sharing, other operating revenue consisted primarily of revenue earned by our California medical clinic operations (approximately $1.2 million for both 2004 and 2003) and approximately $0.3 million of income earned by our New Mexico HMO during 2004 for performing certain administrative services for the state.

Investment Income

Investment income for 2004 increased to $4.2 million from $1.8 million for 2003 due to greater average invested balance and higher investment yields.

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Medical Care Costs

Medical care costs for 2004 were $984.7 million, representing 84.1% of premium and other operating revenue for all of 2004, as compared with $657.9 million, representing 83.1% of premium and other operating revenue for all of 2003.

The increase in the medical care ratio is due in large part to increases in enrollment in states and programs, such as ABD membership, that experience higher medical care ratios than our company-wide average. Increased ABD membership in our Michigan HMO and the acquisition of our New Mexico HMO, which has traditionally experienced a higher medical care ratio than our other HMOs, were major contributors to the higher medical care ratio.

Despite the increase in the medical care ratio noted in the preceding paragraph, all of our HMOs remain profitable. The New Mexico HMO, with per member per month revenues over twice the average of the rest of our HMOs, produces the highest medical margin (defined as the difference between total medical care costs and total premium and other operating revenue) per member per month among our HMOs. Additionally, the increased premium revenues associated with increased ABD membership often offset the increased medical care ratios incurred by members in these categories, resulting in an increase to medical margin on a per member per month basis. On a consolidated basis, medical margin per member per month increased to $23.06 for 2004 from $21.16 for 2003.

Salary, General and Administrative Expenses

SG&A expenses for 2004 were $94.2 million as compared with $61.5 million for 2003. The largest component of the increase in SG&A was an increase in premium tax expense of $15.1 million in 2004. SG&A expenses as a percentage of total revenue were 8.0% for 2004 as compared with 7.8% for 2003. Excluding premium taxes, SG&A expenses decreased to 5.9% of total revenue for 2004 from 6.6% of total revenue for 2003.

Depreciation and Amortization

Depreciation and amortization expense for 2004 increased to $8.9 million from $6.3 million for 2003. The increase was primarily due to increased capital spending for computer equipment and leasehold improvements and increased amortization of purchased member contracts.

Interest Expense

Interest expense decreased to $1.0 million for 2004 from $1.5 million for the 2003 due to decreased debt balances.

Other Income

Other income for 2004 includes a pretax gain of $1.2 million recognized upon the termination of certain Collateral Assignment Split-Dollar Insurance Agreements between our company and the Molina Siblings Trust, a related party, during the first quarter of 2004. We had agreed to make premium payments towards the life insurance policies held by the Molina Siblings Trust on the life of Mary R. Molina. We were not an insured under the policies, but were entitled to receive repayment of all premium advances from the Molina Siblings Trust upon the earlier of Mrs. Molina s death or cancellation of the policies. Receivables, representing premium payments made by us, were discounted based on Mrs. Molina s remaining actuarial life. On March 2, 2004, the Collateral Assignment Split-Dollar Insurance Agreements were terminated by the early repayment of the advances to the Molina Siblings Trust. The gain of $1.2 million represents the recovery of the discounts previously recorded.

Provision for Income Taxes

Income tax expense totaled $31.9 million in 2004, resulting in an effective tax rate of 36.4%, as compared to $23.9 million in 2003, resulting in an effective tax rate of 36.0%. During both 2004 and 2003, we pursued

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various strategies to reduce our federal, state, and local taxes. As a result, we have reduced our state income tax expense due to California Economic Development Tax Credits (Credits). Our tax expense was reduced by approximately $0.9 million and $1.0 million for 2004 and 2003, respectively, by out-of-year Credits. Consulting fees incurred in connection with the Credits, were recorded as salary, general and administrative expenses.

Year Ended December 31, 2003 Compared to Year Ended December 31, 2002

Premium Revenue

Premium revenue for 2003 was $789.5 million, up $150.2 million, or 23.5% from $639.3 million for 2002. Membership growth contributed $109.5 million to the increase in revenue. Year-over-year enrollment increased 15.3% to 564,000 members at December 31, 2003, from 489,000 members at the same date of the prior year. Membership growth was most pronounced at our Michigan HMO, which saw year-over-year enrollment increase to 82,000 from 33,000. The Michigan HMO added 9,400 and 32,000 members in the third and fourth quarters of 2003, respectively, as a result of the acquisition of Medicaid contracts from other health plans. The remainder of the additional revenue, or $40.7 million, was attributable to increases in premium rates (including increased ABD membership) and proportionally greater increases in membership in those states with higher premium rates.

Other Operating Revenue

Other operating revenue decreased to $2.2 million for 2003 from $2.9 million for 2002. The decrease was the result of reduced savings sharing revenue at our California and Michigan HMOs.

Investment Income

Investment income for 2003 decreased to $1.8 million from $2.0 million for 2002 due to lower investment yields, which were partially offset by greater invested balances.

Medical Care Costs

Medical care costs for 2003 were $657.9 million, representing 83.1% of premium and other operating revenue, as compared with $530.0 million, representing 82.5% of premium and other operating revenue, for 2002. The increase in the medical care ratio was due to increases in specialty, hospital, and pharmacy expense, partially offset by reduced capitation costs. Additionally, medical margins in 2003 were reduced by changes in the state of Washington s method of compensating us for certain health care costs reimbursed by the Supplemental Security Income program and increased ABD enrollment.

Salary, General and Administrative Expenses

SG&A expenses for 2003 were $61.5 million as compared with $53.4 million (after deducting $7.8 million in stock option settlement expenses) for 2002. The increase was primarily due to an increase in premium tax expense of $4.2 million in 2003. SG&A expenses as a percentage of total revenue were 7.8% for 2003 as compared with 8.3% (adjusted for the stock option settlement expense) for 2002.

