Risk Factors Comparison 2024-02-13 to 2023-02-13 Form: 10-K

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Our business involves significant risks. You should carefully consider the risks described below and all of the other information set forth in this Form 10- K, including our consolidated financial statements and accompanying notes. These risks and other factors may affect our forward- looking statements, including those we make in this Form 10- K or elsewhere, such as in press releases, presentations to securities analysts or investors, or other communications made by or with the approval of one of our executive officers. The risks described in the following section are not the only risks facing our Company. Additional risks that we are unaware of, or that we currently believe are not material, may also become important factors that adversely affect our business. In addition to the risks relating to the COVID- 19 pandemic that are specifically described in these risk factors, the effects of the COVID- 19 pandemic may also have the effect of significantly heightening many of the other risks associated with our business, including those described below. If any of the following risks actually occurs, our business, financial condition, results of operations, and future prospects could be materially and adversely affected. In that event, among other effects, the trading price of our common stock could decline, and you could lose part or all of your investment. RISKS RELATED TO OUR INDUSTRY Our Medicaid enrollees will be subject..... may pursue. RISKS RELATED TO OUR BUSINESS If the responsive bids of our health plans for new or renewed Medicaid contracts are not successful, or if our government contracts are terminated or are not renewed on favorable terms, our premium revenues could be materially reduced and our operating results could be negatively impacted. We currently derive our premium revenues from health plans that operate in ~~19~~ **20** states. Our Medicaid premium revenue constituted ~~80~~ **81** % of our consolidated premium revenue in the year ended December 31, ~~2022~~ **2023** . Measured by Medicaid premium revenue by health plan, our top four health plans were in **California,** New York ~~, Ohio~~ , Texas, and Washington, with aggregate Medicaid premium revenue of $ 13. ~~3~~ **5** billion, or approximately ~~54~~ **51** % of total Medicaid premium revenue, in the year ended December 31, ~~2022~~ **2023** . If we are unable to continue to operate in any of our existing jurisdictions, or if our current operations in those jurisdictions or any portions of those jurisdictions are significantly curtailed or terminated entirely, our revenues could decrease materially. Many of our government contracts are effective only for a fixed period of time and will only be extended for an additional period of time if the contracting entity elects to do so. When our government contracts expire, they may be opened for bidding by competing health plans, and there is no guarantee that the contracts will be renewed or extended. Even if our contracts are renewed or extended, there can be no assurance that they will be renewed or extended on the same terms or without a reduction in the applicable service areas. ~~Molina Healthcare, Inc. 2022 Form 10- K | 23~~ Even if our responsive bids are successful, the bids may be based upon assumptions regarding enrollment, utilization, medical costs, or other factors which could result in the contract being less profitable than we had expected or could result in a net loss. Furthermore, our contracts contain certain provisions regarding, among other things, eligibility, enrollment and dis- enrollment processes for covered services, eligible providers, periodic financial and information reporting, quality assurance and timeliness of claims payment, and are subject to cancellation if we fail to perform in accordance with the standards set by regulatory agencies. **Our Marketplace business has been volatile and has suffered significant losses in the past. We offer Marketplace plans in many of the states where we offer Medicaid health plans. In 2024, we are participating in the Marketplace in all our markets except for Arizona, Iowa, Massachusetts, Nebraska, New York, and Virginia. Our Marketplace plans allow our Medicaid members to stay with their providers as they transition between Medicaid and the Marketplace. Additionally, our plans remove financial barriers to quality care and seek to minimize members' out- of- pocket expenses. We develop each state' s Marketplace premium rates during the spring of each year for policies effective in the following calendar year. Premium rates are based on our estimates of utilization of services and unit costs, anticipated member risk acuity and related federal risk adjustment transfer amounts, and non- benefit expenses such as administrative costs, taxes, and fees. In the year ended December 31, 2023, Marketplace program PMPM premium rates ranged from $ 270 to $ 1, 140. Marketplace plan selection by members is highly price sensitive, and the Marketplace markets in general are highly volatile and unpredictable from year to year. Any variation from our cost expectations regarding acuity, enrollment levels, adverse selection, or other assumptions utilized in setting premium rates, could have a material adverse effect on our results of operations, financial position, and cash flows. Molina Healthcare, Inc. 2023 Form 10- K | 19** We are subject to risks associated with outsourcing services and functions to third parties. We contract with third party vendors and service providers who provide services to us and our subsidiaries or to whom we delegate selected functions. Some of these third parties have direct access to our systems. Our arrangements with third party vendors and service providers may make our operations vulnerable if those third parties fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data or the information and data relating to our members or customers. We are also at risk of a data security incident involving a vendor or third party, which could result in a breakdown of such third party' s data protection processes or cyber- attackers gaining access to our infrastructure through the third party. To the extent that a vendor or third party suffers a data security incident that compromises its operations, we could incur significant costs and possible service interruption. Any contractual remedies and / or indemnification obligations we may have for vendor or service provider failures or incidents may not be adequate to fully compensate us for any losses suffered as a result of any vendor' s failure to satisfy its obligations to us or under applicable law. Violations of, or noncompliance with, laws and / or regulations governing our business or noncompliance with contract terms by third party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or could result in sanctions and / or fines from the

regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms. We may incur significant costs and / or experience significant disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, and results of operations may be harmed. If we or one of our significant vendors sustain a cyber-attack or suffer data privacy or security breaches that disrupt our information systems or operations, or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, reputational harm, loss of business, and other serious negative consequences. As part of our normal operations, we routinely collect, process, store, and transmit large amounts of data, including sensitive personal information as well as proprietary or confidential information relating to our business or third parties. To ensure information security, we have implemented controls designed to protect the confidentiality, integrity and availability of this data and the systems that store and transmit such data. However, our information technology systems and safety control systems are subject to a growing number of threats from computer programmers, hackers, and other adversaries that may be able to penetrate our network security and misappropriate our confidential information ~~or that of third parties~~ , create system disruptions, or cause damage, security issues, or shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs that attack our systems or otherwise exploit security vulnerabilities. **We may** ~~All of these risks are~~ also ~~faced by our significant vendors who are also in possession of sensitive confidential information. As a result of the COVID- 19 pandemic, we may~~ face increased cybersecurity risks due to our reliance on internet technology and ~~the number of~~ our **fully remote** ~~employees who are~~ working ~~remotely~~ **environment** , which may create additional opportunities for cybercriminals to exploit vulnerabilities **. All of these risks are also faced by our significant vendors who are also in possession of sensitive confidential information** . Because the techniques used to circumvent, gain access to, or sabotage security systems can be highly sophisticated and change frequently, they often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world. We may be unable to anticipate these techniques or implement adequate preventive measures, resulting in potential data loss and damage to our systems. Our systems are also subject to compromise from internal threats such as improper action by employees, including malicious insiders, or by vendors, counterparties, and other third parties with otherwise legitimate access to our systems. Our policies, employee training (including phishing prevention training), procedures and technical safeguards may not prevent all improper access to our network or proprietary or confidential information by employees, vendors, counterparties, or other third parties. Our facilities may also be vulnerable to security incidents or security attacks, acts of vandalism or theft, misplaced or lost data, human errors, or other similar events that could negatively affect our systems and our and our members' data. Moreover, we face the ongoing challenge of managing access controls in a complex environment. The process of enhancing our protective measures can itself create a risk of systems disruptions and security issues. Given the ~~Molina Healthcare, Inc. 2022 Form 10- K | 24~~ breadth of our operations and the increasing sophistication of cyberattacks, a particular incident could occur and persist for an extended period of time before being detected. The extent of a particular cyberattack and the steps that we may need to take to investigate the attack may take a significant amount of time before such an investigation could be completed and full and reliable information about the incident is known. During such time, the extent of any harm or how best to remediate it might not be known, which could further increase the risks, costs, and consequences of a data security incident. In addition, our systems must be routinely updated, patched, and upgraded to protect against known vulnerabilities. The volume of new software vulnerabilities has increased substantially, as has the importance of patches and other remedial measures. In addition to remediating newly **Molina Healthcare, Inc. 2023 Form 10- K | 20** identified vulnerabilities, previously identified vulnerabilities must also be updated. We are at risk that cyber attackers exploit these known vulnerabilities before they have been addressed. The complexity of our systems and platforms, the increased frequency at which vendors are issuing security patches to their products, our need to test patches and, in some instances, coordinate with third ~~-~~parties before they can be deployed, all could further increase our risks. Where doing so is necessary in order to conduct our business, we also provide sensitive personal member information, as well as proprietary or confidential information relating to our business, to our third- party service providers. Although we obtain assurances from those third parties that they have systems and processes in place to protect such data, and that they will take steps to assure the protection of such data by other third parties, those third- party service providers may also be subject to data intrusion or data breach. Any compromise of the confidential data of our members, employees, or business, or the failure to prevent or mitigate the loss of or damage to this data through breach, could result in operational, reputational, competitive, or other business harm, as well as financial costs and regulatory action. The Company maintains cybersecurity insurance in the event of an information security or cyber incident. However, the coverage may not be sufficient to cover all financial losses. **In the future, we may be subject to litigation and governmental investigations related to cyber- attacks and security breaches. Any such future litigation or governmental investigation could divert the attention of management from the operation of our business, result in reputational damage, and have a material adverse impact on our business, cash flows, financial condition, and results of operations. Moreover, our programs to detect, contain, and respond to data security incidents as well as contingency plans and insurance coverage for potential liabilities of this nature may not be sufficient to cover all claims and liabilities. Noncompliance with any privacy, security or data protection laws and regulations, or any security breach, cyber- attack or cyber-security breach, and any incident involving the misappropriation, theft, loss or other unauthorized disclosure or use of, or access to, sensitive or confidential information, whether by us or by one of our third- party service providers, could require us to expend significant resources to continue to modify or enhance our protective measures and to remediate any damage. In addition, this could negatively affect our operations, cause system disruptions, damage our reputation, cause membership losses and contract breaches, and could also result in regulatory enforcement actions, material fines**

and penalties, litigation or other actions that could have a material adverse effect on our business, cash flows, financial condition, and results of operations. We may be unable to successfully integrate our acquisitions or realize the anticipated benefits of such acquisitions. Our growth strategy includes the pursuit of targeted inorganic growth opportunities that we believe will provide a strategic fit, leverage operational synergies, and lead to incremental earnings accretion. For example, in ~~January~~ **September** ~~2022~~ **2023** ~~,~~ we closed on our acquisition of **My Choice Wisconsin** ~~the Medicaid assets of Cigna Corporation in Texas~~ and in ~~October~~ **January** ~~2022~~ **2024** ~~,~~ we closed on ~~our~~ **the** acquisition of ~~the~~ **Bright Health** ~~Medicaid~~ **Medicare** ~~Managed Long Term Care business of AgeWell New York. In July 2022, we entered into a definitive agreement to acquire substantially all the assets of My Choice Wisconsin. Subject to the receipt of applicable federal and state regulatory approvals and the satisfaction of customary closing conditions, the closing of this transaction is expected to occur in 2023~~ . The integration of acquired businesses with our existing business is a complex, costly and time- consuming process. The success of acquisitions we make will depend, in part, on our ability to successfully combine our existing business with such acquired businesses and realize the anticipated benefits, including synergies, cost savings, growth in earnings, innovation, and operational efficiencies, from the combinations. If we are unable to achieve these objectives within the anticipated time frame, or at all, the anticipated benefits may not be **fully** realized ~~fully or at all~~ , or may take longer to realize than expected. Our acquisitions and the related integration activities involve a number of risks, including the following: • The transition services that a seller may have agreed to provide following the closing may not be provided in a timely or efficient manner, or certain necessary transition services may not be provided at all; • Unforeseen expenses or delays associated with the acquisition and / or integration; • The assumptions underlying our expectations regarding the integration process or the expected benefits to be achieved from an acquisition may prove to be incorrect; • Maintaining employee morale and retaining key management and other employees; • Difficulties retaining the business and operational relationships of the acquired business, and attracting new business and operational relationships; • Unanticipated attrition in the membership of the acquired business pending the completion of the proposed transaction or after the closing of the transaction; • Unanticipated difficulties or costs in integrating information technology, communications and other systems, consolidating corporate and administrative infrastructures, and eliminating duplicative operations; • Attention to integration activities may divert management' s attention from ongoing business concerns, which could result in performance shortfalls; **Molina Healthcare, Inc. 2023 Form 10- K | 21** • Successfully addressing the challenges inherent in managing a larger company and coordinating geographically separate organizations; and • Delays in obtaining, or inability to obtain, necessary state or federal regulatory approvals, or such approvals may impose conditions that were not anticipated. ~~Molina Healthcare, Inc. 2022 Form 10- K | 25~~ Many of these factors are outside of our control **,** and any one of them could result in delays, increased costs, decreases in the amount of expected revenues, and diversion of management' s time and energy, which could have a material adverse effect on our business, financial condition, cash flows **,** or results of operations. There can be no assurances that we will be successful in managing our expanded operations as a result of acquisitions or that we will realize the expected growth in earnings, operating efficiencies, cost savings, or other benefits. We may be unable to sustain our projected rate of growth due to a lack of merger and acquisition opportunities. Over the last five years we have ~~entered into seven~~ **closed on eight** merger and acquisition transactions generating approximately $ ~~10~~ **11** billion in premium revenue. Many of the targets of such transaction have been non- profit entities. If the number of health care entities willing and able to enter into consolidation transactions with us declines in the future, we may be unable to fully achieve our growth strategy, which could have an adverse effect on our business, financial condition, or results of operations. Failure to attain profitability in any newly acquired health plans or new start- up operations could negatively affect our results of operations. Start- up costs associated with a new business can be substantial. For example, to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, develop and establish infrastructure and required systems, and demonstrate our ability to process claims. In 2023, we ~~expect to incur~~ **incurred** substantial one- time contract implementation costs related to our expansions in Los Angeles County, Iowa, and Nebraska. Often, we are also required to contribute significant capital to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we are unsuccessful in obtaining a certificate of authority, winning the bid to provide services, building out our provider network, or attracting and retaining members in sufficient numbers to cover our start- up costs, the new business could fail, or the losses we incur could impact our results of operations. The expenses associated with starting up a health plan in a new jurisdiction, expanding a health plan in an existing jurisdiction, or acquiring a new health plan, could have a material adverse effect on our business, financial condition, cash flows, or results of operations. If we lose contracts that constitute a significant amount of our premium revenue, we will lose the administrative cost efficiencies or cost leverage that is inherent in a larger revenue base. In such circumstances, we may not be able to reduce fixed costs proportionally with our lower revenue, and the financial impact of lost contracts may exceed the net income ascribed to those contracts. We currently spread the cost of centralized services over a large revenue base. Many of our administrative costs are fixed in nature ~~,~~ and will be incurred at the same level regardless of the size of our revenue base. If we lose contracts that constitute a significant amount of our revenue, we may not be able to reduce the expense of centralized services in a manner that is proportional to that loss of revenue. In such circumstances, not only will our total dollar margins decline, but our percentage margins, measured as a percentage of revenue, will also decline. This loss of cost efficiency or cost leverage, and the resulting stranded administrative costs, could have a material and adverse impact on our business, financial condition, cash flows, or results of operations. Our health plans are subject to risk associated with various contractual provisions and regulations establishing medical cost expenditure floors, profit ceilings, risk corridors, and quality withholds. A substantial portion of our premium revenue is subject to contract provisions pertaining to medical cost expenditure floors and corridors, administrative cost and profit ceilings, premium stabilization programs, and cost- plus and performance- based reimbursement programs. Many of these contract provisions are complex, or are poorly or ambiguously drafted, and thus are subject to differing interpretations by us and the relevant government agency with whom we contract. If the applicable government agency disagrees with our interpretation or implementation of a particular

contract provision, we could be required to adjust the amount of our obligation under that provision. Any such adjustment could have a material adverse effect on our business, financial condition, cash flows, or results of operations. In addition, many of our contracts contain provisions pertaining to at- risk premiums that require us to meet certain quality performance measures to earn all of our contract revenues. If we are unsuccessful in achieving the stated **Molina Healthcare, Inc. 2023 Form 10- K | 22** performance measure, we will be unable to recognize the revenue associated with that measure, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations. ~~Molina Healthcare, Inc. 2022 Form 10- K | 26~~ Our Medicaid premium revenues could be adversely impacted by retroactive adjustments or states' delays in processing rate changes. The complexity of some of our Medicaid contract provisions, imprecise language in those contracts, the desire of state Medicaid agencies in some circumstances to retroactively adjust for the acuity of the medical needs of our members, and state delays in processing rate changes, can create uncertainty around the amount of revenue we should recognize. Any circumstance such as those described above could have a material adverse effect on our business, financial condition, cash flows, or results of operations. If, in the interest of long- term profitability, we decide to exit certain state contractual arrangements, make changes to our provider networks, or make changes to our administrative infrastructure, we may incur disruptions to our business that could in the short term materially reduce our premium revenues and our net income. Decisions that we make with regard to retaining or exiting our portfolio of state or federal contracts, and changes to the manner in which we serve the members of those contracts, could generate substantial expenses associated with the run out of existing operations and the restructuring of those operations that remain. Such expenses could include, but would not be limited to, goodwill and intangible asset impairment charges, restructuring costs, additional medical costs incurred due to the inability to leverage long- term relationships with medical providers, and costs incurred to finish the run out of businesses that have ceased to generate revenue, all of which could materially reduce our premium revenues and net income. For example, following our exit from Puerto Rico in October 2020, significant accounts receivable under our Puerto Rico Medicaid contract remain uncollected, which we ultimately may never recover. A failure to accurately estimate incurred but not paid medical care costs may negatively impact our results of operations. Because of the lag in time between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time and establish claims reserves related to such estimates. Our estimated reserves for such incurred but not paid, or IBNP, medical care costs are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known incidence of disease, including COVID- 19, or increased incidence of illness such as the flu, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer lines of business or populations is negatively impacted by the more limited experience we have had with those newer lines of business or populations. The IBNP estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the numerous uncertainties inherent in such estimates, our actual claims liabilities for a particular quarter or other period could differ significantly from the amounts estimated and reserved for that quarter or period. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served. If our actual liability for claims payments is higher than previously estimated, our earnings in any particular quarter or annual period could be negatively affected. Our estimates of IBNP may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNP, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results. If we fail to accurately predict and effectively manage our medical care costs, our operating results could be materially and adversely affected. Our profitability depends to a significant degree on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated substantially, and has varied across our health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care ratio can create significant changes in our overall financial results. For example, if our overall medical care ratio of 88. ~~0~~ **1** % for the year ended December 31, ~~2022~~ **2023** , had been one percentage point higher, **Molina Healthcare, Inc. 2023 Form 10- K | 23** or 89. ~~0~~ **1** %, our net income per diluted share for the year ended December 31, ~~2022~~ **2023** would have been approximately $ ~~9~~ **14** . 51 rather than our actual net income per diluted share of $ ~~13~~ **18** . ~~55~~ **77** , a difference of $ 4. ~~04~~ **26** . ~~Molina Healthcare, Inc. 2022 Form 10- K | 27~~ Many factors may affect our medical care costs, including: • the level of utilization of healthcare services ~~; • the impact of the COVID- 19 pandemic~~ ; • changes in the underlying risk acuity of our membership; • unexpected patterns in the annual flu season; • increases in hospital costs; • increased incidences or acuity of high dollar claims related to catastrophic illnesses or medical conditions for which we do not have adequate reinsurance coverage; • increased maternity costs; • changes in state eligibility certification methodologies; • relatively low levels of hospital and specialty provider competition in certain geographic areas; • increases in the cost of pharmaceutical products and services; • changes in healthcare regulations and practices; • epidemics **or pandemics, such as COVID- 19** ; • new medical technologies; and • other various external factors. Many of these factors are beyond our control. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care ratio, either with respect to a particular health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations. If we are unable to deliver quality care, and maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost- effective contracts with such providers, our profitability could be adversely affected. We contract with physicians, hospitals, and other providers as a means to ensure access to healthcare services for our members, to manage medical care costs and utilization, and