Depreciation and Amortization

Depreciation and amortization expense for 2003 increased to $6.3 million from $4.1 million for 2002. The increase was primarily due to increased capital spending for computer equipment and leasehold improvements.

Interest Expense

Interest expense increased to $1.5 million for 2003 from $0.4 million for 2002. Interest expense increased due to the amortization of loan fee expense associated with our credit facility, as well as the payment of interest on amounts borrowed under that facility. Interest expense was reduced by our repayment of a mortgage note in the second quarter of 2003.

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Provision for Income Taxes

Income taxes totaled $23.9 million in 2003, resulting in an effective tax rate of 36.0%, as compared to $17.9 million in 2002, resulting in an effective tax rate of 37.0%. The lower 2003 tax rate was due to: (i) our Washington health plan, which does not pay state income taxes, generating a greater percentage of our total earnings; and (ii) our receiving $1.6 million of California Economic Development Tax Credits (Credits) in 2003 as compared to our receiving $0.4 million in 2002. Approximately $1.0 million of the Credits in 2003 relate to prior years that are being recovered through amended state tax filings. The table below includes a breakdown of the total Credits in 2003, net of recovery fees paid to consultants (included in Salary, General and Administrative expenses):

	Reduced Income Taxes	Recovery Fees	Net Income	Diluted Earnings Per Share
2003	$ 585	$ 107	$ 478	$ 0.02
Prior years	1,034	189	845	0.04
Total Credits in 2003	$ 1,619	$ 296	$ 1,323	$ 0.06

The prior year credit recognized in 2003, net of recovery fees, of $845 ($0.04 per diluted share) was accounted for as a change in estimate.

Acquisitions

Effective June 1, 2004, we completed our acquisition of the Healthy Options (Medicaid) and Basic Health Plan contracts of Premera Blue Cross, adding approximately 56,000 members. We paid to Premera $18.0 million for both contracts in addition to assuming an estimated $0.4 million in medical related liabilities. The transaction was funded with cash internally generated by our Washington HMO.

On July 1, 2004, we closed on our acquisition of Health Care Horizons, Inc., or HCH, the parent company of Cimarron Health Plan, Inc. (now Molina Healthcare of New Mexico, Inc.), a New Mexico corporation. Total consideration for the acquisition, including direct transaction costs was $71.8 million. At the close of the acquisition, we extinguished approximately $5.8 million of outstanding HCH bank debt. We funded the acquisition with proceeds from our initial and secondary public offerings.

Prior to the closing of the HCH acquisition, we announced a definitive agreement had been reached to transfer the commercial membership acquired in the HCH purchase to Lovelace Sandia Health System, Inc., or Lovelace. Effective August 1, 2004, the transfer was completed. We received a total of $18.0 million (net of approximately $0.3 million in direct transactions costs) in connection with the transfer. We also entered into a transition services agreement with Lovelace to provide commercial claims processing, customer and provider call handling, and billing and treasury services through the date the commercial contracts are expected to be fully transitioned to Lovelace.

On October 1, 2004, we transitioned approximately 73,000 members from the Wellness Plan of Michigan into our Michigan HMO. Total consideration paid in connection with the transition of these members was approximately $18.8 million (including direct acquisition costs).

On November 22, 2004, our California HMO and Sharp Health Plan, or Sharp, entered into a definitive Asset Purchase Agreement to transfer Sharp s Medi-Cal (Medicaid) and Healthy Families Program (SCHIP) contracts to our California HMO. As of March 31, 2005, the proposed transfer had been approved by each of the California Department of Health Services, the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. Once effective, the transaction will add approximately 70,000 members to our California HMO s current membership. We anticipate paying approximately $25.0 million for the transfer of these contracts, subject to possible adjustment and an earn-out provision. As part of the transaction, Sharp will assign the bulk of its provider network to our California HMO.

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On December 10, 2004, our California HMO, and Universal Care, Inc., a California corporation, entered into a definitive Asset Purchase Agreement to transfer Universal s Medi-Cal and Healthy Families Program (SCHIP) contracts to our California HMO. As of March 31, 2005, the proposed transfer had been approved by each of the California Department of Health Services, the California Department of Managed Health Care and the California Managed Risk Medical Insurance Board for a transfer effective as of June 1, 2005. Once effective, the transaction will add approximately 17,000 members to our California HMO s current membership. We anticipate paying approximately $6.2 million for the transfer of these contracts, subject to possible adjustment. As part of the transaction, Universal will assign the bulk of its provider network related to its Medi-Cal and Healthy Families members to our California HMO.

Liquidity and Capital Resources

We generate cash from premium revenue, services provided on a fee-for-service basis at our clinics, and investment income. Our primary uses of cash include the payment of expenses related to medical care services, SG&A expenses and acquisitions. We generally receive premium revenue in advance of payment of claims for related health care services, with the exception of our Utah HMO.

In July 2003, we completed the initial public offering of our common stock. We sold 7,590,000 shares, generating net proceeds of approximately $119.6 million after deducting approximately $3.9 million in fees and expenses and $9.3 million in the underwriters discount. In March 2004, we completed a public offering of our common stock. We sold 1,800,000 shares, generating net proceeds of approximately $47.3 million after deducting approximately $0.6 million in fees and expenses and $2.5 million in the underwriters discount.

Our offerings of common stock in July 2003 and March 2004, respectively, have substantially enhanced our liquidity. Additionally, because we generally receive premium revenue in advance of payment for the related medical care costs (with the exception of our Utah HMO), our cash has increased during periods when we experienced enrollment growth. Our ability to support the increase in membership with existing infrastructure also allows us to retain a larger portion of the additional premium revenue as profit.

At March 31, 2005, we had working capital of $219.2 million. At December 31, 2004, we had working capital of $202.2 million as compared to $182.2 million at December 31, 2003. At March 31, 2005, December 31, 2004 and December 31, 2003, cash and cash equivalents were $242.4 million, $228.1 million and $141.9 million, respectively. At March 31, 2005, December 31, 2004 and December 31, 2003, our investments were $73.2 million, $88.5 million and $98.8 million, respectively.

Our subsidiaries are required to maintain minimum capital prescribed by the various jurisdictions in which we operate. As of March 31, 2005, all of our subsidiaries were in compliance with the minimum capital requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements at least through 2005. We also 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.

The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. Our restricted investments are invested principally in certificates of deposit and treasury securities with maturities of up to 12 months.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements. As of March 31, 2005, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. As of March 31, 2005, our investments consisted solely of investment grade debt securities (all of which are classified as

current assets) with a maximum maturity of eight years and an average duration of three years. Two professional portfolio managers operating under documented investment guidelines manage our investments. The states in which we operate prescribe the types of instruments in which our subsidiaries may invest their funds. Our restricted investments are invested principally in certificates of deposit and treasury securities with maturities of up to 12 months.

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The average annualized portfolio yield for the three months ended March 31, 2005 and the years ended December 31, 2004, 2003, and 2002 was approximately 2.2%, 1.4%, 1.1%, and 1.7%, respectively.

Net cash provided by operating activities was $2.4 million for the three months ended March 31, 2005 and $12.0 million for the three months ended March 31, 2004. The decrease in net cash provided by operations for the three months ended March 31, 2005 when compared to the three months ended March 31, 2004 was due to the following factors:

- changes in accounts receivable balances, particularly at our Utah HMO, (a use of $8.7 million in the three months ended March 31, 2005 compared to a provision of $1.1 million in the three months ended March 31, 2004);
- changes in miscellaneous working capital accounts (a use of $2.3 million in the three months ended March 31, 2005 compared to a source of $5.2 million in the three months ended March 31, 2004).

These factors were offset in part by the following factors:

- increased net income ($3.7 million higher in 2005);
- increased depreciation and amortization expense ($1.6 million higher in 2005);
- changes in medical claims liabilities, a use of $4.6 million in the three months ended March 31, 2005 compared to a use of $7.0 million in the three months ended March 31, 2004.

Net cash provided by operations was $91.0 million for 2004 and $45.6 million for 2003. The increase in net cash provided by operations for 2004 when compared to 2003 was due to the following factors:

- increased net income ($13.3 million higher in 2004);
- increased depreciation and amortization expense ($2.5 million higher in 2004);
- increased medical claims and benefits payable (a source of $23.1 million in 2004 compared to a source of $14.7 million in 2003);
- changes in accounts receivable balances (a use of $3.6 million in 2004 compared to a use of $24.1 million in 2003);
- changes in miscellaneous working capital accounts (a source of $6.9 million in 2004 compared to a source of $6.0 million in 2003).

Credit Facility

We entered into a credit agreement dated as of March 19, 2003, under which a syndicate of lenders provided a $75.0 million senior secured credit facility. At December 31, 2004, no amounts were outstanding under the credit facility and we were in compliance with all covenants under the credit agreement.

On March 9, 2005, we entered into an amended and restated five-year secured credit agreement for a $180 million revolving credit facility with a syndicate of lenders. The credit facility will be used for working capital purposes.

The credit facility has a term of five years and all amounts outstanding under the credit facility will be due and payable on March 8, 2010. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the credit facility to up to $200 million.

Borrowings under the credit facility will bear interest based, at our election, on the London interbank deposit, or LIBOR, rate or the base rate plus an applicable margin. The base rate will equal the higher of Bank of America s prime rate or 0.5% above the federal funds rate. We also will pay a commitment fee on the total unused commitments of the lenders under the credit facility. Until the delivery of a compliance certificate with respect to the our financial statements for the quarter ending June 30, 2005, the applicable margin is fixed at 1.25% for LIBOR loans and 0.25% for base rate loans and the commitment fee is fixed at 0.30%. Thereafter, the

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applicable margins and commitment fee will be based on our ratio of consolidated funded debt to consolidated EBITDA. The applicable margins will range between 1.00% and 1.75% for LIBOR loans and between 0% and 0.75% for base rate loans. The commitment fee will range between 0.25% and 0.375%. In addition, we will 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 with our prior credit facility, our obligations under the amended and restated credit facility are secured by a lien on substantially all of our assets and by our previous pledge of the capital stock of our Michigan, New Mexico, Utah, and Washington HMO subsidiaries.

The credit agreement 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, and investments. The credit agreement also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.00 to 1.00 as of the end of each fiscal quarter and a fixed charge coverage ratio of 2.00 to 1.00 (which increases to 3.00 to 1.00 as of December 31, 2006).

At March 31, 2005, $3.1 million was outstanding under the credit facility. We intend to use a portion of the net proceeds from this offering to repay amounts outstanding under our credit facility. See Use of Proceeds.

Regulatory Capital and Dividend Restrictions

At March 31, 2005, our principal operations are conducted through the five HMOs operating in California, Michigan, New Mexico, Utah, and Washington. Our Indiana HMO began operating on April 1, 2005. The HMOs are subject to state laws that, among other things, may 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 their 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 loans, advances, or cash dividends was $142.4 million at March 31, 2005, $130.0 million at December 31, 2004, and $72.0 million at December 31, 2003.

The National Association of Insurance Commissioners has adopted rules effective December 31, 1998, which, if implemented by the states, 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 rules. These HMO rules, which may vary from state to state, have been adopted in Michigan, New Mexico, Utah, and Washington. California has not adopted risk-based capital requirements for HMOs and has not formally given notice of its intention to do so. The National Association of Insurance Commissioners HMO rules, if adopted by California, may increase the minimum capital required for that state.