to better monitor the quality of care being delivered. We compete with other health plans to contract with these providers. We believe providers select plans in which they participate based on criteria including reimbursement rates, timeliness and accuracy of claims payment, potential to deliver new patient volume and / or retain existing patients, effectiveness of resolution of calls and complaints, and other factors. There can be no assurance that we will be able to successfully attract and retain providers to maintain a competitive network in the geographic areas we serve. In addition, in any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher medical care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements. The Medicaid program generally pays doctors and hospitals at levels well below those of Medicare and private insurance. Large numbers of doctors, therefore, do not accept Medicaid patients. In the face of fiscal pressures, some states may reduce rates paid to providers, which may further discourage participation in the Medicaid program. In some markets, certain providers, particularly hospitals and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected. Some providers that render services to our members are not contracted with our health plans. In those cases, there is no pre- established understanding between the provider and our health plan about the amount of compensation that is due to the provider. **If** ~~In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollars. In such instances,~~ providers ~~may~~ claim they are underpaid for their services ~~and~~ **, they** may either litigate or arbitrate their dispute with our health plan. **State and federal laws intended to prevent or limit " surprise billing, " such as the No Surprises Act, define the compensation that must be paid to out- of- network providers in certain scenarios and require rate disputes between payors and out- of- network providers to be resolved through independent dispute resolution (" IDR "). There have been lawsuits challenging portions of the No Surprises Act in federal courts, particularly related to the use of the qualifying payment amount (" QPA ") in the IDR process, which may result in an increase in rates we must pay to out- of- network providers. Federal agencies have continued to issue guidance regarding the implementation of the No Surprises Act, and we expect the agencies' interpretations of law' s requirements will continue to evolve.** The **impact** ~~uncertainty of the amount to pay to such providers and the possibility of subsequent adjustment of the payment or litigation with the provider~~ that **federal** ~~results in an~~ **and** ~~adverse decision~~ **state surprise billing laws will have on our business is uncertain and** could adversely affect our business, financial condition, cash flows, or results of operations. **Molina Healthcare, Inc. 2023 Form 10- K | 24** We rely on the accuracy of eligibility lists provided by state governments. Inaccuracies in those lists would negatively affect our results of operations. Premium payments to our health plans are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a ~~Molina Healthcare, Inc. 2022 Form 10- K | 28~~ different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we make or have made related payments to providers and are unable to recoup such payments from the providers. Further, when a state implements new programs to determine eligibility, establishes new processes to assign or enroll eligible members into health plans, or chooses new subcontractors, there is an increased potential for an unanticipated impact on the overall number of members assigned to managed care health plans. Whenever a state effects an eligibility redetermination for any reason, there is generally an associated reduction in Medicaid membership, which could have an adverse effect on our premium revenues and results of operations. The insolvency of a delegated provider could obligate us to pay its referral claims, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations. Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitated basis. Under capitation arrangements, we pay a fixed amount per member per month to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Due to insolvency or other circumstances, such providers may be unable or unwilling to pay claims they have incurred with third parties in connection with referral services provided to our members. The inability or unwillingness of delegated providers to pay referral claims presents us with both immediate financial risk and potential disruption to member care, as well as potential loss of members. Depending on states' laws, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk. Additionally, competitive pressures or practical regulatory considerations may force us to pay such claims even when we have no legal obligation to do so; or we have already paid claims to a delegated provider and such payments cannot be recouped when the delegated provider becomes insolvent. Liabilities incurred or losses suffered as a result of provider insolvency or other circumstances could have a material adverse effect on our business, financial condition, cash flows, or results of operations. Receipt of inadequate or significantly delayed premiums could negatively affect our business, financial condition, cash flows, or results of operations. Our premium revenues consist of fixed monthly payments per member, and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to healthcare services rise, our medical margins will be compressed, and our earnings will be negatively affected. A state could increase hospital or other provider rates without making a commensurate increase in the rates paid to us, could lower our rates without making a commensurate reduction in the rates paid to hospitals or other providers, or could delay the processing of rate changes. In addition, if the actuarial assumptions made by a state in implementing a rate or benefit change are incorrect or are at variance with the particular utilization patterns of the members of one or more of our health plans, our medical margins could be reduced. Any of these rate adjustments in one or more of the states in which we operate could have a material adverse effect on our business, financial condition, cash flows, or

results of operations. If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease. States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two- to five- year periods and can be renewed on an ongoing basis if the state applies and the waiver request is approved or renewed by CMS. We have no control over this renewal process. If a state in which we operate 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 and medical management systems, and our inability to effectively integrate, manage, update, and keep secure our information and medical management systems could disrupt our operations. Our business is dependent on effective and secure information systems that assist us in processing provider claims, monitoring utilization and other cost factors, supporting our medical management techniques, providing data to our ~~regulators, and implementing our data security measures. Our members and providers also depend upon our information systems for enrollment, premium processing, primary care and specialist physician roster access, membership verifications, claims status, provider payments, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations,~~ **regulators, and implementing our data security measures. Our members and providers also depend upon our information systems for enrollment, premium processing, primary care and specialist physician roster access, membership verifications, claims status, provider payments, and other information. If we experience a reduction in the performance, reliability, or availability of our information and medical management systems, our operations,** ability to pay claims, ability to produce timely and accurate reports, and ability to maintain proper security measures could be adversely affected. We have partnered with third parties to support our information technology systems. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. For example, in February 2019, we entered into a master services agreement with a third party vendor who manages certain of our information technology infrastructure services including, among other things, our information technology operations, end- user services, and data centers. If any licensor or vendor of any technology which is integral to our operations were to become insolvent or otherwise fail to support the technology sufficiently, our operations could be negatively affected. Additionally, our operations are vulnerable to adverse effects if such third parties are unable to perform due to forces outside of their control, such as a natural disaster or serious weather event. For example, in 2021, our third party call center, located in the province of Cebu in the Philippines, suffered significant disruptions as a result of the destruction caused by Super Typhoon Rai. Our encounter data, or the encounter data of the health plans we acquire, may be inaccurate or incomplete, which could have a material adverse effect on our results of operations, financial condition, cash flows and ability to bid for, and continue to participate in, certain programs. Our contracts require the submission of complete and correct encounter data. The accurate and timely reporting of encounter data is increasingly important to the success of our programs because more states are using encounter data to determine compliance with performance standards and to set premium rates. We have been, and continue to be, exposed to operating sanctions and financial fines and penalties for noncompliance. In some instances, our government clients have established retroactive requirements for the encounter data we must submit. There also may be periods of time in which we are unable to meet existing requirements. In either case, it may be prohibitively expensive or impossible for us to collect or reconstruct this historical data. Moreover, these same issues may also apply to the health plans we acquire, and we may be required to expend significant costs or pay fines to correct these deficiencies. ~~We~~ **In the past, we** have experienced challenges in obtaining complete and accurate encounter data ~~,~~due to difficulties with providers and third- party vendors submitting claims in a timely fashion in the proper format, and with state agencies in coordinating such submissions. As states increase their reliance on encounter data, these difficulties could adversely affect the premium rates we receive and how membership is assigned to us and subject us to financial penalties, which could have a material adverse effect on our business, financial condition, cash flows, or results of operations, and on our ability to bid for, and continue to participate in, certain programs. **We may not be successful in our artificial intelligence (" AI ") administrative and operational initiatives, which could adversely affect our business, reputation, or financial results. As part of our operating efficiencies, we are making appreciable investments in certain AI administrative tools and initiatives to enhance our operations and to save costs. There are risks associated with the development and deployment of AI, and there can be no assurance that the usage of AI will enhance our operations or reduce our operational costs. Our AI- related efforts may give rise to risks related to accuracy, bias, discrimination, intellectual property infringement, data privacy, and cybersecurity, among others. In addition, these risks include the possibility of new or enhanced governmental or regulatory scrutiny, litigation, or other legal liability, ethical concerns, negative consumer perceptions as to automation and AI, or other complications that could adversely affect our business, reputation, or financial results. The development and use of AI technologies is still in its early stages. Thus, it is not possible to predict all of the risks and potentially unintended consequences related to the use of AI by vendors, third-party developers, or the Company.** An impairment charge with respect to our recorded goodwill, or our finite- lived intangible assets, could have a material impact on our financial results. As of December 31, ~~2022~~ **2023** , the carrying amount of goodwill was $ 1, ~~115~~ **241** million, and intangible assets, net, were $ ~~275~~ **208** million. Goodwill represents the excess of the purchase consideration over the fair value of net assets acquired in business combinations. Goodwill is not amortized but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Impairment indicators may include experienced or expected operating cash- flow deterioration or losses, significant losses of membership, loss of state funding, loss of state contracts, and other **Molina Healthcare, Inc. 2023 Form 10- K | 26** factors. Goodwill is impaired if the carrying amount of ~~the~~ **a** reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss and adjusted if necessary for the impact of tax- deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit. An event could occur that would cause us to revise our estimates and assumptions used in analyzing the value of

our goodwill, and intangible assets, net. For example, if the responsive bid of one or more of our health plans is not successful, we will lose a contract in the applicable state or states and such loss may be an indicator of impairment. If an event or events occur that would cause us to revise our estimates and assumptions used in analyzing the value of our goodwill and other intangible assets, such revision could result in a non- cash impairment charge that could have a material impact on our results of operations in the period in which the impairment occurs. The May 2020 contract award to our Kentucky Medicaid plan is the subject of ~~an ongoing legal challenge~~ **a pending appeal before the Kentucky Supreme Court** . On September 4, 2020, Anthem Kentucky Managed Care Plan, Inc. brought an action in Franklin County Circuit Court against the Kentucky Finance and Administration Cabinet, the Kentucky Cabinet for Health and Family Services, and all of the five winning bidder health plans, including our Kentucky health plan. This matter ~~remains subject to additional appellate proceedings~~ **is now pending before the Kentucky Supreme Court** , and no assurances can be given regarding the ultimate outcome. In the event the contract award to our Kentucky health plan is overturned, the business and revenue of our Kentucky health plan may be materially and adversely affected. **The value of our investments is influenced by varying economic and market conditions, and a decrease in value may result in a loss charged to income. We maintain a significant investment portfolio of cash equivalents and short- term and long- term investments in a variety of securities, which are subject to general credit, liquidity, market and interest rate risks. As a result, we may experience a reduction in value or loss of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. Changes in the economic environment, including periods of increased volatility in the securities markets and recent increases in inflation and interest rates, can increase the difficulty of assessing investment impairment and increase the risk of potential impairment of these assets. There is continuing risk that declines in the fair value of our investments may occur and material impairments may be charged to income in future periods, resulting in recognized losses. RISKS RELATED TO OUR INDUSTRY Our Medicaid enrollees continue to be subject to eligibility redeterminations and potential disenrollments on a state by state basis, and the number and health acuity level of Medicaid enrollees we retain may be lower than our current estimates. During the COVID- 19 pandemic, Medicaid enrollment across the country, as well as our enrollment, grew substantially compared to before the pandemic. Beginning April 1, 2023, Medicaid eligibility redeterminations commenced, and are expected to be concluded by June 2024. The total number of Medicaid enrollees who may be disenrolled during the unwinding period is uncertain. In 2023, we estimate we lost approximately 500, 000 members due to redeterminations (offset by new enrollment), and we expect to lose an additional 100, 000 members in 2024. Based on our experience to date, we expect that we will retain approximately 40 % of the new Medicaid enrollees who joined our health plans during the pendency of the PHE. However, this expectation is subject to a number of uncertain variables and assumptions. Moreover, actuarial assumptions related to the health acuity of the remaining members may become more difficult to predict or may be inaccurate, resulting in inaccurate rates to be paid to health plans. Errors in our estimates related to redeterminations and disenrollment, and actuarial errors related to the acuity of Medicaid members may materially impact our business, financial condition, cash flows, and results of operations. CMS will end the current MMP program no later than December 2025, which could impact premium revenue. To coordinate care for those who qualify to receive both Medicare and Medicaid services (the " dual eligibles "), under the direction of CMS some states implemented demonstration pilot programs to integrate Medicare and Medicaid services for the dual eligibles. The health plans participating in such demonstrations are referred to as MMPs. Pursuant to the 2023 CMS Medicare Final Rule, which requires MMP plans to end no later than December 2025, the five states in which we operate MMPs – Illinois, Michigan, Ohio, South Carolina, and Texas – have filed transition plans with CMS to move to D- SNPs by January 1, 2026. Illinois and Ohio have included plans to transition to Fully Integrated D- SNPs. Michigan, South Carolina, and Texas are electing to transition to Highly Integrated D- SNPs. We anticipate states to release procurements to contract with D- SNPs in 2024. The economic impact of such transitions to D- SNP on our premium revenue is uncertain at this point.** Molina Healthcare, Inc. ~~the joint~~ **2023 Form 10- K | 27 Moreover,both states and CMS are requiring increasing integration of Medicare and Medicaid programmatic and compliance obligations.Medicare requirements developed by CMS,which were formerly entirely** federal ~~and~~ **in nature,are now being extended to or incorporated into** state **- administered** ~~funding of the~~ Medicaid ~~program~~ **programs** . ~~The~~ **These** ~~termination of enhanced federal matching funds~~ **new state- based requirements could impact our readiness status or eligibility under certain state Medicaid programs or contracts.Further,the Star Rating System utilized by CMS to evaluate Medicare plans** may ~~result in Medicaid~~ **have a significant effect on our revenue,as higher-** ~~rate~~ **rated** ~~cuts~~ **plans tend to experience increased enrollment and plans with a Star rating of 4.0 or higher are eligible for quality- based bonus payments.Beginning in 2016,those Medicare plans that achieve less than a 3.0 Star rating for three consecutive years will be issued a notice of non- renewal of their contract for the following year.If we do not maintain our Star ratings above 3.0 or continue to improve our Star ratings,fail to meet or exceed our competitors' Star ratings,or if quality- based bonus payments are reduced or eliminated,we may experience a negative impact on our revenues and the benefits that our plans can offer,** which could ~~reduce~~ **materially and adversely affect the marketability of our plans,our membership levels,results of operations,financial condition,and cash flows.Similarly,if we fail to meet** ~~our~~ **or exceed any performance standards imposed by** ~~revenues and profit margins.Starting April 1,2023,states~~ **state** ~~can resume~~ Medicaid ~~redeterminations and disenrollments.States would be eligible~~ **programs in which we participate,we may not receive performance- based bonus payments,may incur penalties,** ~~for~~ **or lose our Medicaid contract** ~~phase- down of the enhanced FMAP (6. 2 percentage points~~ **We are periodically subject to government audits,including CMS RADV audits of our Medicare D- SNP plans to validate diagnostic data,patient claims,and financial reporting.These audits could result in significant adjustments in payments made to our health plans,which could adversely affect our financial condition and results of operations.If we fail to report and correct errors discovered** through **our own auditing procedures or during a RADV audit,or otherwise**

fail to ~~March 2023;5 percentage points through June 2023;2.5 percentage points through September 2023 and 1.5 percentage points through December 2023) if they~~ comply with **applicable laws and regulations** ~~certain rules.Due to the uncertainties surrounding what states may do~~ , **we** ~~the ultimate outcomes~~ could ~~differ materially from~~ **be subject to fines,civil penalties** ~~our~~ **or other sanctions** ~~estimates as a result of changes in facts or further developments~~ ,which could have ~~an~~ **a material** adverse effect on our ~~consolidated~~ **ability to participate in these programs,and on our** financial ~~position~~ **condition** , ~~results of operations,or~~ cash flows **and results of operations** . ~~CMS~~ **In addition,if a D- SNP or MMP plan pays minimum MLR rebates for three consecutive years,such plan** will **become** ~~end the current MMP program no later than December 2025,which could impact premium revenue.To coordinate care for those who qualify to receive both Medicare and Medicaid services (the " dual eligibles~~ **ineligible** ~~"),under the direction of CMS some states implemented demonstration pilot programs~~ to ~~integrate Medicare and Medicaid services for the dual eligibles.The health plans participating in such demonstrations are referred to as MMPs.Pursuant to the 2023 CMS Medicare Final Rule,which will require MMP plans to end no later than December 2025,the five states that we operate MMPs in -- Illinois,Michigan,Ohio,South Carolina,and Texas -- were required to submit a transition plan to CMS by October 1,2022,to convert their MMPs to integrated Dual Eligible Special Needs Plan (" D- SNP "").However,the five MMP plans will now be required to wind down or convert their product in line with the applicable state' s MMP transition planning.California concluded its MMP at the end of calendar year 2022 and began transitioning enrollees~~ --- **enroll new members** ~~into integrated EAE- SNPs beginning on January 1,2023.The economic impact of such wind down or conversion to D- SNP on our premium revenue is uncertain at this point~~ .Our health plans operate with very low profit margins,and small changes in operating performance or slight changes to our accounting estimates could have a disproportionate impact on our reported net income.Although most of our health plans over the last several years have generally operated with profit margins higher than those of our direct competitors,nevertheless the profit margins in our industry are low (in the single digits) compared to the profit margins in most other industries.Given these low profit margins,small changes in operating performance or slight changes to our accounting estimates could have a disproportionate impact on our reported net income and adversely affect our business.If state regulators do not approve payments of dividends and distributions by our subsidiaries,it may negatively affect our ability to meet our debt service and other obligations.We are a corporate parent holding company and hold most of our assets in,and conduct most of our operations through,our direct subsidiaries.As a holding company,our results of operations depend on the results of operations of our subsidiaries.Moreover,we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations.The ability of our subsidiaries to pay dividends or make other payments or advances to us depends on their operating results and is subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries.In addition,our health plan subsidiaries are subject to laws and regulations that limit the amount of ordinary dividends and distributions that they can pay to us without prior approval of,or notification to,state regulators.In general,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 that exceed either (a) ten percent of surplus or net worth at the prior year end or (b) the net income for the prior year,depending on the respective state statute.The discretion of the state regulators,if any,in approving or disapproving a dividend is not clearly defined.Our health plans generally must provide notice to the applicable state regulator prior to paying a dividend or other distribution to us.Our parent company received $ **705 million and $** 668 ~~million and $ 564~~ million in dividends from our regulated health plan subsidiaries during ~~2022~~ **2023** and ~~2021,respectively.If the regulators were to deny or significantly restrict our subsidiaries' requests to pay dividends to us,the funds available to our Company as a whole would be limited,which could have a material adverse effect on our business,financial condition,cash flows,or results of operations.Molina Healthcare,Inc.2022 Form 10- K | 20 Our use and disclosure~~ 2022 **,respectively.If the regulators were** to deny or significantly restrict our subsidiaries' requests to pay dividends to us,the funds available to our Company as a whole would be limited,which could have a material adverse effect on our business,financial condition,cash flows,or results of operations.Molina Healthcare,Inc. ~~2022~~ **2023** Form 10- K | ~~20~~ **28** Our use and disclosure of personally identifiable information and other non- public information,including protected health information,is subject to federal and state privacy and security regulations,and our failure or the failure of our vendors to comply with those regulations or to adequately secure the information we hold could result in significant liability or reputational harm.State and federal laws and regulations including,but not limited to,the Health Insurance Portability and Accountability Act,as amended by the Health Information Technology for Economic and Clinical Health Act,and all regulations promulgated thereunder (collectively," HIPAA "),the California Consumer Privacy Act (the " CCPA "),the California Privacy Rights Act (the " CPRA ") **,** and the Gramm- Leach- Bliley Act,govern the collection,dissemination,use,privacy,confidentiality,security,availability,and integrity of personally identifiable information (" PII "),including protected health information (" PHI ").HIPAA establishes basic national privacy and security standards for protection of PHI by covered entities and business associates,including health plans such as ours.HIPAA requires covered entities like us to develop and maintain policies and procedures regarding PHI,and to adopt administrative,physical,and technical safeguards to protect PHI.HIPAA violations may result in significant civil penalties.HIPAA authorizes state attorneys general to file suit under HIPAA on behalf of state residents.Courts can award damages,costs,and attorneys' fees related to violations of HIPAA in such cases.We have experienced HIPAA breaches in the past,including breaches affecting over 500 individuals.Even when HIPAA does not apply,according to the Federal Trade Commission (the " FTC "),failing to take appropriate steps to keep consumers' personal information secure constitutes unfair acts or practices in or affecting commerce in violation of Section 5 (a) of the Federal Trade Commission Act,15 U.S.C § 45 (a).The FTC expects a company' s data security measures to be reasonable and appropriate in light of the sensitivity and volume of consumer information it holds,the size and complexity of its business,and the cost of available tools to improve security and reduce vulnerabilities.Individually identifiable health information is considered sensitive data that merits stronger safeguards.The FTC' s guidance for appropriately securing consumers' personal information is similar to what is required by the HIPAA security regulations.In addition,certain state laws

govern the privacy and security of health information in certain circumstances,many of which differ from each other in significant ways,thus complicating compliance efforts.For example,California enacted the CCPA,which became effective on January 1,2020.The CCPA,among other things,creates new data privacy obligations for covered companies and provides new privacy rights to California residents,including the right to opt out of certain disclosures of their information.The CCPA also creates a private right of action with statutory damages for certain data breaches,thereby potentially increasing risks associated with a data breach.On January 1,2023,the CPRA,which is the successor legislation to the CCPA,became effective.The CPRA amends and expands the CCPA,creating new privacy obligations,consumer privacy rights and enforcement mechanisms.If we or one or more of our significant vendors do not comply with existing or new laws and regulations related to PHI,PII,or non- public information,we could be subject to criminal or civil sanctions.Any security breach involving the misappropriation,loss,or other unauthorized disclosure or use of confidential member information,whether by us or by our vendors,could subject us to civil and criminal penalties,divert management' s time and energy,and have a material adverse effect on our business,financial condition,cash flows,or results of operations.Unforeseen changes in pharmaceutical regulations or market conditions may impact our revenues and adversely affect our results of operations.Pharmaceutical products and services are a significant component of our healthcare costs.Evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members.Other factors affecting our pharmaceutical costs include,but are not limited to,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 a material adverse effect on our business,financial condition,cash flows,or results of operations.Increases in our pharmaceutical costs could have a material adverse effect on the level of our medical costs and our results of operations.Introduction of new high cost specialty drugs and sudden cost spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our capitation rates are not adequate to cover the actual pharmacy costs,which jeopardizes the overall actuarial soundness of our rates.Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism would have an adverse impact on our financial condition and results of operations.In addition,evolving regulations and state and federal mandates regarding coverage may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members.Other factors affecting our pharmaceutical costs include,but are not limited to,geographic variation in utilization of new and existing pharmaceuticals,changes in discounts,civil investigations,and litigation.Some of our competitors have been subject to substantial sanctions related to allegations of improper transfer pricing practices.Further,our principal pharmacy benefit manager,or PBM,CVS Caremark (" CVS "),is party to certain lawsuits and putative class actions regarding its drug pricing practices and its rebate arrangements with drug manufacturers.The ultimate outcome of these complaints may have an adverse impact on our pharmaceutical costs,or potentially could result in our becoming involved or impleaded into similar or related costly litigation.Although we will continue to work with state Medicaid agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends,there can be no assurance that we will be successful in that regard.Large- scale medical emergencies in one or more states in which we operate our health plans could significantly increase utilization rates and medical costs.Large-scale medical emergencies can take many forms and be associated with widespread illness or medical conditions.For example,natural disasters,such as a major earthquake or wildfire in California,or a major hurricane affecting Florida,South Carolina or Texas,could have a significant impact on the health of a large number of our covered members.Other conditions that could impact our members include a virulent flu season or epidemic **,such as a resurgence of COVID- 19** ,or new viruses for which vaccines may not exist,are not effective,or have not been widely administered.In addition,federal and state law enforcement officials have issued warnings about potential terrorist activity involving biological or other weapons of mass destruction.All of these conditions,and others,could have a significant impact on the health of the population of wide- spread areas.If one of the states in which we operate were to experience a large- scale natural disaster,a significant terrorist attack,or some other large- scale event affecting the health of a large number of our members,our covered medical expenses in that state would rise,which could have a material adverse effect on our business,financial condition,cash flows,or results of operations.We face various risks inherent in the government contracting process that could materially and adversely affect our business and profitability,including periodic routine and non- routine reviews,audits,and investigations by government agencies.We are subject to various risks inherent in the government contracting process.These risks include routine and non- routine governmental reviews,audits,and investigations,and compliance with government reporting requirements.Violation of the laws,regulations,or contract provisions governing our operations,or changes in interpretations of those laws and regulations,could result in the imposition of civil or criminal penalties,the cancellation of our government contracts,the suspension or revocation of our licenses,the exclusion from participation in government sponsored health programs,or the revision and recoupment of past payments made based on audit findings.If we are unable to correct any noted deficiencies,or become subject to material fines or other sanctions,we could suffer a substantial reduction in profitability,and could also lose one or more of our government contracts.In addition,government receivables are subject to government audit and negotiation,and government contracts are vulnerable to disagreements with the government.The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.Any changes to the laws and regulations governing our business,or the interpretation and enforcement of those laws or regulations,could require us to modify our operations and could negatively impact our operating results.Our business is extensively regulated by the federal government and the states in which we operate.The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations.The government agencies administering these laws and regulations have broad latitude in interpreting and applying them.Changes in the interpretation or application of our contracts could reduce our profitability if we have detrimentally relied on a prior interpretation or

application.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 our members and the public.For instance,some states mandate minimum medical expense levels as a percentage of premium revenues.These laws and regulations,and their interpretations,are subject to frequent change.The interpretation of certain contract provisions by our governmental regulators may also change.Changes in existing laws or regulations,or their interpretations,or the enactment of new laws or regulations,could reduce our profitability by imposing additional capital requirements,increasing our liability,increasing our administrative and other costs,increasing mandated benefits,forcing us to restructure our ~~relationships with providers,requiring us to implement additional or different programs and systems,or making it~~ Molina Healthcare,Inc. **2023** Form 10- K | 30 ~~routine and non- routine governmental reviews,audits,and investigations,and compliance with government reporting requirements.Violation of the laws,regulations,or contract provisions governing our operations,or changes in interpretations of those laws and regulations,could result in the imposition of civil or criminal penalties,the cancellation of our government contracts,the suspension or revocation of our licenses,the exclusion from participation in government sponsored health programs,or the revision and recoupment of past payments made based on audit findings.If we are unable to correct any noted deficiencies,or become subject to material fines or other sanctions,we could suffer a substantial reduction in profitability,and could also lose one or more of our government contracts.In addition,government receivables are subject to government audit and negotiation,and government contracts are vulnerable to disagreements with the government.The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.Any changes to the laws and regulations governing our business,or the interpretation and enforcement of those laws or regulations,could require us to modify our operations and could negatively impact our operating results.Our business is extensively regulated by the federal government and the states in which we operate.The laws and regulations governing our operations are generally intended to benefit and protect health plan members and providers rather than managed care organizations.The government agencies administering these laws and regulations have broad latitude in interpreting and applying them.Changes in the interpretation or application of our contracts could reduce our profitability if we have detrimentally relied on a prior interpretation or application.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 our members and the public.For instance,some states mandate minimum medical expense levels as a percentage of premium revenues.These laws and regulations,and their interpretations,are subject to frequent change.The interpretation of certain contract provisions by our governmental regulators may also change.Changes in existing laws or regulations,or their interpretations,or the enactment of new laws or regulations,could reduce our profitability by imposing additional capital requirements,increasing our liability,increasing our administrative and other costs,increasing mandated benefits,forcing us to restructure our~~ relationships with providers,requiring us to implement additional or different programs and systems,or making it ~~Molina Healthcare,Inc.2022 Form 10- K | 22~~ more difficult to predict future results.Thus,any significant changes in existing health care laws or regulations could materially impact our business,financial condition,cash flows,or results of operations.We are subject to extensive fraud and abuse laws that may give rise to lawsuits and claims against us,the outcome of which may have a material adverse effect on our business,financial condition,cash flows,or results of operations.Because we receive payments from federal and state governmental agencies,we are subject to various laws commonly referred to as " fraud and abuse " laws,including federal and state anti- kickback statutes,prohibited referrals,and the federal False Claims Act,which permit agencies and enforcement authorities to institute a suit against us for violations and,in some cases,to seek treble damages,criminal and civil fines,penalties,and assessments.Violations of these laws can also result in exclusion,debarment,temporary or permanent suspension from participation in government healthcare programs,or the institution of corporate integrity agreements.Liability under such federal and state statutes and regulations may arise if we know,or it is determined that we should have known,that information we provide to form the basis for a claim for government payment is false or fraudulent,and some courts have permitted False Claims Act suits to proceed if the claimant was out of compliance with program requirements.Fraud,waste and abuse prohibitions encompass a wide range of operating activities,including kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan,billing for unnecessary medical services by a provider,upcoding,payments made to excluded providers,improper marketing,and the violation of patient privacy rights.In particular,there has recently been increased scrutiny by the Department of Justice on health plans' risk adjustment practices,particularly in the Medicare program.Companies involved in ~~public~~ **government** healthcare programs such as Medicaid and Medicare are required to maintain compliance programs to detect and deter fraud,waste and abuse,and are often the subject of fraud,waste and abuse investigations and audits.The federal government has taken the position that claims presented in violation of the federal anti- kickback statute may be considered a violation of the federal False Claims Act.In addition,under the federal civil monetary penalty statute,the U.S.Department of Health and Human Services' Office of Inspector General has the authority to impose civil penalties against any person who,among other things,knowingly presents,or causes to be presented,certain false or otherwise improper claims.Qui tam actions under federal and state law are brought by a private individual,known as a relator,on behalf of the government.A relator who brings a successful qui tam lawsuit can receive 15 to 30 percent of the damages the government recovers from the defendants,which damages are trebled under the False Claims Act.Because of these financial inducements offered to plaintiffs,qui tam actions have increased significantly in recent years,causing greater numbers of healthcare companies to incur the costs of having to defend false claims actions,many of which are spurious and without merit.In addition,meritorious false claims actions could result in fines,or debarment from the Medicare,Medicaid,or other state or federal healthcare programs.If we are subject to liability under a qui tam or other actions,our business,financial condition,cash flows,or results of operations could be adversely affected.Even if we are successful in defending qui tam actions against us,the fact that these actions were filed against us,even if ultimately determined to be without merit,could result in expensive defense costs,and also could have an adverse impact on our reputation and our ability to obtain regulatory approval for acquisitions that we may pursue. ~~RISKS~~

~~RELATED TO OUR~~ **Adverse credit market conditions may have a material adverse effect on our liquidity or our ability to obtain credit on acceptable terms.In the past,the securities and credit markets have experienced extreme volatility and disruption.The availability of credit,from virtually all types of lenders,has at times been restricted.In the event we need access to additional capital to pay our operating expenses,fund subsidiary surplus requirements,make payments on or refinance our indebtedness,pay capital expenditures,or fund acquisitions,our ability to obtain such capital may be limited and the cost of any such capital may be significant,particularly if we are unable to access our existing revolving credit facility.Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions,the general availability of credit,the overall availability of credit to our industry,our credit ratings and credit capacity,and perceptions of our financial prospects.Similarly,our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us.If one or any combination of these factors were to occur,our internal sources of liquidity may prove to be insufficient,and in such case,we may not be able to successfully obtain sufficient additional financing on favorable terms,within an acceptable time,or at all.Molina Healthcare,Inc.2023 Form 10- K | 31 We are party to a credit agreement (the " Credit Agreement ") which includes a revolving credit facility (" Credit Facility ") of $ 1.0 billion,among other provisions.Our Credit Agreement,and the indentures governing our notes,require us to comply with various covenants that impose restrictions on our operations,including our ability to incur additional indebtedness,create liens,pay dividends,make certain investments or other restricted payments,sell or otherwise dispose of substantially all of our assets and engage in other activities.Our Credit Agreement also requires us to comply with a maximum consolidated net leverage ratio and a minimum consolidated interest coverage ratio.These restrictive covenants could limit our ability to pursue our business strategies.In addition,any failure by us to comply with these restrictive covenants could result in an event of default under the Credit Agreement and,in some circumstances,under the indentures governing our notes,which,in any case,could have a material adverse effect on our financial condition.** GENERAL RISK FACTORS We are dependent on the leadership of our chief executive officer and other executive officers and key employees. The success of our business and the ability to execute our strategy are highly dependent on the efforts of Mr. Zubretsky, our chief executive officer, and our other key executive officers and employees. The loss of their leadership, expertise, and experience could negatively impact our operations. Our ability to replace them or any other key employee may be difficult and may take an extended period of time because of the limited number of individuals in the healthcare industry who have the breadth and depth of skills and experience necessary to operate and lead a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain, or motivate these personnel. If we are unsuccessful in recruiting, retaining, managing, and motivating such personnel, our business, financial condition, cash flows, or results of operations could be adversely affected. We face ~~claims~~ **risks** related to litigation ~~which could result in substantial monetary damages~~. We are subject to a variety of legal actions **that may affect our business** , including **but not limited to** provider claims, employment related disputes ~~, healthcare regulatory law- based litigation~~ and ~~enforcement actions~~ **employee benefit claims** , breach of contract actions, qui tam or False Claims Act actions, **administrative matters before government agencies, tort claims, intellectual property- related litigation,** and ~~securities~~ class actions **of various kind. These actions or proceedings could result in substantial costs to us, require management to spend substantial time focused on litigation, result in negative media attention, and may adversely affect our business, reputation, financial condition, results of operations, or cash flows** . If we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer ~~. Even if any claims brought against us are unsuccessful or without merit, we may have to defend ourselves against such claims. The defense of any such actions may be time- consuming and costly, and may distract our management' s attention. Such legal actions could have a material adverse effect on our business, financial condition, results of operations, or cash flows~~. Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price, and could subject us to sanctions by regulatory authorities. A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis. We have identified material weaknesses in our internal control over financial reporting in the past, which have subsequently been remediated. If additional material weaknesses in our internal control over financial reporting are discovered or occur in the future, **the risk of material misstatements in** our consolidated financial statements may **increase** ~~contain material misstatements~~ and we could be required to restate our financial results. Because our corporate headquarters are located in Southern California, our business operations may be disrupted as a result of a major earthquake or wildfire. Our corporate headquarters are located in Long Beach, California. In addition, some of our health plans' claims are processed in Long Beach, California. Southern California is exposed to a statistically greater risk of a major earthquake and wildfires than most other parts of the United States. If a major earthquake or wildfire were to strike Southern California, our corporate functions and claims processing could be impaired for an unforeseen period of time. If there is a major Southern California earthquake or wildfire, there can be no assurances that our disaster recovery plan will be successful or that the business operations of our health plans, including those that are remote from any such event, would not be impacted. Molina Healthcare, Inc. ~~2022~~ **2023** ~~Form 10- K | 31 PROPERTIES We own and lease certain real properties to support the business operations of our reportable segments. In the fourth quarter of 2022, we completed a plan to reduce the real estate footprint used in our business operations to accommodate our move to a permanent remote work environment, a model we have been working under successfully for over two years. Our remaining office space is being reconfigured and optimized for utilization and efficiency. While we believe our current and anticipated facilities are adequate to meet our operational needs in the near term, we continually evaluate the adequacy of our properties for our anticipated future needs. LEGAL PROCEEDINGS Kentucky RFP. On September 4, 2020, Anthem Kentucky Managed Care Plan, Inc. brought an action in Franklin County Circuit Court against the Kentucky Finance and Administration Cabinet, the Kentucky Cabinet for Health and Family Services, and all of the~~

~~five winning bidder health plans, including our Kentucky health plan. On September 9, 2022, the Kentucky Court of Appeals ruled that, with regard to the earlier Circuit Court ruling granting Anthem relief, the Circuit Court should not have invalidated the 2020 procurement and thus should not have awarded a contract to Anthem. Anthem has sought discretionary review by the Kentucky Supreme Court of the ruling by the Court of Appeals. Pending further Court order, our Kentucky health plan will continue to operate for the foreseeable future under its current Medicaid contract. Puerto Rico. On August 13, 2021, Molina Healthcare of Puerto Rico, Inc. (" MHPR ") filed a complaint asserting, among other claims, breach of contract against Puerto Rico Health Insurance Administration (" ASES "). On September 13, 2021, ASES filed a counterclaim and a third- party complaint against MHPR and the Company. This matter remains subject to significant additional proceedings, and no prediction can be made as to the outcome. Refer to the Notes to Consolidated Financial Statements, Note 15, " Commitments and Contingencies — Legal Proceedings, " for further information. MARKET FOR REGISTRANT' S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES STOCK REPURCHASE PROGRAMS Purchases of common stock made by us or on our behalf during the quarter ended December 31, 2022, including shares withheld by us to satisfy our employees' income tax obligations, are set forth below: Total Numberof SharesPurchased (1) Average Price Paid perShareTotal Number ofShares Purchased asPart of PubliclyAnnounced Plans orPrograms (2) Approximate Dollar Value of Shares That May Yet Be Purchased Under the Plans or Programs (2) October 1 — October 312, 000 $ 331. 74 — $ 300, 000, 000 November 1 — November 30147, 000 $ 328. 85 147, 000 $ 451, 658, 000 December 1 — December 31443, 000 $ 342. 44 443, 000 $ 300, 000, 000 592, 000 $ 339. 03 590, 000 _____ (1) During the three months ended December 31, 2022, there were approximately 590, 000 shares repurchased as part of our publicly announced share repurchase program and we withheld approximately 2, 000 shares of common stock to settle employee income tax obligations, for releases of awards granted under the Molina Healthcare, Inc. 2019 Equity Incentive Plan. For further information refer to Notes to Consolidated Financial Statements, Note 13, " Stockholders' Equity. " (2) For further information on our stock repurchase programs, refer to Notes to Consolidated Financial Statements, Note 13, " Stockholders' Equity. " STOCK PERFORMANCE GRAPH The following graph and related discussion are being furnished solely to accompany this Annual Report on Form 10- K pursuant to Item 201 (e) of Regulation S- K and shall not be deemed to be " soliciting materials " or to be " filed " with the U. S. Securities and Exchange Commission (" SEC ") (other than as provided in Item 201) nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, whether made before or after the date hereof and irrespective of any general incorporation language contained therein, except to the extent that we specifically incorporate it by reference into a filing. Molina Healthcare, Inc. 2022~~ Form 10- K | 32 **Item 1C. CYBERSECURITY CYBERSECURITY RISK MANAGEMENT, GOVERNANCE AND RISK ASSESSMENT** The ~~following line graph compares~~ **Company is committed to protecting the confidentiality, integrity, and availability of its information systems and the data** ~~the~~ **they** ~~percentage change in the cumulative total return on our common stock against the cumulative total return~~ **contain from cybersecurity threats. The Company recognizes that cybersecurity is a dynamic and evolving area** of ~~the Standard & Poor' s Corporation Composite 500 Index~~ **risk that requires ongoing assessment, management, and oversight. The Company has established a cybersecurity program** (the **" Program"** ~~" S & P 500 "~~) **that** ~~and a peer group index for the five- year period from December 31, 2017 to December 31, 2022. The comparison assumes $ 100 was invested on December 31, 2017, in our common stock and in each of the foregoing indices and assumes reinvestment of dividends. The stock performance shown on the graph below represents historical stock price performance and~~ is **designed** ~~not necessarily indicative of future stock price performance. The peer group index consists of Acadia Healthcare Company, Inc. (ACHC), Elevance Health, Inc. (ELV), Centene Corporation (CNC), Cigna Corporation (CI), Community Health Systems, Inc. (CYH), HCA Healthcare, Inc. (HCA), Humana, Inc. (HUM), Laboratory Corporation of America Holdings (LH), Magellan Health, Inc. (MGLN), Quest Diagnostics Incorporated (DGX), Tenet Healthcare Corporation (THC) and Universal Health Services, Inc. (UHS). STOCK TRADING SYMBOL AND DIVIDENDS Our common stock is listed on the New York Stock Exchange under the trading symbol " MOH. " As of February 10, 2023, there were 14 registered holders of record of our common stock, including Cede & Co. To date we have not paid cash dividends on our common stock. We currently intend~~ to **assess** ~~retain any future earnings to fund our projected business operations. However~~ , **identify** ~~we intend to periodically evaluate our cash position to determine whether to pay a cash dividend in the future. Our ability to pay dividends is partially dependent on~~ , **manage** ~~among other things~~ , **and mitigate material cybersecurity threats** ~~our receipt of cash dividends from our regulated subsidiaries. The ability of our regulated subsidiaries to pay dividends to us is limited by the state departments of insurance in the states in which we operate or may operate~~ , as well as **to respond to and recover from cybersecurity incidents. The Program is based on the National Institute of Standards and Technology (" NIST ") Cybersecurity Framework (" CSF "), NIST Special Publication 800- 53, and the Payment Card Industry standards, as applicable, and designed to comply with applicable laws and regulations, including HIPAA and the New York Department of Financial Services Cybersecurity Regulation, as applicable. This does not imply that we meet any particular technical standards, specifications, or** requirements ~~of~~ **, only that we use the NIST CSF and Payment Card Industry standards as guides to help us identify, assess, and manage cybersecurity risks relevant to our business. The Program is aligned with the Company' s overall enterprise risk management system and processes and shares common methodologies, reporting channels and governance processes that apply across the enterprise risk management program to** ~~the~~ **other** ~~government~~ **legal, compliance, strategic, operational, and financial risk areas. Control procedures are assessed regularly to confirm their effectiveness. The Company undergoes an annual Service Organization Controls (" SOC ") Type 2 attestation report covering the performance of safeguards deployed to protect certain Company systems and applications. The Company maintains cybersecurity insurance providing coverage for certain costs related to security failures and specified cybersecurity** ~~- sponsored health~~ **related incidents that interrupt our network or networks of our vendors, in all cases up to specified limits and subject to certain exclusions. The Company has a designated Chief Information Security**