As of March 31, 2005, our HMOs had aggregate statutory capital and surplus of approximately $171.7 million, compared with the required minimum aggregate statutory capital and surplus of approximately $85.1 million. All of our HMOs were in compliance with the minimum capital requirements.

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 and requires the application of significant judgment by our management and, as a result, is subject to an inherent degree of uncertainty.

Our medical care costs include actual historical claims experience and estimates for medical care costs incurred but not reported to us (IBNR). We, together with our independent actuaries, estimate medical claims liabilities using actuarial methods based upon historical data adjusted for payment patterns, cost trends, product mix, seasonality, utilization of health care services, and other relevant factors. The estimation methods and the

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resulting reserves are frequently reviewed and updated, and adjustments, if necessary, are reflected in the period known. We also record reserves for estimated referral claims related to medical groups under contract with us that are financially troubled or insolvent and that may not be able to honor their obligations for the payment of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses are not expected to be significant. In applying this policy, we use judgment to determine the appropriate assumptions for determining the required estimates. While we believe our estimates are adequate, it is possible that future events could require us to make significant adjustments or revisions to these estimates. In assessing the adequacy of accruals for medical claims liabilities, we consider our historical experience, the terms of existing contracts, our knowledge of trends in the industry, information provided by our customers, and information available from other sources, as appropriate.

The most significant estimates involved in determining our claims liability concern the determination of claims payment completion factors and trended per member per month cost estimates.

For the five months of service prior to the reporting date and earlier, we estimate our outstanding claims liability based upon 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 a date subsequent to that month of service. Completion factors are based upon historical payment patterns. The following table reflects the change in our estimate of claims liability as of March 31, 2005 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding that date by the percentages indicated. A reduction in the completion factor results in an increase in medical liabilities. Our Utah HMO is excluded from these calculations, as the majority of the Utah business is conducted under a cost reimbursement contract. Amounts are in thousands.

Increase (Decrease) in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ 14,388
(2)%	9,592
(1)%	4,796
1%	(4,796)
2%	(9,592)
3%	(14,388)

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 delay inherent 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 upon trended per member per month cost estimates. These estimates 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 March 31, 2005 that would have resulted had we altered our trend factors by the percentages indicated. Our Utah HMO is excluded from these calculations, as the majority of the Utah business is conducted under a cost reimbursement contract. Amounts are in thousands.

Increase (Decrease) in Trended Per member Per Month Cost Estimates	Increase (Decrease) in Medical Claims and Benefits Payable

(3)%	$	(5,973)
(2)%		(3,982)
(1)%		(1,991)
1%		1,991
2%		3,982
3%		5,973

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Assuming a hypothetical 1% change in both completion factors and per member per month cost estimates from those used in our calculation of IBNR at March 31, 2005, net income for the three months ended March 31, 2005 would increase or decrease by approximately $1.7 million, or $0.06 per diluted share, net of tax.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2004, our lease obligations for the next five years and thereafter are as follows: $6.9 million in 2005, $6.6 million in 2006, $5.9 million in 2007, $5.6 million in 2008, $4.8 million in 2009, and an aggregate of $10.0 million thereafter.

We lease certain equipment at our New Mexico HMO under capital leases. As of December 31, 2004, our lease obligations for the next five years and thereafter are as follows: $0.2 million in 2005, $0.2 million in 2006, $0.2 million in 2007, $0.1 million in 2008, and none thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in the Commitments and Contingencies section of our consolidated financial statements and the notes thereto included or incorporated by reference in this prospects. We have in the past made certain advances and loans to related parties, which are discussed in the consolidated financial statements and the notes thereto included or incorporated by reference in this prospectus.

Contractual Obligations

In the table below, we set forth our contractual obligations as of December 31, 2004. Some of the figures we include in this table are based on management s estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	2005	2006 2007	2008 2009	2010 and Beyond
Operating lease obligations	$ 6,891	$ 12,522	$ 10,418	$ 9,990
Capital lease obligations	183	366	107	
Purchase commitments	2,305	1,986	30	
Mortgage note obligation	82	179	179	1,520
Total contractual obligations	$ 9,461	$ 15,053	$ 10,734	$ 11,510

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BUSINESS

Overview

We are a multi-state managed care organization that arranges for the delivery of health care services to persons eligible to receive health care benefits through government-sponsored programs for low-income families and individuals, such as Medicaid and the State Children s Health Insurance Program, or SCHIP. We currently have health plans in California, Indiana, Michigan, New Mexico, Utah, and Washington that are administered by our health maintenance operation, or HMO, licensed subsidiaries operating in these states. We also operate 21 company-owned primary care clinics in California that are staffed by physicians, physician assistants, and nurse practitioners. We arrange health care services for members enrolled in our health plans through contracts with health care providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. As of March 31, 2005, approximately 803,000 members were enrolled in our health plans.

C. David Molina, M.D. founded our company in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. We recognized the growing need for more effective management and delivery of health care services to underserved populations, predominantly Medicaid beneficiaries, and became licensed as an HMO. We were incorporated in California in 1999, as the parent company of our health plan subsidiaries, under the name American Family Care, Inc. We changed our name to Molina Healthcare, Inc. in March of 2000 and reincorporated in Delaware on June 26, 2003. We have grown over the past several years by taking advantage of attractive expansion opportunities, often involving either the acquisition or the start-up of health plans. We established our Utah health plan in 1997 as a start-up operation, and later acquired health plans in Michigan, New Mexico, and Washington. We have also recently established a start-up operation in Indiana, where our HMO-licensed subsidiary will begin serving members in April 2005. In July 2003, we completed our initial public offering of common stock.