Officer (the " CISO "). The ~~programs -~~ **Program** ~~in~~ **is implemented and managed by the Company' s executive management under the leadership of the CISO. The Company contracts with third- party service providers to support aspects of the Program implementation, operations, and review of information technology operations and cybersecurity technologies. Additionally, the Company has retained a number of well- established and reputable cybersecurity consultants, including forensics experts, auditors, as well as outside cybersecurity legal counsel to assist with cybersecurity matters as needed from time to time. The Company has a Computer Incident Response Team (" CIRT ")** which ~~we participate. Additionally~~ **is responsible for monitoring** , ~~our credit agreement contains various covenants~~ **preventing, detecting, assisting with the investigation, and responding to cybersecurity threats. The Company has in place an Information Security Incident Response Plan (" IRP ") Protocol which provides an operational framework to coordinate the response to any type of cybersecurity incident affecting the Company. The CIRT team informs the CISO of cybersecurity threats consistent with the IRP. The IRP also provides the process and oversight to manage cybersecurity incidents** that ~~limit our ability to~~ **may arise from a third-** ~~pay~~ **party** ~~dividends~~ **service provider. In addition, the IRP addresses management responsibility with respect to disclosure determinations related to a cybersecurity incident and provides for Audit Committee and Board briefings as appropriate. The Company' s cybersecurity policies and procedures are reviewed by the CISO and updated at least annually. In addition, under the IRP, following the resolution of a cybersecurity incident, the Company will generally consider the effectiveness of the Program and the IRP, make adjustments as appropriate, and report to senior management and the Audit Committee as appropriate** on **these matters. The cybersecurity policies and procedures are communicated and enforced throughout the Company, as well as with the third- party service providers that have access to the Company' s information systems** ~~our -~~ **or** ~~common stock~~ **nonpublic information** . ~~Any future determination~~ **Cybersecurity policies and procedures are also subject** to ~~pay dividends will be at~~ **periodic review and audits by internal and external parties, such as** the ~~discretion of~~ **internal audit function, external auditors, regulators,** ~~our -~~ **or** ~~board of directors~~ **independent assessors. The Company requires employees to undergo cybersecurity- related training, including phishing prevention training,** and **employees are tested regularly through phishing exercises. The CISO is responsible for developing, maintaining, and enforcing the Program' s policies and procedures, as** ~~will~~ **well** ~~depend upon, among~~ **as reporting on the Program' s performance and material cybersecurity risks to the Audit Committee. The CISO has the relevant expertise and authority to carry out the Program' s objectives and to coordinate with** other **key stakeholders within** ~~factors, our results of operations, financial condition, capital requirements~~ and **outside the Company** ~~contractual and regulatory restrictions~~ . ~~For~~ **The CISO' s expertise includes decades of information technology and cybersecurity as a subject matter expert, including** more **than a decade** ~~information regarding restrictions on the ability~~ of **executive management experience as a CISO for Fortune 500 companies** ~~our regulated subsidiaries to pay dividends to us, please see the Notes to Consolidated Financial Statements, Note 15, " Commitments and Contingencies — Regulatory Capital Requirements and Dividend Restrictions~~ . " Molina Healthcare, Inc. ~~2022~~ **2023** Form 10- K | 33 **The Program is overseen by the Company** ~~MANAGEMENT' S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS (" MD & A ") Management~~ ' s **Board** ~~discussion and analysis~~ of **Directors through its Audit Committee** ~~financial condition and results of operations as of and for the years ended December 31, 2022 and 2021, are presented in the sections that follow. Our MD & A as of and for the year ended December 31, 2020, may be found in our 2021 Annual Report on Form 10- K,~~ which ~~prior disclosure~~ **, pursuant to** ~~is~~ **its charter** ~~incorporated by reference herein. OVERVIEW Molina Healthcare~~ , ~~Inc., a FORTUNE 500~~ **assists the Board with oversight of** ~~company~~ **Company privacy** ~~(currently ranked 125)~~ , **data security** ~~provides managed healthcare services under the Medicaid and Medicare programs~~ , and **cybersecurity matters** ~~through the state insurance marketplaces (the " Marketplace "). We served approximately 5. 3 million members as of December 31, 2022, located across 19 states. 2022 HIGHLIGHTS Highlights of our 2022 results included the following: • Net income of $ 792 million, or $ 13. 55 per diluted share, compared to $ 659 million, or $ 11. 25 per diluted share, in 2021; • Total revenue of $ 32. 0 billion, which increased 15 % compared to 2021; • Premium revenue of $ 30. 9 billion, which increased 15 % compared to 2021; • Consolidated medical care ratio (" MCR ") of 88. 0 %, compared to 88. 3 % in 2021; • Membership increased 59, 000 members year over year to 5. 3 million at December 31, 2022; • General~~ and **risks** ~~administrative expense ratio (" G & A ratio ") improved to 7~~ . ~~2 %, compared to 7. 4 % in 2021; and • After- tax margin of 2. 5 %, compared to 2. 4 % in 2021. Net Effect Of COVID~~ The **Audit Committee meets regularly** ~~net effect of COVID decreased 2022 net income per diluted share by $ 2. 50 and decreased 2021 net income per diluted share by $ 3. 50. The net effect of COVID impacted all three lines of business and increased the 2022 consolidated MCR by approximately 60 basis points, compared to an increase of approximately 90 basis points to the consolidated MCR in 2021. The net effect of COVID reflects COVID- related inpatient costs and COVID- related risk corridors enacted by a number of our state customers beginning in the second quarter of 2020, partially offset by a decrease in medical costs due to COVID- related utilization curtailment. Real Estate Impairment In the fourth quarter of 2022, we recognized an impairment charge of $ 208 million, or $ 2. 72 per diluted share, on right- of- use lease assets and related property and equipment in connection~~ with the **Company** ~~reduction in leased space used in our business operations, to accommodate the move to a permanent remote work environment. Growth Initiatives Our growth initiatives, including accretive acquisitions, state Medicaid procurement awards and other organic growth priorities, are driving increases in our current and expected future premium revenue base and operating income. The acquisitions of Affinity Health Plan, Inc.~~ ' s **executive management** ~~New York Medicaid business in October 2021~~ , ~~Cigna~~ **including the CISO and the Chief Information Officer, and receives updates on the status and overall effectiveness of the Program, changes to the Program, relevant information technology** ~~Corporation --~~ **operations , any changes in material cybersecurity risks and any significant cybersecurity incidents consistent with the IRP. The Audit Committee also discusses with executive management the steps management has taken to monitor and mitigate privacy, data security, and cybersecurity risk exposures, the Company** ' s ~~Texas Medicaid~~ **information governance policies** and **programs**

~~Medicare- Medicaid Plan contracts in January 2022~~ , and ~~AgeWell New York~~ **major legislative and regulatory developments that could materially impact the Company** ' s ~~Medicaid Long Term Care~~ **exposure regarding privacy, data security risk, and cybersecurity. The Audit Committee reports to the full Board regarding its activities, including those related to cybersecurity. The Audit Committee and the Board consider cybersecurity as part of the Company' s** business **strategy, financial planning, and capital allocation** ~~in October 2022 are all contributing to our 2022 results of operations~~ . **CYBERSECURITY RISK ASSESSMENT** The **CISO is responsible for assessing** ~~commencement of Nevada Medicaid operations in January 2022 also contributed to our 2022 results of operations. Our recent Medicaid procurement wins in California, Iowa~~ and ~~Nebraska demonstrate our ability~~ **managing the Company' s material risks from cybersecurity threats. The Company conducts regular risk assessments** to ~~win new~~ **identify, evaluate, and prioritize material cybersecurity risks to the Company, including its health plans and** state contracts ~~and~~ , **shared services and IT operations, or** ~~along with the acquisition of My Choice Wisconsin' s LTSS~~ business **strategy** ~~that we expect to close in mid- 2023, will contribute to our expected growth in premium revenues and results of operations in 2023 and 2024~~ . **The risk assessments are informed** ~~We expect our future results of operations will also be impacted~~ by **various sources of information** ~~organic membership growth in Medicare~~ , ~~partially offset by~~ **such as internal and external audits, vulnerability scans, penetration tests, threat intelligence, incident reports, industry benchmarks, and accepted industry practices. The risk assessments consider** the **potential** impact ~~of known pharmacy carve- outs in Medicaid, the resumption of Medicaid redeterminations beginning in April 2023, the impact of lower Marketplace membership,~~ and **likelihood of various cybersecurity threats** ~~2022 Medicaid premium revenue for directed payments in Texas that we don' t expect to recur in 2023. Molina Healthcare~~ , **such** ~~Inc. 2022 Form 10- K | 34 FINANCIAL RESULTS SUMMARY Year Ended December 31, 20222021 (In millions, except per- share amounts) Premium revenue $ 30, 883 $ 26, 855 Less: medical care costs 27, 175 23, 704 Medical margin 3, 708 3, 151 MCR (1) 88. 0 % 88. 3 % Other revenues: Premium tax revenue873 787 Investment income143 52 Other revenue75 77 General and administrative expenses2, 311 2, 068 G & A ratio (2) 7. 2 % 7. 4 % Premium tax expenses873 787 Depreciation and amortization 176 131 Impairment208 — Other 58 61 Operating income1, 173 1, 020 Interest expense110 120 Other expenses, net — 25 Income before income tax expense1, 063 875 Income tax expense271 216 Net income $ 792 $ 659 Net income per diluted share $ 13. 55 $ 11. 25 Diluted weighted average shares outstanding 58. 5 58. 6 Other Key Statistics: Ending Membership 5. 3 5. 2 Effective income tax rate25. 5 % 24. 7 % After- tax margin (3) 2. 5 % 2. 4 % (1) MCR represents medical care costs~~ as **ransomware** ~~a percentage of premium revenue. (2) G & A ratio represents general and administrative expenses as a percentage of total revenue. (3) After- tax margin represents net income as a percentage of total revenue. CONSOLIDATED RESULTS NET INCOME AND OPERATING INCOME Net income amounted to $ 792 million~~ , **malware** ~~or $ 13. 55 per diluted share in 2022~~ , **social engineering** ~~compared with net income of $ 659 million~~ , ~~or $ 11. 25 per diluted share, in 2021. We estimate that the net effect of COVID decreased net income by approximately $ 2. 50 per diluted share in 2022 and by approximately $ 3. 50 per diluted share in 2021. Operating income was $ 1, 173 million in 2022, compared with $ 1, 020 million in 2021. The improvement in operating income was mainly due to membership growth and higher premium revenues, and a year- over- year decrease in the Molina Healthcare, Inc. 2022 Form 10- K | 35 MCR, partially offset by the impact of the $ 208 million impairment charge that we recognized in connection with the reduction in leased space. Net income per share in 2022 was favorably impacted by the reduction in common shares outstanding as a result of our share repurchase programs in the second and fourth quarters of 2022. Net income per share in 2021 was favorably impacted by the reduction in common shares outstanding as a result of our share repurchase programs in 2020. See further discussion and information in " Liquidity and Financial Condition, " below. PREMIUM REVENUE Premium revenue increased $ 4. 0 billion, or 15 %, in 2022, when compared with 2021. The higher premium revenue reflects the impact of acquisitions, and increased organic membership in the Medicaid and Medicare segments, partially offset by a decline in the Marketplace segment. MEDICAL CARE RATIO The consolidated MCR decreased to 88. 0 % in 2022, compared with 88. 3 % in 2021. The improvement relates to improved operating performance in our Medicaid segment, partially offset by an increase in the Medicare and Marketplace segments. The results also reflect a favorable year- over- year change in the net effect of COVID, which impacted all of our segments and increased the consolidated MCR by approximately 60 basis points in 2022, compared to approximately 90 basis points in 2021. The year- over- year change in the net effect of COVID mainly reflects lower COVID- related risk corridors and COVID inpatient costs, partially offset by lower COVID- related utilization curtailment. The prior year reserve development in 2022 was favorable, but its impact on earnings was partially absorbed by the COVID- related risk corridors. PREMIUM TAX REVENUE AND EXPENSES The premium tax ratio decreased to 2. 7 % in 2022, compared with 2. 8 % in 2021. The current year ratio decrease was mainly due to changes in business mix. INVESTMENT INCOME Investment income increased to $ 143 million in 2022, compared with $ 52 million in 2021. The improvement was driven by recent increases in market interest rates and higher invested assets. Additionally, investment income was lower in the first half of 2021 due to a temporary allocation in shorter- term invested assets due to the COVID- 19 pandemic, which was ended in the second quarter of 2021. OTHER REVENUE Other revenue decreased slightly to $ 75 million in 2022, compared with $ 77 million in 2021. Other revenue mainly includes service revenue associated with long- term services and supports consultative services we provide in Wisconsin. GENERAL AND ADMINISTRATIVE (" G & A ") EXPENSES The G & A expense ratio decreased slightly to 7. 2 % in 2022 compared with 7. 4 % in 2021, which reflects the benefits of scale produced by our increase in revenue and disciplined cost management. DEPRECIATION AND AMORTIZATION Depreciation and amortization increased to $ 176 million in 2022, compared with $ 131 million in 2021. The increase was due primarily to amortization associated with acquisitions completed in the fourth quarter of 2021 and the year ended December 31, 2022. IMPAIRMENT In the fourth quarter of 2022, we recognized an impairment of $ 208 million on right- of- use lease assets and related property and equipment in connection with the reduction in leased space to accommodate the move to a permanent remote work environment. Approximately $ 192 million of the impairment is directly associated with the reduction in leased space used in our business operations. We assessed ROU assets for impairment based on~~

a valuation and recoverability analysis, which was determined with the assistance of a third- party real estate specialist **incidents, supply chain attacks and insider threats, and contemplates the adequacy of controls to detect, prevent, respond, and recover to reduce the possibility of an adverse material cybersecurity event** . The **Company has in place processes** remaining $ 16 million of the impairment relates to **identify material risks from cybersecurity threats** leasehold improvements and other property and equipment associated with the reduction in leased space. Molina Healthcare, Inc. 2022 Form 10- K | 36 OTHER OPERATING EXPENSES Other operating expenses decreased slightly to $ 58 million in 2022, compared with $ 61 million in 2021. Other operating expenses mainly include service costs associated with long- term services and supports consultative services we provide in Wisconsin, as noted above. INTEREST EXPENSE Interest expense decreased to $ 110 million in 2022, compared with $ 120 million in 2021. The decrease resulted from our early redemption of $ 700 million aggregate principal amount of our 5. 375 % senior notes due 2022 in the fourth quarter of 2021, partially offset by interest related to the private offering of $ 750 million aggregate principal amount of the 3. 875 % Notes due 2032 in the same period. OTHER EXPENSES, NET In 2021, we recognized a loss on debt repayment of $ 25 million in connection with early redemption of our 5. 375 % Notes. INCOME TAXES Income tax expense amounted to $ 271 million in 2022, or 25. 5 % of pretax income, compared with income tax expense of $ 216 million in 2021, or 24. 7 % of the pretax income. The difference in the effective tax rate is primarily due to an increase in nondeductible expenses and state and local income taxes, and differences in discrete tax benefits recognized in the respective periods. REPORTABLE SEGMENTS As of December 31, 2022, we served approximately 5. 3 million members eligible for Medicaid, Medicare, and other government- sponsored healthcare programs for low- income families and individuals, including Marketplace members, most of whom receive government premium subsidies. We currently have reportable segments consisting of: 1) Medicaid; 2) Medicare; 3) Marketplace; and 4) Other. The Medicaid, Medicare, and Marketplace segments represent the government- funded or sponsored programs under which we offer managed healthcare services. The Other segment, which is insignificant to our consolidated results of operations, includes long- term services and supports consultative services in Wisconsin. See Part I, Item 1. Business for further description of our segments. HOW WE ASSESS PERFORMANCE We derive our revenues primarily from health insurance premiums. Our primary customers are state Medicaid agencies and the federal government. The key metrics used to assess the performance of our Medicaid, Medicare, and Marketplace segments are premium revenue, medical margin and MCR. MCR represents the amount of medical care costs as a percentage of premium revenue. Therefore, the underlying medical margin, or the amount earned by the Medicaid, Medicare, and Marketplace segments after medical costs are deducted from premium revenue, represents the most important measure of earnings reviewed by management, and is used by our chief executive officer to review results, assess performance, and allocate resources. The key metric used to assess the performance of our Other segment is service margin. The service margin is equal to service revenue minus cost of service revenue. Management' s discussion and analysis of the change in medical margin is discussed below under " Segment Financial Performance. " For more information, see Notes to Consolidated Financial Statements, Note 16, " Segments. " TRENDS AND UNCERTAINTIES For a discussion of the trends, uncertainties and other developments that affected our reportable segments during the year, refer to " Item 1. Business — Our Business, " " — COVID- 19 Pandemic, " " — Legislative and Political Environment, " " — Operations — Medical Management, " and " — Regulation. " Molina Healthcare, Inc. 2022 Form 10- K | 37 SEGMENT FINANCIAL PERFORMANCE The following table summarizes our membership by segment as of the dates indicated: As of December 31, 20222021Medicaid4, 754, 000 4, 329, 000 Medicare156, 000 142, 000 Marketplace348, 000 728, 000 Total5, 258, 000 5, 199, 000 The tables below summarize premium revenue, medical margin, and MCR by segment for the periods indicated (dollars in millions): Year Ended December 31, 20222021Premium RevenueMedical MarginMCRPremium RevenueMedical MarginMCRMedicaid $ 24, 827 $ 2, 981 88. 0 % $ 20, 461 $ 2, 322 88. 7 % Medicare 3, 795 437 88. 5 3, 361 430 87. 2 Marketplace2, 261 290 87. 2 3, 033 399 86. 9 Total $ 30, 883 $ 3, 708 88. 0 % $ 26, 855 $ 3, 151 88. 3 % Key factors affecting results for this segment include: • Membership growth of 425, 000 during the year, driven by our growth initiatives, including our acquisitions and expansion into new states; • The status of the PHE and the associated suspension of membership redeterminations; • Improved operating performance, including medical cost management; and • The net effect of COVID, which increased the 2022 MCR by approximately 10 basis points, compared to an increase of 20 basis points in the 2021 MCR. Medicaid premium revenue increased $ 4. 4 billion, or 21 % in 2022, when compared with 2021. The increase was mainly due to the impact from the Affinity, Cigna and AgeWell acquisitions, and state directed payments in our Texas health plan, as well as organic membership growth, including our entry into Nevada. We also benefited from organic membership growth across several other states, driven mainly by the extension of the PHE period and the associated suspension of membership redeterminations due to COVID- 19. As described in " Item 1. Business — COVID- 19 Pandemic, " we recognized approximately $ 197 million in 2022 for the impact of COVID- related risk corridors, enacted by several states in 2020 in response to the lower utilization of medical services resulting from COVID- 19. We recognized approximately $ 323 million in 2021, for the impact of these risk corridors in 2021. The decrease was due to the elimination of most of the COVID- 19 risk corridors. The medical margin of our Medicaid program increased $ 659 million in 2022, or 28 %, when compared with 2021. The increase in margin was driven by the growth in membership and premium revenues discussed above and the MCR decrease discussed below. The Medicaid MCR decreased 70 basis points to 88. 0 % in 2022, from 88. 7 % in 2021. The improvement is mainly attributable to improved operating performance, including medical cost management, and the year- over- year change in the net effect of COVID, partially offset by the impact of state directed payments in our Texas health plan. The year- over- year change in the net effect of COVID for 2022 mainly reflects lower COVID- related risk corridors, partially offset by lower COVID- related utilization curtailment. The 2022 MCR of 88 % is at the low end of our long- term target range of 88 % to 89 % and is consistent with pre- pandemic levels. • Our expansion in MAPD and D- SNP membership; Molina Healthcare, Inc. 2022 Form 10- K | 38 • Achievement of member risk scores and associated risk- adjusted premium that are commensurate with the health status, or acuity, of our Medicare members; and • The net effect of COVID, which increased the 2022 MCR by

approximately 300 basis points, compared to an increase of 220 basis points in the 2021 MCR. Medicare premium revenue increased $ 434 million, or 13 %, in 2022 compared to 2021. The increase was primarily due to the impact of MAPD and D-SNP membership expansion, including organic membership growth in existing states, partially offset by lower premium revenue PMPM from the change in business mix. The medical margin for Medicare increased $ 7 million in 2022 compared to 2021. The year- over- year increase is mainly due to the increase in premium revenue, partially offset by the increase in the MCR discussed below. The Medicare MCR increased to 88. 5 % in 2022, from 87. 2 % in 2021, or 130 basis points. The MCR increase was primarily driven by the year- over- year change in the net effect of COVID. COVID- related utilization curtailment and corridor adjustments drove a lower MCR for 2021, and COVID inpatient costs increased in 2022. Additionally, the increase in MCR was driven by higher non- COVID utilization and the impact of lower risk- adjusted premiums associated with first year MAPD members, partially offset by higher risk scores on renewing members that more closely reflect the acuity of our membership, and strong medical cost management. The 2022 MCR of 88. 5 % was modestly above our long- term target range of 87 % to 88 % due to the net effect of COVID. • Our product and pricing strategy, which resulted in an overall reduction in membership and repositioning in the metallic tier membership mix; • Achievement of member risk scores and associated risk- adjusted premium that are commensurate with the health status, or acuity, of our Marketplace members; and • The net effect of COVID, which increased the 2022 MCR by approximately 120 basis points, compared to an increase of 430 basis points in the 2021 MCR. Marketplace premium revenue decreased $ 772 million in 2022 compared to 2021. The decrease was mainly due to an expected decrease in membership in line with our product and pricing strategy, partially offset by an increase in premium revenue PMPM. Our Marketplace membership as of December 31, 2022, amounted to 348, 000 members, representing a decrease of 380, 000 members compared to December 31, 2021. The increase in premium revenue PMPM is consistent with the change in metallic tier mix, which reflects an increase of members in the sliver metal tier and a decrease of members in the bronze metal tier, partially offset by an increase in the 2021 risk adjustment payment that was finalized in June 2022. The Marketplace medical margin decreased $ 109 million in 2022, primarily due to the net decrease in membership and premiums, and the increase in the MCR described below. The Marketplace MCR increased to 87. 2 % in 2022, compared to 86. 9 % in 2021, or 30 basis points. The increase in 2022 reflects changes in membership mix that includes higher acuity members, the unfavorable change in the 2021 risk adjustment payable recognized in the second quarter of 2022, and the unfavorable impact of settling prior year provider balances, partially offset by the year- over- year change in the net effect of COVID. The 2022 MCR of 87. 2 % is higher than our long- term target range of 78 % to 80 % due to these factors. We expect MCR performance in 2023 to be within our target range, as we continue to execute on our product and pricing strategy. The Other segment includes service revenues and costs associated with the long- term services and supports consultative services we provide in Wisconsin, and also includes certain corporate amounts not allocated to the Medicaid, Medicare, or Marketplace segments. Such amounts were immaterial to our consolidated results of operations for 2022 and 2021. LIQUIDITY AND FINANCIAL CONDITION We manage our cash, investments, and capital structure to meet the short- and long- term obligations of our business while maintaining liquidity and financial flexibility. We forecast, analyze, and monitor our cash flows to enable prudent investment management and financing within the confines of our financial strategy. We maintain liquidity at two levels: 1) the regulated health plan subsidiaries; and 2) the parent company. Molina Healthcare, Inc. 2022 Form 10- K | 39 Our regulated health plan subsidiaries' primary liquidity requirements include payment of medical claims and other health care services; payment of certain settlements with our state and federal customers, such as minimum medical loss ratio and risk corridors and Marketplace risk transfers on behalf of CMS; general and administrative costs directly incurred or paid through an administrative services agreement to the parent company; and federal tax payments to the parent company under an intercompany tax sharing agreement. Our regulated health plan subsidiaries meet their liquidity needs by generating cash flows from operating activities, primarily from premium revenue; cash flows from investing activities, including investment income and sales of investments; and capital contributions received from our parent company. Our regulated health plan subsidiaries generally receive premiums in advance of payments of claims for medical and other health care services; however, cash and cash equivalents in regulated health plan subsidiaries can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners. Any decline or delay in receipt of premium revenue could have a negative impact on our liquidity. We did not experience noticeable delays to, or changes in, the timing or level of premium receipts in 2022 or 2021 as a result of the COVID- 19 pandemic, but there can be no assurance that we will not experience such delays in the future. See further discussion below in " Future Sources and Uses of Liquidity — Future Uses — Potential Impact of COVID- 19 Pandemic. " Our regulated health plan subsidiaries are each subject to applicable state regulations that, among other things, require the maintenance of minimum levels of capital and surplus. We continue to maintain appropriate levels of aggregate excess statutory capital and surplus in our regulated health plan subsidiaries. See further discussion under " Regulatory Capital and Dividend Restrictions " below. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plan subsidiaries is generally paid in the form of dividends to our parent company to be used for general corporate purposes. The regulated health plan subsidiaries paid dividends to the parent company amounting to $ 668 million in 2022 and $ 564 million in 2021. Parent company liquidity requirements generally consist of payment of administrative costs not directly incurred by our regulated operations, including, but not limited to, staffing costs, lease payments, branding and certain information technology services; capital contributions paid to our regulated health plan subsidiaries, including funding for newer health plans; capital expenditures; debt service; funding for common stock purchases, acquisitions and other growth- related activities; and federal tax payments. The parent company contributed capital of $ 159 million and $ 440 million in 2022 and 2021, respectively, to our regulated health plan subsidiaries to satisfy statutory capital and surplus requirements. The higher contributions in 2021 were mainly attributed to fund growth in our New York and Kentucky health plans. Our parent company normally meets its liquidity requirements from administrative services fees earned under administrative services agreements; dividends received from our regulated subsidiaries; federal tax payments collected from the regulated subsidiaries; proceeds received from the issuance of debt and

equity securities; and cash flows from investing activities, including investment income and sales of investments. Cash, cash equivalents and investments at the parent company amounted to $ 375 million and $ 348 million as of December 31, 2022, and 2021, respectively. The increase in 2022 was primarily due to the dividends received from our regulated health plan subsidiaries, partially offset by the share repurchase program and the timing of corporate payments and capital contributions to regulated health plan subsidiaries. Investments After considering expected cash flows from operating activities, we generally invest cash of regulated subsidiaries that exceeds our expected short- term obligations in longer term, investment- grade, and marketable debt securities to improve our overall investment return. These investments are made pursuant to board- approved investment policies which conform to applicable state laws and regulations. Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of less than 15 years, or less than 15 years average life for structured securities. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments where the loss position of those investments exceeds certain levels. We believe that the risks of the COVID- 19 pandemic, as they relate to our investments, are minimal. The overall rating of our portfolio is A . Our investment policy has directives in conjunction with state guidelines to minimize risks and exposures in volatile markets. Additionally, our portfolio managers assist us in navigating the current volatility in the capital markets. Our restricted investments are invested principally in cash, cash equivalents, U. S. Molina Healthcare, Inc. 2022 Form 10- K | 40 Treasury securities, and corporate debt securities; we have the ability to hold such restricted investments until maturity. All of our unrestricted investments are classified as current assets. Cash Flow Activities Our cash flows are summarized as follows: Year Ended December 31, 20222021Change (In millions) Net cash provided by operating activities $ 773 $ 2, 119 $ (1, 346) Net cash used in investing activities (790) (1, 653) 863 Net cash used in financing activities (441) (183) (258) Net (decrease) increase in cash, cash equivalents, and restricted cash and cash equivalents $ (458) $ 283 $ (741) Operating Activities We typically receive capitation payments monthly, in advance of payments for medical claims; however, government payors may adjust their payment schedules, positively or negatively impacting our reported cash flows from operating activities in any given period. For example, government payors may delay our premium payments, or they may prepay the following month' s premium payment. Net cash provided by operations was $ 773 million in 2022, compared with $ 2, 119 million in 2021. The $ 1, 346 million decrease in 2022 cash flow was mainly due to the net impact of timing differences in government receivables and payables, including larger risk adjustment payments made in 2022 for the Marketplace 2021 plan year and payment for Medicaid minimum MLR and risk corridor settlements related to prior plan years. Investing Activities Net cash used in investing activities was $ 790 million in 2022, compared with $ 1, 653 million in 2021, an increase in year- over- year cash flow of $ 863 million. This change in cash flow was primarily due to the net impact of proceeds and purchases of investments. In 2022 and 2021, we funded acquisitions in the amounts of $ 134 million and $ 129 million, respectively. Financing Activities Net cash used in financing activities was $ 441 million in 2022, compared with $ 183 million in 2021, a decrease in year- over- year cash flow of $ 258 million. In 2022, cash outflows included common stock purchases of $ 400 million and $ 54 million for common stock withheld to settle employee tax obligations. In 2021, cash inflows included $ 740 million from the issuance of the 3. 875 % Notes due 2032, and cash outflows included $ 723 million in repayment of the 5. 375 % Notes due 2022, common stock purchases of $ 128 million and $ 53 million for common stock withheld to settle employee tax obligations. Additionally, we paid $ 20 million in each of 2022 and 2021 to settle contingent consideration liabilities relating to our Kentucky Passport acquisition that closed in 2020. We believe that our cash resources, borrowing capacity available under our Credit Agreement as discussed further below in " Future Sources and Uses of Liquidity — Future Sources, " and internally generated funds will be sufficient to support our operations, regulatory requirements, debt repayment obligations and capital expenditures for at least the next 12 months. On a consolidated basis, as of December 31, 2022, our working capital was $ 3. 2 billion compared with $ 3. 0 billion as of December 31, 2021. At December 31, 2022, our cash and investments amounted to $ 7. 7 billion, compared with $ 7. 9 billion of cash and investments at December 31, 2021. A significant portion of our portfolio is held in cash and cash equivalents and we do not anticipate the fluctuations in the aggregate fair value of our financial assets to have a material impact on our liquidity or capital position since we intend to hold our securities to maturity. Net unrealized losses on our investments classified as current and available for sale increased to $ 210 million at December 31, 2022 compared to $ 6 million at December 31, 2021. We have determined that the unrealized losses primarily resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. Because of the statutory restrictions that inhibit the ability of our health plan subsidiaries to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, Molina Healthcare, Inc. 2022 Form 10- K | 41 cash equivalents and investments held by our unregulated parent. For more information, see the " Liquidity " discussion presented above. Regulatory Capital and Dividend Restrictions Each of our regulated, wholly owned subsidiaries must maintain a minimum amount of statutory capital determined by statute or regulations. Such statutes, regulations and capital requirements also restrict the timing, payment and amount of dividends and other distributions, loans or advances that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based upon current statutes and regulations, the minimum capital and surplus requirement for these subsidiaries was estimated to be approximately $ 2. 3 billion at December 31, 2022, compared with $ 2. 1 billion at December 31, 2021. The aggregate capital and surplus of our wholly owned subsidiaries was in excess of these minimum capital requirements as of both dates. Under applicable regulatory requirements, the amount of dividends that may be paid by our wholly owned subsidiaries without prior approval by regulatory authorities as of December 31, 2022, was approximately $ 210 million in the aggregate. The subsidiaries may pay dividends over this amount, but only after approval is granted by the regulatory authorities. Based on our cash and investments balances as of December 31, 2022, management believes that our regulated wholly owned subsidiaries remain well

capitalized and exceed their regulatory minimum requirements. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with statutory capital and surplus requirements. Capital Structure In November 2022, our board of directors authorized the purchase of up to $ 500 million, in the aggregate, of our common stock. This new program supersedes the stock purchase program previously approved by our board of directors in September 2021. This new program will be funded with cash on hand and extends through December 31, 2023. During the fourth quarter of 2022, we used $ 200 million to repurchase 590, 000 shares under this program. As debt held by the parent company comes due, we typically engage in a new private offering of debt to retire and replace the prior issuance. For several years we saw a continued decline in interest rates, which benefited our overall cost of capital during that time. However, interest rates have increased since we issued our 3. 875 % Notes due 2032 in 2021. Accordingly, future refinancing may occur at a higher rate than those we have achieved historically. This would increase our cost of capital in the future or may cause us to pursue alternative financing sources, should the need arise. We are not a party to any off- balance sheet financing arrangements. Debt Ratings Each of our senior notes is rated " BB- " by Standard & Poor' s, and " Ba3 " by Moody' s Investor Service, Inc. A downgrade in our ratings could adversely affect our borrowing capacity and increase our borrowing costs. Financial Covenants The Credit Agreement contains customary non- financial and financial covenants, including a net leverage ratio and an interest coverage ratio. Such ratios are computed as defined by the terms of the Credit Agreement. In addition, the indentures governing each of our outstanding senior notes contain cross- default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. As of December 31, 2022, we were in compliance with all financial and non- financial covenants under the Credit Agreement and other long- term debt. FUTURE SOURCES AND USES OF LIQUIDITY Our regulated subsidiaries generate significant cash flows from premium revenue, which is generally received a short time before related healthcare services are paid. Premium revenue is our primary source of liquidity. Thus, any decline in the receipt of premium revenue, and our profitability, could have a negative impact on our liquidity. Potential Impact of COVID- 19 Pandemic. Excluding acquisitions and our exit from Puerto Rico, we added approximately 750, 000 new Medicaid members since March 31, 2020, when we first began to report on the impacts of the pandemic. We believe this membership increase was mainly due to the suspension of redeterminations for Molina Healthcare, Inc. 2022 Form 10- K | 42 Medicaid eligibility. The recently passed Consolidated Appropriations Act of 2023 authorizes states to resume redeterminations and terminate coverage for ineligible enrollees starting on April 1, 2023, irrespective of the status of the PHE. Consequently, we expect Medicaid enrollment to continue to benefit from the current pause on membership redeterminations through March 31, 2023, and then decline thereafter as states resume normal enrollment and renewal operations on April 1, 2023. Dividends from Subsidiaries. When available and as permitted by applicable regulations, cash in excess of the capital needs of our regulated health plans is generally paid in the form of dividends to our unregulated parent company to be used for general corporate purposes. As a result of the COVID- 19 pandemic, state regulators could restrict the ability of our regulated health plan subsidiaries to pay dividends to the parent company, which could reduce the liquidity of the parent company. For more information on our regulatory capital requirements and dividend restrictions, refer to Notes to Consolidated Financial Statements, Note 15, " Commitments and Contingencies — Regulatory Capital Requirements and Dividend Restrictions, " and Note 17, " Condensed Financial Information of Registrant — Note C- Dividends and Capital Contributions. " Credit Agreement Borrowing Capacity. As of December 31, 2022, we had available borrowing capacity of $ 1 billion under the revolving credit facility of our Credit Agreement. In addition, the Credit Agreement provides for a $ 15 million swingline sub- facility and a $ 100 million letter of credit sub- facility, as well as incremental term loans available to finance certain acquisitions up to $ 500 million, plus an unlimited amount of such term loans as long as we maintain a minimum consolidated net leverage ratio. See further discussion in the Notes to Consolidated Financial Statements, Note 11, " Debt. " Common Stock Purchases. In November 2022, our board of directors authorized the purchase of up to $ 500 million, in the aggregate, of our common stock. This new program supersedes the stock purchase program previously approved by our board of directors in September 2021. This new program will be funded with cash on hand and extends through December 31, 2023. The exact timing and amount of any repurchase is determined by management based on market conditions and share price, in addition to other factors, and subject to the restrictions relating to volume, price, and timing under applicable law. As of February 13, 2023, $ 300 million remained available to purchase our common stock under this program through December 31, 2023. See further information in the Notes to Consolidated Financial Statements, Note 13, " Stockholders' Equity. " Acquisitions. We have a disciplined and steady approach to growth. Organic growth, which includes leveraging our existing health plan portfolio and winning new territories, is our highest priority. In addition to organic growth, we will consider targeted acquisitions that are a strategic fit that we believe will leverage operational synergies, and lead to incremental earnings accretion. For further information on our acquisitions, refer to the Notes to Consolidated Financial Statements, Note 4, " Business Combinations. " On July 13, 2022, we announced a definitive agreement to acquire substantially all the assets of My Choice Wisconsin (" MCW "). The purchase price for the transaction is approximately $ 150 million, net of expected tax benefits and required regulatory capital, which we intend to fund with cash on hand. The transaction is subject to receipt of applicable federal and state regulatory approvals, and the satisfaction of other customary closing conditions. We currently expect the transaction to close in mid- 2023. Potential Impact of COVID- 19 Pandemic. As described in " Item 1. Business — COVID- 19 Pandemic, " we have been subject to Medicaid risk corridors as a result of the pandemic. Beginning in 2020, various states enacted temporary risk corridors in response to the reduced demand for medical services stemming from COVID- 19, which have resulted in a reduction of our medical margin. In some cases, these risk corridors were retroactive to earlier periods in 2020, or as early as the beginning of the states' fiscal years in 2019. We have recognized risk corridors that we believe to be probable, and where the ultimate premium amount is reasonably estimable. For the year ended December 31, 2022, we recognized approximately $ 197 million, in the aggregate, related to such risk corridors, in 2022, and approximately $ 323 million, in the aggregate, was recognized in 2021. It is possible that certain states could change the structure of existing risk