Our members have distinct social and medical needs and are characterized by their cultural, ethnic, and linguistic diversity. From our inception, we have designed our company to work with government agencies to serve low-income populations. Our success has resulted from our expertise in working with government agencies, our extensive experience with meeting the needs of our members, our 25 years of owning and operating primary care clinics, our cultural and linguistic expertise, and our focus on operational and administrative efficiency.

Our total annual revenue has increased from $185.7 million in 1999 to $1.175 billion in 2004. Over the same period, our net income grew from $9.4 million to $55.8 million. Our California HMO has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state. In Michigan, we became the state s largest Medicaid HMO in 2004 while increasing our enrollment nearly five-fold between December 31, 2003 and December 31, 2004. Our New Mexico HMO, acquired on July 1, 2004, generated over 18% of our total premium revenue during the second half of 2004. In Utah, we continue to generate substantial savings for the state Medicaid program, and we now have the largest Medicaid HMO in Washington, with approximately 50% market share.

Our principal executive offices are located at One Golden Shore Drive, Long Beach, CA 90802, and our telephone number is (562) 435-3666. Our website is located at www.molinahealthcare.com. Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this prospectus.

Our Industry

Medicaid and SCHIP. Medicaid provides health care coverage to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within federal guidelines. SCHIP is a program that provides health care coverage to children not otherwise covered by Medicaid or other insurance programs. States have the option of administering SCHIP through their Medicaid programs.

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The state and federal governments jointly finance Medicaid and SCHIP through a matching program in which the federal government pays a percentage based on the average per capita income in each state. Typically, this percentage match is at least 50%. Federal payments for Medicaid have no set dollar ceiling and are limited only by the amount states are willing to spend. State and local governments pay the share of Medicaid costs not paid by the federal government.

Characteristics of the Medicaid Population. The majority of our members have traditionally been eligible to receive Medicaid benefits as a result of their participation in the Temporary Assistance for Needy Families, or TANF, program of each state where we operate. This membership is for the most part comprised of mothers and their children, and was the first portion of the Medicaid population that states sought to move into managed care. This is a comparatively healthy population, and while it comprises the largest group of Medicaid members, Medicaid funds spent on its care are proportionally less than those spent on other segments of the Medicaid population.

Seeking to expand upon the benefits offered by Medicaid managed care, many states now wish to transition certain other segments of the Medicaid population into managed care. Chief among these groups is the Aged, Blind and Disabled, or ABD, Medicaid population. Like our TANF members, these individuals have distinct social and medical needs and are characterized by their cultural, ethnic, and linguistic diversity. Furthermore, members of this population often suffer from chronic conditions and require extensive and coordinated care spanning multiple medical and behavioral health specialties. Monthly premiums for ABD members are substantially higher than those for TANF members, as is the cost of their care.

According to the Urban Institute s Health Policy Center, based on 2003 data, annual Medicaid spending is estimated to be over five times greater for ABD members than for TANF members. We have pursued ABD membership over the past few years. At December 31, 2004, approximately 46,000 of our members were ABD enrollees, up from approximately 25,000 members in 2003.

Special Needs Plans (SNP) to Serve the Dual Eligible Population. Consistent with our intent to reach beyond the TANF population is our effort to serve the dual eligible population. This population is comprised of those Medicare beneficiaries who are also entitled to Medicaid benefits. Recent changes to the Medicare regulations allow us to offer a combined package of Medicare and Medicaid benefits to the dual eligible population, thereby integrating Medicare and Medicaid benefits to provide a single point of accountability for care and services. This integration of care is accomplished by the establishment of a Special Needs Plan, or SNP.

We have has submitted applications to operate SNPs (including a Medicare Part D prescription benefit) in California, Michigan, Utah, and Washington. In addition, we have submitted an application to service Medicare Long Term Care beneficiaries, as a subset of the Utah SNP. As is the case with our support of the ABD population, we believe our effort to establish SNPs is a natural extension of our commitment to providing quality, accessible healthcare to underserved populations served by government programs.

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and SCHIP, but without federal matching funds. Our Washington HMO served approximately 21,000 such members under that state s Basic Health Plan at December 31, 2004.

Medicaid Managed Care. The Medicaid members we serve generally represent diverse cultures and ethnicities. Many have had limited educational opportunities and do not speak English as their first language. Lack of adequate transportation is common.

Under traditional Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These individuals typically have minimal access to preventive care, such as immunizations, and access to primary care physicians is limited. As a consequence, treatment is often postponed until medical conditions become more severe, leading to higher utilization of costly emergency room services. In addition, providers are paid on a fee-for-service basis and lack incentive to monitor utilization and control costs.

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In an effort to improve quality and provide more uniform and more cost-effective care, most states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives a predetermined payment per enrollee for the covered health care services. The health plan, in turn, arranges for the provision of such services by contracting with a network of providers who are responsible for providing a comprehensive range of medical and hospital services. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore, and, in many cases, to mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandatory Medicaid managed care programs.

Our Approach

We focus on serving low-income families and individuals who receive health care benefits through government-sponsored programs within a managed care model. We believe we are well positioned to capitalize on the growth opportunities in our markets. Our approach to managed care is based on the following key attributes:

Experience. For 25 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. In that time we have developed and forged strong relationships with the constituents whom we serve members, providers, and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, has allowed us to compete successfully for government contracts. We have a strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

Administrative Efficiency. We have centralized and standardized various functions and practices across all of our health plans to increase administrative efficiency. The steps we have taken include centralizing claims processing and information services onto a single platform. We have standardized medical management programs, pharmacy benefits management contracts, and health education. As a result, we believe our administrative efficiency is among the best in our industry. In addition, we have designed our administrative and operational infrastructure to be scalable for rapid and cost-effective expansion into new and existing markets.