corridors, implement new risk corridors in the future or discontinue existing risk corridors. Due to these uncertainties, the ultimate outcomes could differ materially from our estimates as a result of changes in facts or further developments, which could have an adverse effect on our consolidated financial position, results of operations, or cash flows. Regulatory Capital Requirements and Dividend Restrictions. We have the ability, and have committed to provide, additional capital to each of our health plans as necessary to ensure compliance with minimum statutory capital requirements. Molina Healthcare, Inc. 2022 Form 10- K | 43 The Molina Healthcare Charitable Foundation. In 2020, we announced our commitment of $ 150 million to fund The Molina Healthcare Charitable Foundation (the " Foundation "), an independent not- for- profit charitable foundation. We have contributed $ 20 million to the Foundation on a cumulative basis as of December 31, 2022. Contractual Obligations. We are party to various contractual obligations that we will be required to satisfy over the short and long term. The majority are discussed in the Notes to Consolidated Financial Statements and primarily include the following: medical claims and benefits payable, amounts due to government agencies, principal and interest on our debt and leases. Some items are based on management' s estimates and assumptions about obligations, including 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. Additionally, we have a variety of other contractual agreements related to acquiring services used in our operations. However, we believe these other agreements do not contain material non- cancelable commitments. CRITICAL ACCOUNTING ESTIMATES When we prepare our consolidated financial statements, we use estimates and assumptions that may affect reported amounts and disclosures. Actual results could differ from these estimates, and some differences could be material. Our most significant accounting estimates, which include a higher degree of judgment and / or complexity, include the following: • Medical claims and benefits payable. See discussion below, and refer to the Notes to Consolidated Financial Statements, Notes 2, " Significant Accounting Policies, " and 10, " Medical Claims and Benefits Payable " for more information. • Contractual provisions that may adjust or limit revenue or profit. For a discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, " Significant Accounting Policies. " • Quality incentives. For a discussion of this topic, refer to the Notes to Consolidated Financial Statements, Note 2, " Significant Accounting Policies. " • Business Combinations, and Goodwill and intangible assets, net. For a comprehensive discussion of this topic, including amounts recorded in our consolidated financial statements, refer to the Notes to Consolidated Financial Statements, Note 2, " Significant Accounting Policies, " Note 4, " Business Combinations, " and Note 9, " Goodwill and Intangible Assets, Net. " MEDICAL CARE COSTS, MEDICAL CLAIMS AND BENEFITS PAYABLE Medical care costs are recognized in the period in which services are provided and include fee- for- service claims, pharmacy benefits, capitation payments to providers, and various other medically- related costs. Under fee- for- service claims arrangements with providers, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of hospital and physician services. Such medical care costs include amounts paid by us as well as estimated medical claims and benefits payable for costs that were incurred but not paid as of the reporting date (" IBNP "). Pharmacy benefits represent payments for members' prescription drug costs, net of rebates from drug manufacturers. We estimate pharmacy rebates based on historical and current utilization of prescription drugs and contractual provisions. Capitation payments represent monthly contractual fees paid to providers, who are responsible for providing medical care to members, which could include medical or ancillary costs like dental, vision and other supplemental health benefits. Such capitation costs are fixed in advance of the periods covered and are not subject to significant accounting estimates. Other medical care costs include all medically- related administrative costs, amounts due to providers pursuant to risk- sharing or other incentive arrangements, provider claims, and other healthcare expenses. Examples of medically- related administrative costs include expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24- hour on- call nurses. Additionally, we include an estimate for the cost of settling claims incurred through the reporting date in our medical claims and benefits payable liability. Molina Healthcare, Inc. 2022 Form 10- K | 44 The following table illustrates consolidated medical care costs by type for the periods indicated: Year Ended December 31, 20222021AmountPMPM % ofTotalAmountPMPM % ofTotal (In millions, except PMPM amounts) Fee- for- service $ 19, 703 $ 318. 55 72. 5 % $ 17, 433 $ 303. 80 73. 5 % Pharmacy4, 346 70. 26 16. 0 3, 831 66. 77 16. 2 Capitation1, 637 26. 47 6. 0 1, 471 25. 64 6. 2 Other1, 489 24. 07 5. 5 969 16. 88 4. 1 Total $ 27, 175 $ 439. 35 100. 0 % $ 23, 704 $ 413. 09 100. 0 % Medical claims and benefits payable consist mainly of fee- for- service IBNP, unpaid pharmacy claims, capitation costs, other medical costs, including amounts payable to providers pursuant to risk- sharing or other incentive arrangements and amounts payable to providers on behalf of certain state agencies for certain state assessments in which we assume no financial risk. IBNP includes the costs of claims incurred as of the balance sheet date which have been reported to us, and our best estimate of the cost of claims incurred but not yet reported to us. We also include an additional reserve to ensure that our overall IBNP liability is sufficient under moderately adverse conditions. We reflect changes in these estimates in the consolidated results of operations in the period in which they are determined. The estimation of the IBNP liability requires a significant degree of judgment in applying actuarial methods, determining the appropriate assumptions and considering numerous factors. Of those factors, we consider estimated completion factors (measures the cumulative percentage of claims expense that will ultimately be paid for a given month of service based on historical payment patterns) and the assumed healthcare cost trend (the year- over- year change in per- member per- month medical care costs) to be the most critical assumptions. Other relevant factors also include, but are not limited to, healthcare service utilization trends, claim inventory levels, changes in membership, product mix, seasonality, benefit changes or changes in fee schedules, provider contract changes, prior authorizations and the incidence of catastrophic or pandemic cases. For claims incurred more than three months before the financial statement date, we mainly use estimated completion factors to estimate the ultimate cost of those claims. Completion factors measure the cumulative percentage of claims expense that will ultimately be paid for a given month of service based on historical claims payment patterns. We analyze historical claims payment patterns by comparing claim incurred dates to claim payment dates to estimate completion factors. The estimated completion factors are

then applied to claims paid through the financial statement date to estimate the ultimate claims cost for a given month' s incurred claim activity. The difference between the estimated ultimate claims cost and the claims paid through the financial statement date represents our estimate of claims remaining to be paid as of the financial statement date and is included in our IBNP liability. For claims incurred within three months before the financial statement date, actual claims paid are a less reliable measure of our ultimate cost since a large portion of medical claims are not submitted to us until several months after services have been submitted. Accordingly, we estimate our IBNP liability for claims incurred during these months based on a blend of estimated completion factors and assumed medical care cost trend. The assumed medical care cost trend represents the year- over- year change in per- member per- month medical care costs, which can be affected by many factors including, but not limited to, our ability and practices to manage medical and pharmaceutical costs, changes in level and mix of services utilized, mix of benefits offered, including the impact of co- pays and deductibles, changes in medical practices, changes in member demographics, catastrophes and epidemics, and other relevant factors. Actuarial standards of practice generally require a level of confidence such that our overall best estimate of the IBNP liability has a greater probability of being adequate versus being insufficient, where the liability is sufficient to account for moderately adverse conditions. Adverse conditions are situations that may cause actual claims to be higher than the otherwise estimated value of such claims at the time of the estimate, such as changes in the magnitude or severity of claims, uncertainties related to our entry into new geographical markets or provision of services to new populations, changes in state- controlled fee schedules, and modifications or upgrades to our claims processing systems and practices. Therefore, in many situations, the claim amounts ultimately settled will be less than the estimate that satisfies the actuarial standards of practice. Molina Healthcare, Inc. 2022 Form 10- K | 45 When subsequent actual claims payments are less than we estimated, we recognize a benefit for favorable prior period development that is reported as part of " Components of medical care costs related to: Prior years " in the table presented in Note 10, " Medical Claims and Benefits Payable. " Our reserving practice is to consistently recognize the actuarial best estimate including a provision for moderately adverse conditions for each current period. This provision is reported as part of " Components of medical care costs related to: Current year " in the table presented in Note 10. Assuming stability in the size of our membership, the use of this consistent methodology, during any given period, usually results in the replenishment of reserves at a level that generally offsets the benefit of favorable prior period development in that period. In the case of material growth or decline of membership, replenishment can exceed or fall short of the favorable development, assuming all other factors remain unchanged. Because of the significant degree of judgment involved in estimation of our IBNP liability, there is considerable variability and uncertainty inherent in such estimates. The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2022 that would result if we change our completion factors for the fourth through the twelfth months preceding December 31, 2022, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Dollar amounts are in millions. Increase (Decrease) in Estimated Completion FactorsIncrease (Decrease) in Medical Claims andBenefits Payable (6) % $ 869 (4) % 579 (2) % 290 2 % (290) 4 % (579) 6 % (869) The following table reflects the hypothetical change in our estimate of claims liability as of December 31, 2022 that would result if we alter our assumed medical care cost trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Dollar amounts are in millions. (Decrease) Increase in Trended Per Member Per Month Cost Estimates (Decrease) Increase in Medical Claims andBenefits Payable (6) % $ (307) (4) % (204) (2) % (102) 2 % 102 4 % 204 6 % 307 There are many related factors working in conjunction with one another that determine the accuracy of our estimates, some of which are qualitative in nature rather than quantitative. Therefore, we are seldom able to quantify the impact that any single factor has on a change in estimate. Given the variability inherent in the reserving process, we will only be able to identify specific factors if they represent a significant departure from expectations. As a result, we do not expect to be able to fully quantify the impact of individual factors on changes in estimates. RECENTLY ISSUED ACCOUNTING STANDARDS Refer to the Notes to Consolidated Financial Statements, Note 2, " Significant Accounting Policies, " for a discussion of recent accounting pronouncements that affect us. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK Our earnings and financial position are exposed to financial market risk relating to changes in interest rates, and the resulting impact on investment income and interest expense. Molina Healthcare, Inc. 2022 Form 10- K | 46 Substantially all of our investments and restricted investments are subject to interest rate risk and will decrease in value if market interest rates increase. Assuming a hypothetical and immediate 1 % increase in market interest rates at December 31, 2022, the fair value of our fixed income investments would decrease by approximately $ 81 million. Declines in interest rates over time will reduce our investment income. For further information on fair value measurements and our investment portfolio, please refer to the Notes to Consolidated Financial Statements, Note 5, " Fair Value Measurements, " and Note 6, " Investments. " Borrowings under the Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus, in each case, the applicable margin. For further information, see Notes to Consolidated Financial Statements, Note 11, " Debt. " Molina Healthcare, Inc. 2022 Form 10- K | 47 MOLINA HEALTHCARE, INC. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA PageConsolidated Statements of Income49Consolidated Statements of Comprehensive Income49Consolidated Balance Sheets50Consolidated Statements of Stockholders' Equity51Consolidated Statements of Cash Flows52Notes to Consolidated Financial Statements54 Molina Healthcare, Inc. 2022 Form 10- K | 48 CONSOLIDATED STATEMENTS OF INCOME Year Ended December 31, 202220212020 (In millions, except per- share data) Revenue: Premium revenue $ 30, 883 $ 26, 855 $ 18, 299 Premium tax revenue873 787 649 Health insurer fees reimbursed — — 271 Marketplace risk corridor judgment — — 128 Investment income143 52 59 Other revenue75 77 17 Total revenue31, 974 27, 771 19, 423 Operating expenses: Medical care costs27, 175 23, 704 15, 820 General and administrative expenses2, 311 2, 068 1, 480 Premium tax expenses873 787 649 Health insurer fees — — 277 Depreciation and amortization176 131 88 Impairment208 — — Other58 61 31 Total operating expenses30, 801 26, 751 18, 345 Operating income1, 173 1, 020 1, 078 Other expenses, net: Interest expense110 120 102 Other expenses, net — 25 15 Total other expenses, net 110 145 117 Income before income tax expense1, 063 875 961 Income tax

expense271 216 288 Net income $ 792 $ 659 $ 673 Net income per share: Basic $ 13. 72 $ 11. 40 $ 11. 40 Diluted $ 13. 55 $ 11. 25 $ 11. 23 Weighted average shares outstanding: Basic57. 8 57. 8 59. 0 Diluted58. 5 58. 6 59. 9 CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME Year Ended December 31, 202220212020 (In millions) Net income $ 792 $ 659 $ 673 Other comprehensive (loss) income: Unrealized investment (loss) income (204) (55) 44 Less: effect of income taxes (49) (13) 11 Other comprehensive (loss) income, net of tax (155) (42) 33 Comprehensive income $ 637 $ 617 $ 706 See accompanying notes. Molina Healthcare, Inc. 2022 Form 10- K | 49 CONSOLIDATED BALANCE SHEETS December 31, 20222021 (Dollars in millions, except per- share amounts) ASSETSCurrent assets: Cash and cash equivalents $ 4, 006 $ 4, 438 Investments3, 499 3, 202 Receivables2, 302 2, 177 Prepaid expenses and other current assets277 247 Total current assets10, 084 10, 064 Property, equipment, and capitalized software, net259 396 Goodwill and intangible assets, net1, 390 1, 252 Restricted investments238 212 Deferred income taxes 220 106 Other assets123 179 Total assets $ 12, 314 $ 12, 209 LIABILITIES AND STOCKHOLDERS' EQUITYCurrent liabilities: Medical claims and benefits payable $ 3, 528 $ 3, 363 Amounts due government agencies 2, 079 2, 472 Accounts payable, accrued liabilities and other889 842 Deferred revenue359 370 Total current liabilities6, 855 7, 047 Long- term debt2, 176 2, 173 Finance lease liabilities215 219 Other long- term liabilities104 140 Total liabilities9, 350 9, 579 Stockholders' equity: Common stock, $ 0. 001 par value per share; 150 million shares authorized; outstanding: 58 million shares at each of December 31, 2022, and December 31, 2021 — — Preferred stock, $ 0. 001 par value per share; 20 million shares authorized, no shares issued and outstanding — — Additional paid- in capital328 236 Accumulated other comprehensive loss (160) (5) Retained earnings2, 796 2, 399 Total stockholders' equity2, 964 2, 630 Total liabilities and stockholders' equity $ 12, 314 $ 12, 209 See accompanying notes. Molina Healthcare, Inc. 2022 Form 10- K | 50 CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY Common StockAdditionalPaid- inCapitalAccumulatedOtherComprehensive (Loss) IncomeRetainedEarningsTotalOutstandingAmount (In millions) Balance at December 31, 201962 $ — $ 175 $ 4 $ 1, 781 $ 1, 960 Net income — — — 673 673 Common stock purchases (4) — (11) — (594) (605) Termination of warrants — — (30) — — (30) Other comprehensive income, net — — — 33 — 33 Share- based compensation1 — 65 — — 65 Balance at December 31, 202059 — 199 37 1, 860 2, 096 Net income — — — 659 659 Common stock purchases (1) — (2) — (120) (122) Other comprehensive loss, net — — — (42) — (42) Share- based compensation — — 39 — — 39 Balance at December 31, 202158 — 236 (5) 2, 399 2, 630 Net income — — — — 792 792 Common stock purchases (1) — (5) — (395) (400) Other comprehensive loss, net — — — (155) — (155) Share- based compensation1 — 97 — — 97 Balance at December 31, 202258 $ — $ 328 $ (160) $ 2, 796 $ 2, 964 Molina Healthcare, Inc. 2022 Form 10- K | 51 CONSOLIDATED STATEMENTS OF CASH FLOWS Year Ended December 31, 202220212020 (In millions) Operating activities: Net income $ 792 $ 659 $ 673 Adjustments to reconcile net income to net cash provided by operating activities: Depreciation and amortization176 131 88 Deferred income taxes (66) (24) (19) Share- based compensation103 72 57 Loss on debt repayment — 25 15 Impairment 208 — — Other, net8 33 12 Changes in operating assets and liabilities, net of the effect of acquisitions: Receivables (95) (415) (100) Prepaid expenses and other current assets (124) (19) (16) Medical claims and benefits payable153 471 544 Amounts due government agencies (428) 1, 046 446 Accounts payable, accrued liabilities and other55 138 86 Deferred revenue (11) (5) 126 Income taxes2 7 (14) Net cash provided by operating activities773 2, 119 1, 898 Investing activities: Purchases of investments (1, 913) (2, 713) (670) Proceeds from sales and maturities of investments1, 398 1, 329 1, 097 Net cash paid in business combinations (134) (129) (755) Purchases of property, equipment and capitalized software (91) (77) (74) Other, net (50) (63) 2 Net cash used in investing activities (790) (1, 653) (400) Financing activities: Common stock purchases (400) (128) (606) Common stock withheld to settle employee tax obligations (54) (53) (8) Contingent consideration liabilities settled (20) (20) — Proceeds from senior notes offerings, net of issuance costs — 740 1, 429 Repayment of senior notes — (723) (338) Repayment of term loan facility — — (600) Proceeds from borrowings under term loan facility — — 380 Cash paid for partial termination of warrants — — (30) Cash paid for partial settlement of conversion option — — (27) Cash received for partial settlement of call option — — 27 Repayment of principal amount of convertible senior notes — — (12) Other, net33 1 2 Net cash (used in) provided by financing activities (441) (183) 217 Net (decrease) increase in cash and cash equivalents, and restricted cash and cash equivalents (458) 283 1, 715 Cash and cash equivalents, and restricted cash and cash equivalents at beginning of period4, 506 4, 223 2, 508 Cash and cash equivalents, and restricted cash and cash equivalents at end of period $ 4, 048 $ 4, 506 $ 4, 223 Molina Healthcare, Inc. 2022 Form 10- K | 52 (continued) Year Ended December 31, 202220212020 (In millions) Supplemental cash flow information: Cash paid during the period for: Income taxes $ 340 $ 235 $ 321 Interest $ 108 $ 127 $ 112 Molina Healthcare, Inc. 2022 Form 10- K | 53 NOTES TO CONSOLIDATED FINANCIAL STATEMENTS 1. Organization and Basis of Presentation Organization and Operations Molina Healthcare, Inc. provides managed healthcare services under the Medicaid and Medicare programs, and through the state insurance marketplaces (the " Marketplace "). Molina was founded in 1980 as a provider organization serving low- income families in Southern California and reincorporated in Delaware in 2002. We currently have four reportable segments consisting of: 1) Medicaid; 2) Medicare; 3) Marketplace; and 4) Other. Our reportable segments are consistent with how we currently manage the business and view the markets we serve. As of December 31, 2022, we served approximately 5. 3 million members eligible for government- sponsored healthcare programs, located across 19 states. Our state Medicaid contracts typically have terms of three to five years, contain renewal options exercisable by the state Medicaid agency, and allow either the state or the health plan to terminate the contract with or without cause. Such contracts are subject to risk of loss in states that issue requests for proposal (" RFP ") open to competitive bidding by other health plans. If one of our health plans is not a successful responsive bidder to a state RFP, its contract may not be renewed. In addition to contract renewal, our state Medicaid contracts may be periodically amended to include or exclude certain health benefits (such as pharmacy services, behavioral health services, or long- term care services); populations such as the aged, blind or disabled (" ABD "); and regions or service areas. In Medicare, we enter into Medicare Advantage- Part D contracts with the Centers for Medicare and Medicaid Services (" CMS ") annually, and for dual- eligible plans, we enter into contracts with CMS, in partnership with each state' s department of

health and human services. Such contracts typically have terms of one to three years. In Marketplace, we enter into contracts with CMS, which end on December 31 of each year, and must be renewed annually. Recent Developments Texas Procurement — Medicaid. On January 27, 2023, the Texas Health and Human Services Commission posted a notice on its website indicating that it was issuing a Notice of Intent to Award to Molina Healthcare of Texas, Inc. a STAR PLUS ABD contract in each of Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Northeast Texas, and Tarrant Service Areas. The notice follows a proposal that we submitted in June 2022 to continue serving STAR PLUS members in the same service areas, in response to an RFP posted in March 2022. The start of operations for the new contract is expected to begin in February 2024. Further, in December 2022, the RFP was posted for the TANF and CHIP programs (known as the STAR & CHIP programs, and both existing contracts for Molina), with awards expected in February 2024 and the start of operations in February 2025. California Procurement — Medicaid. In January 2023, we announced that the California Department of Health Care Services (" DHCS ") had confirmed our California health plan' s footprint as originally announced in August 2022, including Medi- Cal contract awards in each of Riverside, San Bernardino, Sacramento, and San Diego Counties. In Los Angeles County, we will share membership equally with the current commercial incumbent. The Medi- Cal contracts are expected to commence on January 1, 2024, which enables us to continue serving Medi- Cal members in our existing counties and expand our footprint in Los Angeles County. DHCS has also agreed to grant Molina a contract to offer EAE- SNP products for dual eligible members in Los Angeles County. New York Acquisition — Medicaid. On October 1, 2022, we closed on our acquisition of the Medicaid Managed Long Term Care business of AgeWell New York (" AgeWell "). See Note 4, " Business Combinations, " for further information. Nebraska Procurement — Medicaid. In September 2022, we announced that our Nebraska health plan had been selected by the Nebraska Department of Health and Human Services to provide health care services to Nebraskans under the state' s Medicaid managed care program. The new five- year contract is expected to begin on January 1, 2024, and may be extended for an additional two- years. Iowa Procurement — Medicaid. In August 2022, we announced that our Iowa health plan had been notified by the Iowa Department of Health and Human Services (" Iowa HHS ") of its intent to award a Medicaid managed care contract pursuant to the RFP issued by Iowa HHS in February 2022. The new four- year contract is expected to begin on July 1, 2023, and may be extended for an additional four years. Molina Healthcare, Inc. 2022 Form 10- K | 54 Mississippi Procurement — Medicaid. In August 2022, we announced that our Mississippi health plan had been notified by the Mississippi Division of Medicaid (" DOM ") of its intent to award a Medicaid Coordinated Care Contract for its Mississippi Coordinated Access Program and Mississippi Children' s Health Insurance Program pursuant to the Request for Qualifications issued by DOM in December 2021. The four- year contract is expected to begin on July 1, 2023, and may be extended for an additional two years. The award enables us to continue serving Medicaid members across the state. Wisconsin Acquisition — Medicaid and Medicare. On July 13, 2022, we announced a definitive agreement to acquire substantially all the assets of My Choice Wisconsin (" MCW "). The purchase price for the transaction is approximately $ 150 million, net of expected tax benefits and required regulatory capital, which we intend to fund with cash on hand. The transaction is subject to receipt of applicable federal and state regulatory approvals, and the satisfaction of other customary closing conditions. We currently expect the transaction to close in mid- 2023. Nevada Procurement — Medicaid. Our new contract in Clark and Washoe Counties commenced on January 1, 2022, and offers health coverage to TANF, CHIP and Medicaid Expansion beneficiaries. This new contract is four years with a potential two- year extension. Texas Acquisition — Medicaid and Medicare. On January 1, 2022, we closed on our acquisition of Cigna Corporation' s Texas Medicaid and Medicare- Medicaid Plan (" MMP ") contracts, along with certain operating assets. See Note 4, " Business Combinations, " for further information. Consolidation and Presentation The consolidated financial statements include the accounts of Molina Healthcare, Inc., and its subsidiaries. All significant inter- company balances and transactions have been eliminated in consolidation. Financial information related to subsidiaries acquired during any year is included only for periods subsequent to their acquisition. In the opinion of management, all adjustments considered necessary for a fair presentation of the results as of the date and for the periods presented have been included; such adjustments consist of normal recurring adjustments. Use of Estimates The preparation of consolidated financial statements in conformity with U. S. generally accepted accounting principles (" GAAP ") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from these estimates. 2. Significant Accounting Policies Cash and Cash Equivalents Cash and cash equivalents consist of cash and short- term, highly liquid investments that are both readily convertible into known amounts of cash and have a maturity of three months or less on the date of purchase. The following table provides a reconciliation of cash, cash equivalents, and restricted cash and cash equivalents reported within the accompanying consolidated balance sheets that sum to the total of the same such amounts presented in the accompanying consolidated statements of cash flows. The restricted cash and cash equivalents presented below are included in " Restricted investments " in the accompanying consolidated balance sheets. December 31, 202220212020 (In millions) Cash and cash equivalents $ 4, 006 $ 4, 438 $ 4, 154 Restricted cash and cash equivalents42 68 69 Total cash and cash equivalents, and restricted cash and cash equivalents presented in the consolidated statements of cash flows $ 4, 048 $ 4, 506 $ 4, 223 Our investments are principally held in debt securities, which are grouped into two separate categories for accounting and reporting purposes: available- for- sale securities, and held- to- maturity securities. Available- for- sale (" AFS ") securities are recorded at fair value and unrealized gains and losses, if any, are recorded in stockholders' equity as other comprehensive income, net of applicable income taxes. Held- to- maturity (" HTM ") securities are recorded at amortized cost, which approximates fair value, and unrealized holding gains or losses are not generally recognized. Realized gains and losses and unrealized losses arising from credit- related factors with respect to AFS Molina Healthcare, Inc. 2022 Form 10- K | 55 and HTM securities are included in the determination of net income. The cost of securities sold is determined using the specific- identification method. Our investment policy requires that all of our investments have final maturities of less than 15 years, or less than 15 years average life for structured securities. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. Declines in interest rates over time

will reduce our investment income. In general, our AFS securities are classified as current assets without regard to the securities' contractual maturity dates because they may be readily liquidated. We monitor our investments for credit- related impairment. For comprehensive discussions of the fair value and classification of our investments, see Note 5, " Fair Value Measurements, " and Note 6, " Investments. " Accrued interest receivable relating to our AFS and HTM securities is presented within " Prepaid expenses and other current assets " in the accompanying consolidated balance sheets, and amounted to $ 35 million and $ 11 million at December 31, 2022, and 2021, respectively. We do not measure an allowance for credit losses on accrued interest receivable. Instead, we write off - **of** accrued interest receivable that has not been collected within 90 days of the interest payment due date. We recognize such write offs as a reversal of investment income. No accrued interest was written off during the year ended December 31, 2022. Receivables consist primarily of premium amounts due from government agencies, which are subject to potential retroactive adjustments. Because substantially all of our receivable amounts are readily determinable and substantially all of our creditors are governmental authorities, our allowance for credit losses is insignificant. Any amounts determined to be uncollectible are charged to expense when such determination is made. December 31, 20222021 (In millions) Government receivables $ 1, 702 $ 1, 566 Pharmacy rebate receivables291 276 Other309 335 Total receivables $ 2, 302 $ 2, 177 We account for business combinations using the acquisition method of accounting, which requires us to recognize the assets acquired and the liabilities assumed at their acquisition date fair values. As discussed below, the excess of the purchase consideration transferred over the fair value of the net tangible and intangible assets acquired is recorded as goodwill. While we use our best estimates and assumptions to accurately value assets acquired and liabilities assumed at the acquisition date, our estimates are inherently uncertain and subject to refinement. As a result, during the measurement period, which may be up to one year from the acquisition date, we may record adjustments to the assets acquired and liabilities assumed with the corresponding offset to goodwill. Measurement period adjustments are recorded in the period in which they are determined, as if they had been completed at the acquisition date. Upon the conclusion of the final determination of the values of assets acquired or liabilities assumed, or one year after the date of acquisition, whichever comes first, any subsequent adjustments are recorded within our consolidated results of operations. The purchase price for the acquisition of certain assets of Passport Health Plan, Inc. in 2020 included contingent consideration payable to seller relating to guarantees for minimum operating income in the post- acquisition period in 2020 and minimum membership targets in 2021. The liabilities are recorded at fair value on a recurring basis, which totaled $ 8 million as of December 31, 2022. For the amounts paid in the year ended December 31, 2022, $ 20 million has been presented in " Financing activities " in the accompanying consolidated statements of cash flows, with the balance reflected in " Operating activities. " We paid the remaining balance of the liabilities, reported in " Accounts payable, accrued liabilities and other " in the accompanying consolidated balance sheets, in January 2023. Refer to Note 4, " Business Combinations, " and Note 9, " Goodwill and Intangible Assets, Net, " for further details. Molina Healthcare, Inc. 2022 Form 10- K | 56 Long- Lived Assets, including Intangible Assets Long- lived assets consist primarily of property, equipment, capitalized software (see Note 7, " Property, Equipment, and Capitalized Software, Net "), and intangible assets resulting from acquisitions. Long- lived assets are subject to impairment tests when events or circumstances indicate that the asset' s (or asset group' s) carrying value may not be recoverable. Refer to the discussion in " Leases " below for impairment charges related to leasehold improvements and other property and equipment associated with the reduction in leased space used in our business operations. Finite- lived, separately- identified intangible assets acquired in business combinations are assets that represent future expected benefits but lack physical substance (such as purchased contract rights and provider contracts). Intangible assets are initially recorded at fair value and are then amortized on a straight- line basis over their expected useful lives, generally between five and 16 years. Determining the fair value of separately identifiable intangible assets requires management to make estimates, which are based on all available information and in some cases assumptions with respect to the timing and amount of future revenues and expenses associated with an asset. Determining the useful life of an intangible asset also requires judgment, as different types of intangible assets will have different useful lives. The most significant intangible asset we typically record in a business combination is contract rights associated with membership assumed. In determining the estimated fair value of the intangible assets, we typically apply the income approach, which discounts the projected future net cash flows using an appropriate discount rate that reflects the risk associated with such projected future cash flows. The most critical assumptions used in determining the fair value of contract rights include forecasted operating margins and the weighted average cost of capital. Our intangible assets are subject to impairment tests when events or circumstances indicate that a finite- lived intangible asset' s (or asset group' s) carrying value may not be recoverable. Consideration is given to a number of potential impairment indicators, including the ability of our health plan subsidiaries to obtain the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. Following the identification of any potential impairment indicators, to determine whether an impairment exists, we would compare the carrying amount of a finite- lived intangible asset with the greater of the undiscounted cash flows that are expected to result from the use of the asset or related group of assets, or its value under the asset liquidation method. If it is determined that the carrying amount of the asset is not recoverable, the amount by which the carrying value exceeds the estimated fair value is recorded as an impairment. Refer to Note 9, " Goodwill and Intangible Assets, Net, " for further details. Goodwill represents the excess of the purchase consideration over the fair value of net assets acquired in business combinations. Goodwill is not amortized but is tested for impairment on an annual basis and more frequently if impairment indicators are present. Impairment indicators may include experienced or expected operating cash- flow deterioration or losses, significant losses of membership, loss of state funding, loss of state contracts, and other factors. Goodwill is impaired if the carrying amount of the reporting unit exceeds its estimated fair value. This excess is recorded as an impairment loss and adjusted if necessary for the impact of tax- deductible goodwill. The loss recognized may not exceed the total goodwill allocated to the reporting unit. When testing goodwill for impairment, we may first assess qualitative factors, such as industry and market factors, the dynamic economic and political environments in which we operate, cost factors, and changes in overall performance, to determine if it is more likely

than not that the carrying value of our reporting units exceed their estimated fair values. If our qualitative assessment indicates that it is more likely than not that the carrying value of a reporting unit exceeds its estimated fair value, we perform the quantitative assessment. We may also elect to bypass the qualitative assessment and proceed directly to the quantitative assessment. We performed a qualitative goodwill assessment of our reporting units, and did not identify any factors indicating that the carrying value of our reporting units exceeded their estimated fair values. If performing a quantitative assessment, we generally estimate the fair values of our reporting units by applying the income approach, using discounted cash flows. The base year in the reporting units' discounted cash flows is derived from the annual financial planning cycle, which commences in the fourth quarter of the year. As part of a quantitative assessment, we may also apply the asset liquidation method to estimate the fair value of individual reporting units, which is computed as total assets minus total liabilities, excluding intangible assets and deferred taxes. Finally, we apply a market approach to reconcile the value of our reporting units to our consolidated market value. Under the market approach, we consider publicly- traded comparable company information to determine revenue and earnings multiples which are used to estimate our reporting units' fair values. The assumptions used are consistent with those used in our long- range business plan and annual planning process. However, if these assumptions differ from actual results, the outcome of our goodwill impairment tests could be adversely affected. Molina Healthcare, Inc. 2022 Form 10- K | 57 Right- of- use (" ROU ") assets represent our right to use the underlying assets over the lease term, and lease liabilities represent our obligation for lease payments arising from the related leases. ROU assets and lease liabilities are recognized at the lease commencement date based on the present value of lease payments over the lease term. Lease terms may include options to extend or terminate the lease when we believe it is reasonably certain that we will exercise such options. If applicable, we account for lease and non- lease components within a lease as a single lease component. Because most of our leases do not provide an implicit interest rate, we generally use our incremental borrowing rate to determine the present value of lease payments. Lease expenses for operating lease payments are recognized on a straight- line basis over the lease term, and the related ROU assets and liabilities are reduced to the present value of the remaining lease payments at the end of each period. Finance lease payments reduce finance lease liabilities, the related ROU assets are amortized on a straight- line basis over the lease term, and interest expense is recognized using the effective interest method. The significant majority of our operating leases consist of long- term operating leases for office space. Short- term leases (those with terms of 12 months or less) are not recorded as ROU assets or liabilities in the consolidated balance sheets. For certain leases that represent a portfolio of similar assets, such as a fleet of vehicles, we apply a portfolio approach to account for the related ROU assets and liabilities, rather than account for such assets and the related liabilities individually. A nominal number of our lease agreements include rental payments that adjust periodically for inflation. Our lease agreements do not contain any material residual value guarantees or material restrictive covenants. In the fourth quarter of 2022, we recognized $ 192 million of ROU asset impairments in connection with the reduction in leased space to accommodate our move to a remote work environment, including vacating and abandonment of various leased properties. We assessed the ROU assets for impairment as a result of the reduction in leased space used in our business operations, and we engaged a third- party real estate specialist to determine the recoverability of the leased properties, based on estimated fair values. The valuation primarily considered comparable leased properties in each market and the assessment of actual and potential future rental income generated by the ROU assets. For further information, including the amount and location of the ROU assets and lease liabilities recognized in the accompanying consolidated balance sheets, see Note 8, " Leases. " We also recognized $ 16 million in impairment charges related to leasehold improvements and other property and equipment associated with the reduction in leased space used in our business operations. Please refer to Note 7, " Property, Equipment, and Capitalized Software, Net " for further discussion. Medical care costs are recognized in the period in which services are provided and include fee- for- service claims, pharmacy benefits, capitation payments to providers, and various other medically- related costs. Under fee- for- service claims arrangements with providers, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of hospital and physician services. Such medical care costs include amounts paid by us as well as estimated medical claims and benefits payable for costs that were incurred but not paid as of the reporting date (" IBNP "). Pharmacy benefits represent payments for members' prescription drug costs, net of rebates from drug manufacturers. We estimate pharmacy rebates based on historical and current utilization of prescription drugs and contractual provisions. Capitation payments represent monthly contractual fees paid to providers, who are responsible for providing medical care to members, which could include medical or ancillary costs like dental, vision and other supplemental health benefits. Such capitation costs are fixed in advance of the periods covered and are not subject to significant accounting estimates. Other medical care costs include all medically- related administrative costs, amounts due to providers pursuant to risk- sharing or other incentive arrangements, provider claims, and other healthcare expenses. Examples of medically- related administrative costs include expenses relating to health education, quality assurance, case management, care coordination, disease management, and 24- hour on- call nurses. Additionally, we include an estimate for the cost of settling claims incurred through the reporting date in our medical claims and benefits payable liability. Molina Healthcare, Inc. 2022 Form 10- K | 58 conditions. We reflect changes in these estimates in the consolidated results of operations in the period in which they are determined. The estimation of the IBNP liability requires a significant degree of judgment in applying actuarial methods, determining the appropriate assumptions and considering numerous factors. Of those factors, we consider estimated completion factors and the assumed healthcare cost trend to be the most critical assumptions. Other relevant factors also include, but are not limited to, healthcare service utilization trends, claim inventory levels, changes in membership, product mix, seasonality, benefit changes or changes in Medicaid fee schedules, provider contract changes, prior authorizations and the incidence of catastrophic or pandemic cases. Because of the significant degree of judgment involved in estimation of our IBNP liability, there is considerable variability and uncertainty inherent in such estimates. Each reporting period , **conducts assessments** the recognized IBNP liability represents our best estimate of the total amount of unpaid claims incurred as of the balance sheet date using a consistent methodology in estimating our IBNP liability. We believe our current estimates are