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations and the transition of members from other health plans. The integration of our New Mexico acquisition, which closed on July 1, 2004, is substantially complete and demonstrates our ability to integrate stand-alone acquisitions. The establishment of our health plans in Utah and Indiana reflects our ability to replicate our business model in new states, while acquisitions in Michigan and Washington have demonstrated our ability to acquire and successfully integrate existing health plan operations into our own business model.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include our own clinics, independent physicians and medical groups, hospitals, and ancillary providers. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates, and diagnostics related groups. Our provider network strategy is to contract with providers that are best suited, based on expertise, proximity, cultural sensitivity, and experience, to provide services to the membership we serve.

We operate 21 company-owned primary care clinics in California. Our clinics are profitable, requiring low capital expenditures and minimal start-up time. We believe that our clinics serve an important role in providing certain communities with access to primary care and provide us with insights into physician practice patterns, first hand knowledge of the needs of our members, and a platform to pilot new programs.

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Cultural and Linguistic Expertise. National census data shows that the U.S. population is becoming increasingly diverse. We have a 25-year history of developing targeted health care programs for our culturally diverse membership and believe we are well-positioned to successfully serve these growing populations. We contract with a diverse network of community-oriented providers who have the capabilities to address the linguistic and cultural needs of our members. We educate employees and providers about the differing needs among our members. These efforts are overseen by our full-time cultural anthropologist. We develop member education material in a variety of media and languages and ensure that the literacy level is appropriate for our target audience. In addition, our website is accessible in six languages.

Proven Medical Management. We believe that our experience as a health care provider has helped us to improve medical outcomes for our members while at the same time enhancing the cost effectiveness of care. We carefully monitor day-to-day medical management in order to provide appropriate care to our members, contain costs and ensure an efficient delivery network. We have developed disease management and health education programs that address the particular health care needs of our members. We have established pharmacy management programs and policies that have allowed us to manage our pharmaceutical costs effectively. For example, our staff pharmacists educate our providers on the use of generic drugs rather than branded drugs. As a result, we believe our generic utilization rate is among the highest in our industry.

Our Strategy

Our objective is to be the leading managed care organization serving Medicaid, SCHIP, and other low-income members. To achieve this objective, we intend to:

Focus on Serving Low-Income Families and Individuals. We believe that the Medicaid population, characterized by low income and significant ethnic diversity, requires unique services to meet its health care needs. Our 25 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members. We will continue to focus on serving the beneficiaries of Medicaid and other government-sponsored programs, as our experience, infrastructure, and health care programs position us to optimally serve this population.

Increase our Membership. We have grown our membership through a combination of acquisitions and internal growth. Increasing our membership provides the opportunity to grow and diversify our revenues, increase profits, enhance economies of scale, and strengthen our relationships with providers and government agencies. We will seek to grow our membership by:

- *Expanding within Existing Markets*. We expect to grow in existing markets by expanding our service areas and provider networks, increasing awareness of the Molina brand name, maintaining positive provider relationships, and integrating members from other health plans; and

- *Entering New Markets*. We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion on markets with strong provider dynamics, a fragmented competitive landscape, significant size and, where possible, mandated Medicaid managed care enrollment.

Manage Medical Costs. We will continue to use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the efficacy of treatment, these programs facilitate the identification of our members with special or high cost needs and help limit the cost of the members treatment.

Leverage Operational Efficiencies. Our centralized administrative infrastructure, flexible information systems and dedication to controlling administrative costs provide economies of scale. Our administrative infrastructure has significant expansion capacity, allowing us to integrate new members and expand quickly in new and existing markets.

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Our Health Plans

As of March 31, 2005, our operating health plans were located in California, Michigan, New Mexico, Utah, and Washington. We have also recently established a start-up operation in Indiana, where our HMO-licensed subsidiary began serving members in April 2005. An overview of our health plans as of March 31, 2005 is provided in the table below:

State	Total Members	Number of Contracts	Expiration Date
California	254,000	5	Three expire March 31, 2006, one expires June 30, 2005, and one is evergreen
Michigan	157,000	1	September 30, 2006
New Mexico	61,000	1	June 30, 2005
Utah	55,000	3	Two expire June 30, 2005, and one expires June 30, 2006
Washington	276,000	4	December 31, 2005

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. We are usually paid a negotiated amount per member per month, with the amount varying from contract to contract. We are also paid an additional amount for each newborn delivery in Washington, Michigan, and New Mexico. Since July 1, 2002, our Utah health plan has been reimbursed by the state for all medical costs incurred by Utah Medicaid members plus a 9% administrative fee. Our contracts in Washington, New Mexico, and Michigan have higher monthly payments than in California, but require us to cover more services. In California, the state retains responsibility for certain high cost services, such as specified organ transplants and pediatric oncology cases. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. Molina Healthcare of California, our California HMO, has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state, with 253,000 members at December 31, 2004. We arrange health care services for our members either as a direct contractor to the state or through subcontracts with other health plans. Our plan serves counties with three of the largest Medicaid populations in California Riverside, San Bernardino, and Los Angeles counties as well as Sacramento and Yolo counties.

Indiana. In December 2004, our Indiana subsidiary, Molina Healthcare of Indiana, Inc., was licensed by the Indiana Department of Insurance to operate as an HMO in the State of Indiana. The license award precedes the implementation of a two-year contract, which commenced on January 1, 2005, for our Indiana subsidiary to provide Medicaid services within thirteen mandatory managed care counties. Our Indiana HMO began serving members in April 2005.

Michigan. Molina Healthcare of Michigan, Inc., our Michigan HMO, is now the largest Medicaid managed care health plan in the state, having grown to 158,000 members at December 31, 2004 from 82,000 members at December 31, 2003. Effective October 1, 2004, we assumed responsibility for approximately 73,000 members transferred from the Wellness Plan into our Michigan HMO. Our Michigan HMO serves 39 counties throughout Michigan, including the Detroit metropolitan area.

New Mexico. On July 1, 2004, we acquired the capital stock of Health Care Horizons, Inc., the parent company of Cimarron Health Plan, Inc. On August 1, 2004, we transferred the commercial membership of Cimarron Health Plan to Lovelace Sandia Health Systems, Inc. On the same date, the name of Cimarron Health Plan, Inc. was changed to Molina Healthcare of New Mexico, Inc., our New Mexico HMO. As of December 31, 2004, our New Mexico HMO served 65,000 members. Our New Mexico HMO serves members in all of New Mexico s 33 counties.

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Utah. Molina Healthcare of Utah, Inc., our Utah HMO, is the largest non-governmental Medicaid managed care health plan in Utah. Under the terms of our Medicaid agreement with the state, we are reimbursed for 100% of our medical costs plus 9% of medical costs as an administrative fee. In addition, if the actual medical costs and administrative fee are less than a predetermined amount, we will receive all or a portion of the difference as additional revenue. Our Utah HMO is compensated for coverage offered to SCHIP members on a per member per month (risk) basis. Our Utah HMO serves 25 of 29 counties in the state, including the Salt Lake City metropolitan area.

Washington. Molina Healthcare of Washington, Inc., our Washington HMO, is now the largest Medicaid managed care health plan in the state, with 263,000 members at December 31, 2004. We serve members in 33 of the state s 39 counties.

Provider Networks

We arrange health care services for our members through contracts with providers that include our own clinics, independent physicians and groups, hospitals, and ancillary providers. Our strategy is to contract with providers in those geographic areas and medical specialties necessary to meet the needs of our members. We also strive to ensure that our providers have the appropriate cultural and linguistic experience and skills.

The following table shows the total approximate number of primary care physicians, specialists, and hospitals participating in our network as of December 31, 2004:

	California	Michigan	New Mexico	Utah	Washington	Total
Primary care physicians	2,201	1,249	1,488	1,250	2,714	8,902
Specialists	6,366	1,899	6,275	2,097	5,325	21,962
Hospitals	85	41	69	38	81	314

Physicians. We contract with primary care physicians, medical groups, specialists, and independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. Our most frequently utilized specialists are obstetricians/gynecologists, ear nose and throat specialists, and orthopedic surgeons. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

Primary Care Clinics. We operate 21 company-owned primary care clinics in California staffed by physicians, physician assistants, and nurse practitioners. In 2004, the clinics provided services to approximately 41,000 of our California enrollees. Additionally, during 2004 our clinic received approximately 53,000 patient visits from non-members. These clinics are located in neighborhoods where our members reside, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers.

Hospitals. We generally contract with hospitals that have significant experience dealing with the medical needs of the Medicaid population. We reimburse hospitals under a variety of payment methods, including fee-for-service, per diems, diagnostic-related groups, and case rates.

Medical Management

Our experience in medical management extends back to our roots as a provider organization. Primary care physicians are the focal point of the delivery of health care to our members, providing routine and preventive care, coordinating referrals to specialists, and assessing the need for hospital care. This model has proven to be an effective method for coordinating medical care for our members.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*[sm] is a comprehensive program designed to

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improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*[sm] is a multidisciplinary disease management program that provides intensive health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*[sm] is a diabetes disease management program. *Heart Health Living* is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure. We anticipate that all of these programs will be fully implemented in our California, Michigan, New Mexico, Utah, and Washington HMOs by the end of 2005.

Educational Programs. Educational programs are an important aspect of our approach to health care delivery. These programs are designed to increase awareness of various diseases, conditions, and methods of prevention in a manner that supports our providers while meeting the unique needs of our members. For example, we provide our members with a copy of *What To Do When Your Child Is Sick*. This book, available in Spanish, Vietnamese, and English, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management. Our pharmacy management programs focus on physician education regarding appropriate medication utilization and encouraging the use of generic medications. Our pharmacists and medical directors work with our pharmacy benefits manager to maintain a formulary that promotes both improved patient care and generic drug use. We employ full-time pharmacists and pharmacy technicians who work with physicians to educate them on the uses of specific drugs, the implementation of best practices, and the importance of cost-effective care. This has resulted in a 99% generic utilization rate when a generic alternative is available in our drug formulary (and an overall generic utilization rate of approximately 75%), while at the same time enhancing our quality of care.

Plan Administration and Operations

Management Information Systems. All of our health plan information technology and systems operate on a single platform. This approach avoids the costs associated with maintaining multiple systems, improves productivity, and enables medical directors to compare costs, identify trends, and exchange best practices among our plans. Our single platform also facilitates our compliance with current and future regulatory requirements.

The software we use is based on client-server technology and is highly scalable. The software is flexible, easy to use, and readily allows us to accommodate enrollment growth and new contracts. The open architecture of the system gives us the ability to transfer data from other systems without the need to write a significant amount of computer code, thereby facilitating rapid and efficient integration of new plans and acquisitions.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement company-wide programs and strategic initiatives such as preparation of the Health Plan Employer Data and Information Set (HEDIS) and accreditation by the National Committee on Quality Assurance, or NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. Our California, Michigan, New Mexico, Utah, and Washington HMOs have each been accredited by the NCQA and we intend to seek accreditation for our Indiana HMO.

Claims Processing. We pay at least 90% of properly billed claims within 30 days. Claims received electronically can be imported directly into our claims system, and many can be adjudicated automatically, thus eliminating the need for manual intervention. Most physician claims that we

receive on paper are scanned into electronic format and processed automatically. Our California headquarters is a central processing center for all of our health plan claims.

Compliance. Our health plans have established high standards of ethical conduct. Our compliance programs are modeled after the compliance guidance statements published by the Office of the Inspector General

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of the U.S. Department of Health and Human Services. Our uniform approach to compliance makes it easier for our health plans to share information and practices and reduces the potential for compliance errors and any associated liability.

Competition

We operate in a highly competitive environment. The Medicaid managed care industry is fragmented and currently subject to significant changes as a result of business consolidations and new strategic alliances entered into by other managed care organizations. We compete with a large number of national, regional, and local Medicaid service providers, principally on the basis of size, location, and quality of provider network, quality of service, and reputation. Below is a general description of our principal competitors for state contracts, members, and providers:

Multi-Product Managed Care Organizations National and regional managed care organizations that have Medicaid members in addition to members in Medicare and private commercial plans.

Medicaid HMOs National and regional managed care organizations that focus principally on providing health care services to Medicaid beneficiaries, many of which operate in only one city or state.

Prepaid Health Plans Health plans that provide less comprehensive services on an at-risk basis or that provide benefit packages on a non-risk basis.

Primary Care Case Management Programs Programs established by the states through contracts with primary care providers to provide primary care services to Medicaid beneficiaries, as well as provide limited oversight of other services.

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

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

Regulation

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.

In order to operate a health plan in a given state, we must apply for and obtain a certificate of authority or license from that state. Our health plans are licensed to operate as HMOs in California, Indiana, Michigan, New Mexico, Utah, and Washington. In those states we are regulated by the agency with responsibility for the oversight of HMOs. In most cases that agency is the state department of insurance. In California, that agency is the Department of Managed Health Care. Licensing requirements are the same for us as they are for health plans serving commercial or Medicare members. We must demonstrate that our provider network is adequate, that our quality and utilization management processes comply with state requirements, and that we have adequate procedures in place for responding to member and provider complaints and grievances. We must also demonstrate that we can meet requirements for the timely processing of provider claims, and that we can collect

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and analyze the information needed to manage our quality improvement activities. In addition, we must prove that we have the financial resources necessary to pay our anticipated medical care expenses and the infrastructure needed to account for our costs.

Each of our health plans is required to report quarterly on its performance to the appropriate state regulatory agencies. They also undergo periodic examinations and reviews by the states. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. Any acquisition of another plan s members must also be approved by the state, and our ability to invest in certain financial securities may be proscribed by statute.

In addition, we are also regulated by each state s department of health services, or the equivalent agency charged with oversight of Medicaid and SCHIP. These agencies typically require demonstration of the same capabilities mentioned above and perform periodic audits of performance, usually annually.

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the state and federal governments fund it, Medicaid is a state-operated and implemented program. Our contracts with the state Medicaid programs place additional requirements on us. Within broad guidelines established by the federal government, each state:

- establishes its own eligibility standards,
- determines the type, amount, duration, and scope of services,
- sets the rate of payment for services, and
- administers its own program.

We obtain our Medicaid contracts in different ways. Some states, such as Washington, award contracts to any applicant demonstrating that it meets the state s requirements. Others, such as California, engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state s operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor s office using public transportation,
- Our quality improvement programs must emphasize member education and outreach and include measures designed to promote utilization of preventive services,
- We must have linkages with schools, city or county health departments, and other community-based providers of health care, in order to demonstrate our ability to coordinate all of the sources from which our members may receive care,

We must be able to meet the needs of the disabled and others with special needs,

Our providers and member service representatives must be able to communicate with members who do not speak English or who are deaf, and

Our member handbook, newsletters and other communications must be written at the prescribed reading level, and must be available in languages other than English.

In addition, we must demonstrate that we have the systems required to process enrollment information, to report on care and services provided, and to process claims for payment in a timely fashion. We must also have the financial resources needed to protect the state, our providers, and our members against insolvency.

Once awarded, our contracts generally have terms of one to six years, with renewal options at the discretion of the states. Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the contracts expiration. Our health plans are subject to periodic reporting

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requirements and comprehensive quality assurance evaluations, and must submit periodic utilization reports and other information to state or county Medicaid authorities. We are not permitted to enroll members directly, and are permitted to market only in accordance with strict guidelines.

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

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

The Federal Centers for Medicare and Medicaid Services are still working to adopt final regulations to fully implement HIPAA. We expect to achieve compliance with HIPAA by the applicable deadlines. However, because of the complexity of HIPAA, the recent adoption of some final regulations, the need to adopt additional final regulations, the possibility that the regulations may change and may be subject to changing, and perhaps conflicting, interpretation, our ability to comply with all HIPAA requirements is uncertain and the cost of compliance difficult to predict.

Fraud and Abuse Laws. Federal and state governments have made investigating and prosecuting health care fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. Companies involved in public health care programs such as Medicaid are often the subject of fraud and abuse investigations. The regulations and contractual requirements applicable to participants in these public-sector programs are complex and subject to change. Although we believe that our compliance efforts are adequate, ongoing vigorous law enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources.

Employees. As of December 31, 2004, we had approximately 1,300 employees, including physicians, nurses, and administrators. Our employee base is multicultural and reflects the diverse member base we serve. We believe we have good relations with our employees. None of our employees are represented by a union.

Table of Contents

MANAGEMENT

Officers and Directors

The following table sets forth the name, age and position of our executive officers and directors (as of March 31, 2005).

Name	Age	Position
Charles Z. Fedak, CPA, M.B.A.(1)(2)(3)	53	Director
George S. Goldstein, Ph.D.	63	Executive Vice President, Public Policy and Director