reasonable and adequate; however, the development of our estimate is a continuous process that we monitor and update as more complete claims payment information and healthcare cost trend data becomes available. Actual medical care costs may be less than we previously estimated (favorable development) or more than we previously estimated (unfavorable development), and any differences could be material. Any adjustments to reflect favorable development would be recognized as a decrease to medical care costs, and any adjustments to reflect unfavorable development would be recognized as an increase to medical care costs, in the period in which the adjustments are determined. Refer to Note 10, " Medical Claims and Benefits Payable, " for a table presenting the components of the change in our medical claims and benefits payable, for all periods presented in the accompanying consolidated financial statements. Premium Revenue Recognition and Amounts Due Government Agencies Premium revenue is generated from our contracts with state and federal agencies, in connection with our participation in the Medicaid, Medicare, and Marketplace programs. Premium revenue is generally received based on per member per month (" PMPM ") rates established in advance of the periods covered. These premium revenues are recognized in the month that members are entitled to receive healthcare services, and premiums collected in advance are deferred. State Medicaid programs and the federal Medicare program periodically adjust premium rates, including certain components of premium revenue that are subject to accounting estimates and are described below, under " Contractual Provisions That May Adjust or Limit Revenue or Profit, " and " Quality Incentives. " Many of our contracts contain provisions that may adjust or limit revenue or profit, as described below. Consequently, we recognize premium revenue as it is earned under such provisions. Liabilities accrued for premiums to be returned under such provisions are reported in the aggregate as " Amounts due government agencies " in the accompanying consolidated balance sheets. Categorized by program, such amounts due government agencies included the following: December 31, 20222021 (In millions) Medicaid program: Minimum MLR, corridors, and profit sharing $ 1, 145 $ 1, 016 Other premium adjustments482 263 Medicare program: Risk adjustment and Part D risk sharing76 89 Minimum MLR and profit sharing 84 101 Other premium adjustments27 35 Marketplace program: Risk adjustment230 902 Minimum MLR2 18 Other premium adjustments33 48 Total amounts due government agencies $ 2, 079 $ 2, 472 Molina Healthcare, Inc. 2022 Form 10- K | 59 Medicaid Program Minimum MLR and Medical Cost Corridors. A portion of our premium revenue may be returned if certain minimum amounts are not spent on defined medical care costs as a percentage of premium revenue, or minimum medical loss ratio (" Minimum MLR "). Under certain medical cost corridor provisions, the health plans may receive additional premiums if amounts spent on medical care costs exceed a defined maximum threshold. Beginning in 2020, various states enacted temporary risk corridors in response to the reduced demand for medical services stemming from COVID- 19, which have resulted in a reduction of our medical margin. In some cases, these risk corridors were retroactive to earlier periods in 2020, or as early as the beginning of the states' fiscal years in 2019. We have recognized risk corridors that we believe to be probable, and where the ultimate premium amount is reasonably estimable. For the year ended December 31, 2022, we recognized approximately $ 197 million related to such risk corridors, primarily in the Medicaid segment, compared to $ 323 million recognized in the year ended December 31, 2021. The decrease in 2022 is due to the elimination of most of the COVID- 19 risk corridors. Profit Sharing. Our contracts with certain states contain profit sharing provisions under which we refund amounts to the states if our health plans generate profit above a certain specified percentage. In some cases, we are limited in the amount of administrative costs that we may deduct in calculating the refund, if any. Other Premium Adjustments. State Medicaid programs periodically adjust premium revenues on a retroactive basis for rate changes and changes in membership and eligibility data. In certain states, adjustments are made based on the health status of our members (as measured through a risk score). In these cases, we adjust our premium revenue in the period in which we determine that the adjustment is probable and reasonably estimable, based on our best estimate of the ultimate premium we expect to realize for the period being adjusted. Medicare Program Risk Adjustment. Our Medicare premiums are subject to retroactive increase or decrease based on the health status of our Medicare members (as measured by member risk score). We estimate our members' risk scores and the related amount of Medicare revenue that will ultimately be realized for the periods presented based on our knowledge of our members' health status, risk scores and CMS practices. Minimum MLR. The Affordable Care Act (" ACA ") established a Minimum MLR of 85 % for Medicare. Federal regulations define what constitutes medical costs and premium revenue. If the Minimum MLR is not met, we may be required to pay rebates to the federal government. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. Marketplace Program Risk Adjustment. Under this program, our health plans' composite risk scores are compared with the overall average risk score for the relevant state and market pool. Generally, our health plans will make a risk adjustment payment into the pool if their composite risk scores are below the average risk score (risk adjustment payable), and will receive a risk adjustment payment from the pool if their composite risk scores are above the average risk score (risk adjustment receivable). We estimate our ultimate premium based on insurance policy year- to- date experience, and recognize estimated premiums relating to the risk adjustment program as an adjustment to premium revenue in our consolidated statements of income. As of December 31, 2022, Marketplace risk adjustment payables amounted to $ 230 million and related receivables amounted to $ 135 million, for a net payable of $ 95 million. As of December 31, 2021, Marketplace risk adjustment payables amounted to $ 902 million and related receivables amounted to $ 7 million, for a net payable of $ 895 million. Minimum MLR. The ACA established a Minimum MLR of 80 % for the Marketplace. If the Minimum MLR is not met, we may be required to pay rebates to our Marketplace policyholders. The Marketplace risk adjustment program is taken into consideration when computing the Minimum MLR. We recognize estimated rebates under the Minimum MLR as an adjustment to premium revenue in our consolidated statements of income. At many of our health plans, revenue ranging from approximately 1 % to 4 % of certain health plan premiums is earned only if certain performance measures are met. Such performance measures are generally found in our Medicaid and MMP contracts. Recognition of quality incentive premium revenue is subject to the use of estimates. Molina Healthcare, Inc. 2022 Form 10- K | 60 Reinsurance We bear underwriting and reserving risks associated with our health plan subsidiaries. In certain cases, we limit our risk of significant catastrophic losses by maintaining high deductible reinsurance coverage with a highly- rated, unaffiliated

insurance company (the " third- party **service providers with respect to** reinsurer "). Because we remain liable for losses in the **their** event the **cybersecurity programs and risks and requires** third- party **service providers** reinsurer is unable to pay **notify the Company if they experienced a cybersecurity incident. The Company hires experienced security professionals to conduct advanced and realistic cybersecurity attack simulations to verify** its **Program** portion of the losses , we continually monitor the **and conducts regular cybersecurity tabletop exercises with executive management, which are coordinated by a** third- party reinsurer' s financial condition, including its ability to maintain high credit ratings. Intercompany transactions with our captive are eliminated in consolidation. We report reinsurance premiums as a reduction to premium revenue, while related reinsurance recoveries are reported as a reduction to medical care costs. In certain cases, we participate in state- run reinsurance programs for which no reinsurance premium is paid. Reinsurance premiums amounted to $ 2 million, $ 2 million, and $ 9 million for the years ended December 31, 2022, 2021, and 2020, respectively. Reinsurance recoveries amounted to $ 35 million, $ 33 million, and $ 23 million for the years ended December 31, 2022, 2021, and 2020, respectively. Reinsurance recoverable of $ 27 million, $ 51 million, and $ 30 million, as of December 31, 2022, 2021, and 2020, respectively, is included in " Receivables " in the accompanying consolidated balance sheets. Premium Deficiency Reserves on Loss Contracts We assess the profitability of our contracts to determine if it is probable that a loss will be incurred in the future by reviewing current results and forecasts. For purposes of this assessment, contracts are grouped in a manner consistent with our method of acquiring, servicing and measuring the profitability of such contracts. A premium deficiency reserve (" PDR ") is recognized if anticipated future medical care and administrative costs exceed anticipated future premium revenue, investment income and reinsurance recoveries. Income Taxes We account for income taxes under the asset and liability method. Deferred tax assets and liabilities are determined based on the difference between the financial statement and tax bases of assets and liabilities using enacted tax rates expected to be in effect during the year in which the basis differences reverse. Valuation allowances are established when management determines it is more likely than not that some portion, or all, of the deferred tax assets will not be realized. For further discussion and disclosure, see Note 12, " Income Taxes. " Taxes Based on Premiums Health Insurer Fee (" HIF "). Under the Affordable Care Act, the federal government imposed an annual fee, or excise tax, on health insurers for each calendar year (the " HIF "). The Further Consolidated Appropriations Act, 2020 repealed the HIF effective for years after 2020. Premium and Use Tax. Certain of our health plans are assessed a tax based on premium revenue collected. The premium revenues we receive from these states include reimbursement for the premium tax assessment . We have reported these taxes on a gross basis **not identified risks from known cybersecurity threats** , **including** as premium tax revenue and as premium tax expenses in the consolidated statements of income. Concentrations of Credit Risk Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, investments, receivables, and restricted investments. Our investments and a portion **result** of **any** our cash equivalents are managed by professional portfolio managers operating under documented investment guidelines. Our portfolio managers must obtain our prior **cybersecurity incidents** approval before selling investments where the loss position of those investments exceeds certain levels. Our investments consist primarily of investment- grade debt securities with final maturities of less than 15 years, or less than 15 years average life for structured securities. Restricted investments are invested principally in cash, cash equivalents, U. S. Treasury securities, and corporate debt securities. Concentration of credit risk with respect to accounts receivable is limited because our payors consist principally of the federal government, and governments of each state in which our health plan subsidiaries operate. Risks and Uncertainties Our profitability depends in large part on our ability to accurately predict and effectively manage medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in healthcare practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows. Molina Healthcare, Inc. 2022 Form 10- K | 61 We operate health plans primarily as a direct contractor with the states, and in Los Angeles County, California, as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a relatively small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. In addition, our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows. Significant Customers We receive the majority of our revenues under contracts or subcontracts with state Medicaid managed care programs, which are considered individual external customers. Instances where these contracts were at least 10 % of our total premium revenue for the year ended December 31, 2022 were New York with 10. 0 %, Texas with 12. 0 % and Washington with 13. 6 %. Recent Accounting Pronouncements Recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the American Institute of Certified Public Accountants, and the Securities and Exchange Commission (" SEC ") did not have, nor does management expect such pronouncements to have, a significant impact on our present or future consolidated financial statements. 3. Net Income Per Share The following table sets forth the calculation of basic and diluted net income per share: Year Ended December 31, 202220212020 (In millions, except net income per share) Numerator: Net income $ 792 $ 659 $ 673 Denominator: Shares outstanding at the beginning of the period57. 9 58. 0 61. 9 Weighted- average number of shares issued: Stock purchases (0. 5) (0. 5) (3. 0) Stock- based compensation0. 4 0. 3 0. 1 Denominator for basic net income per share57. 8 57. 8 59. 0 Effect of dilutive securities: (1) Stock- based compensation0. 7 0. 8 0. 9 Denominator for diluted net income per share58. 5 58. 6 59. 9 Net income per share- Basic (2) $ 13. 72 $ 11. 40 $ 11. 40 Net income per share- Diluted (2) $ 13. 55 $ 11. 25 $ 11. 23 _____ (1) The dilutive effect of all potentially dilutive common shares is calculated using the treasury stock method. Certain potentially dilutive common shares issuable are not included in the computation of diluted

net income per share because to do so would have been anti- dilutive. (2) Source data for calculations in thousands. Molina Healthcare, Inc. 2022 Form 10- K | 62 4. Business Combinations In 2022, we closed on two business combinations primarily in the Medicaid segment, consistent with our growth strategy. For these transactions, we applied the acquisition method of accounting, where the total purchase price was allocated to the tangible and intangible assets acquired and liabilities assumed, based on their fair values as of the acquisition date. The proforma effects of these acquisitions for prior periods were not material to our consolidated results of operations. Costs to complete acquisitions amounted to $ 2 million in the aggregate for the year ended December 31, 2022, and were recorded as " General and administrative expenses " in the accompanying consolidated statements of income. AgeWell. On October 1, 2022, we closed on our acquisition of the Medicaid Managed Long Term Care business of AgeWell New York for purchase consideration of approximately $ 134 million. We acquired membership and a provider network with a fair value of approximately $ 47 million. We allocated the remaining $ 87 million of purchase consideration to goodwill, which relates to future economic benefits arising from expected synergies from the use of our existing infrastructure to support the added membership. The goodwill is deductible for income tax purposes. Cigna. On January 1, 2022, we closed on our acquisition of Cigna Corporation' s Texas Medicaid and Medicare- Medicaid Plan contracts, along with certain operating assets, for purchase consideration of approximately $ 60 million. Because the closing date fell on a holiday, the purchase price was paid on December 31, 2021 and was recorded to prepaid expenses and other assets. We acquired membership and a provider network with a fair value of approximately $ 35 million. We allocated the remaining $ 25 million of purchase consideration to goodwill, primarily in the Medicaid segment, which relates to future economic benefits arising from expected synergies from the use of our existing infrastructure to support the added membership, and from the assembled workforce. The goodwill is deductible for income tax purposes. The table below presents intangible assets acquired, by major class, for the AgeWell and Cigna acquisitions. Fair ValueLifeWeighted- Average Life (In millions) (Years) (Years) Contract rights- member list $ 81 2- 53. 7Provider network1 2- 54. 0 $ 82 3. 7 Affinity. On October 25, 2021, we closed on our acquisition of substantially all of the assets of Affinity Health Plan, Inc., a Medicaid health plan in New York, for purchase consideration of approximately $ 176 million. In the year ended December 31, 2022, we recorded various measurement period adjustments, including an increase of $ 12 million to " Medical claims and benefits payable, " and an increase of $ 4 million to " Amounts due government agencies " net of " Receivables. " In the aggregate, we recorded a net increase of $ 21 million to goodwill for these measurement period adjustments and various purchase price adjustments, which have been finalized as of December 31, 2022. 5. Fair Value Measurements We consider the carrying amounts of current assets and current liabilities to approximate their fair values because of the relatively short period of time between the origination of these instruments and their expected realization or payment. For our financial instruments measured at fair value on a recurring basis, we prioritize the inputs used in measuring fair value according to a three- tier fair value hierarchy as follows: Level 1 — Observable Inputs. Level 1 financial instruments are actively traded and therefore the fair value for these securities is based on quoted market prices for identical securities in active markets. Level 2 — Directly or Indirectly Observable Inputs. Fair value for these investments is determined using a market approach based on quoted prices for similar securities in active markets or quoted prices for identical securities in inactive markets. Level 3 — Unobservable Inputs. Level 3 financial instruments are valued using unobservable inputs that represent management' s best estimate of what market participants would use in pricing the financial instrument at the measurement date. As of December 31, 2022 and 2021, our Level 3 financial instruments consisted of contingent consideration liabilities. Molina Healthcare, Inc. 2022 Form 10- K | 63 The net changes in fair value of Level 3 financial instruments are reported in " Other " operating expenses in our consolidated statements of income. In the years ended December 31, 2022 and 2021, we recognized a loss of $ 4 million and $ 24 million, respectively, primarily for the increase in the fair value of the contingent consideration liability described below. Our financial instruments measured at fair value on a recurring basis at December 31, 2022, were as follows: TotalLevel 1Level 2Level 3 (In millions) Corporate debt securities $ 2, 184 $ — $ 2, 184 $ — Mortgage- backed securities731 — 731 — Asset- backed securities288 — 288 — Municipal securities149 — 149 — U. S. Treasury notes105 — 105 — Other42 — 42 — Total assets $ 3, 499 $ — $ 3, 499 $ — Contingent consideration liabilities $ 8 $ — $ — $ 8 Total liabilities $ 8 $ — $ — $ 8 Our financial instruments measured at fair value on a recurring basis at December 31, 2021, were as follows: TotalLevel 1Level 2Level 3 (In millions) Corporate debt securities $ 1, 833 $ — $ 1, 833 $ — Mortgage- backed securities614 — 614 — Asset- backed securities247 — 247 — Municipal securities123 — 123 — U. S. Treasury notes353 — 353 — Other32 — 32 — Total assets $ 3, 202 $ — $ 3, 202 $ — Contingent consideration liabilities $ 47 $ — $ — $ 47 Total liabilities $ 47 $ — $ — $ 47 Level 3 Contingent Consideration Liabilities Our Level 3 financial instruments at December 31, 2022 are comprised solely of contingent consideration liabilities of $ 8 million, in connection with our 2020 acquisition of certain assets of Passport Health Plan, Inc., a Medicaid health plan in Kentucky. Refer to Note 2, " Significant Accounting Policies — Business Combinations ", for further details. Such liabilities are recorded at fair value on a recurring basis. In 2022, the estimated fair value of contingent purchase consideration increased by approximately $ 4 million, relating to an operating income guarantee. In the year ended December 31, 2022, we paid the seller $ 43 million, of which $ 23 million was for the remaining half of the consideration due for minimum member enrollment targets and $ 20 million was for the first payment of the consideration due for the operating income guarantee. Molina Healthcare, Inc. 2022 Form 10- K | 64 Fair Value Measurements — Disclosure Only The carrying amounts and estimated fair values of our notes payable are classified as Level 2 financial instruments. Fair value for these securities is determined using a market approach based on quoted market prices for similar securities in active markets or quoted prices for identical securities in inactive markets. December 31, 2022December 31, 2021 CarryingAmountFair Value CarryingAmountFair Value (In millions) 4. 375 % Notes due 2028 $ 792 $ 729 $ 791 $ 829 3. 875 % Notes due 2030643 554 642 675 3. 875 % Notes due 2032741 629 740 760 Total $ 2, 176 $ 1, 912 $ 2, 173 $ 2, 264 6. Investments Available- for- Sale We consider all of our investments classified as current assets to be available- for- sale. The following tables summarize our current investments as of the dates indicated: December 31, 2022AmortizedCostGrossUnrealizedEstimatedFair ValueGainsLosses (In millions) Corporate debt securities $ 2, 303 $ 2 $ 121

$ 2, 184 Mortgage- backed securities787 — 56 731 Asset- backed securities308 — 20 288 Municipal securities160 — 11 149 U. S. Treasury notes106 — 1 105 Other45 — 3 42 Total $ 3, 709 $ 2 $ 212 $ 3, 499 December 31, 2021AmortizedCostGrossUnrealizedEstimatedFair ValueGainsLosses (In millions) Corporate debt securities $ 1, 836 $ 9 $ 12 $ 1, 833 Mortgage- backed securities616 2 4 614 Asset- backed securities248 — 1 247 Municipal securities123 1 1 123 U. S. Treasury notes353 — — 353 Other32 — — 32 Total $ 3, 208 $ 12 $ 18 $ 3, 202 Molina Healthcare, Inc. 2022 Form 10- K | 65 The contractual maturities of our current investments as of December 31, 2022 are summarized below: AmortizedCostEstimatedFair Value (In millions) Due in one year or less $ 318 $ 315 Due after one year through five years2, 249 2, 127 Due after five years through ten years364 345 Due after ten years778 712 Total $ 3, 709 $ 3, 499 Gross realized gains and losses from sales of available- for- sale securities are calculated under the specific identification method and are included in investment income. Gross realized investment gains amounted $ 1 million, $ 10 million and $ 6 million in the years ended December 31, 2022, 2021 and 2020, respectively, and were reclassified into earnings from other comprehensive income on a net- of- tax basis. Gross realized investment losses amounted to $ 7 million in the year ended December 31, 2022, and were reclassified into earnings from other comprehensive income on a net- of- tax basis. Gross realized investment losses were insignificant in the years ended December 31, 2021 and 2020. We have determined that unrealized losses at December 31, 2022 and 2021 primarily resulted from fluctuating interest rates, rather than a deterioration of the creditworthiness of the issuers. Therefore, we determined that an allowance for credit losses was not necessary. So long as we maintain the intent and ability to hold these securities to maturity, we are unlikely to experience realized losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be insignificant. The following table segregates those available- for- sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2022: In a Continuous Loss Positionfor Less than 12 MonthsIn a Continuous Loss Positionfor 12 Months or MoreEstimatedFairValueUnrealizedLossesTotal Number of PositionsEstimatedFairValueUnrealizedLossesTotal Number of Positions (Dollars in millions) Corporate debt securities $ 1, 124 $ 45 683 $ 887 $ 76 371 Mortgage- backed securities395 20 220 319 36 131 Asset- backed securities161 6 108 118 14 59 Municipal securities75 4 83 57 7 57 U. S. Treasury notes88 1 6 — — — Other15 1 16 17 2 6 Total $ 1, 858 $ 77 1, 116 $ 1, 398 $ 135 624 The following table segregates those available- for- sale investments that have been in a continuous loss position for less than 12 months, and those that have been in a continuous loss position for 12 months or more as of December 31, 2021: In a Continuous Loss Positionfor Less than 12 MonthsIn a Continuous Loss Positionfor 12 Months or MoreEstimatedFairValueUnrealizedLossesTotal Number of PositionsEstimatedFairValueUnrealizedLossesTotal Number of Positions (Dollars in millions) Corporate debt securities $ 1, 063 $ 12 395 $ — $ — — Mortgage- backed securities408 4 146 — — — Asset- backed securities166 1 75 — — — Municipal securities69 1 61 — — — Total $ 1, 706 $ 18 677 $ — $ — — Molina Healthcare, Inc. 2022 Form 10- K | 66 Restricted Investments Held- to- Maturity Pursuant to the regulations governing our state health plan subsidiaries, we maintain statutory deposits and deposits required by government authorities primarily in cash, cash equivalents, U. S. Treasury securities, and corporate debt securities. We also maintain restricted investments as protection against the insolvency of certain capitated providers. The use of these funds is limited as required by regulations in the various states in which we operate, or as needed in the event of insolvency of capitated providers. Therefore, such investments are reported as " Restricted investments " in the accompanying consolidated balance sheets. We have the ability to hold these restricted investments until maturity, and as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Our held- to- maturity restricted investments are carried at amortized cost, which approximates fair value, of which $ 193 million will mature in one year or less, $ 37 million will mature in one through five years, and $ 8 million will mature after five years. The following table presents the balances of restricted investments: December 31, 20222021 (In millions) Cash and cash equivalents $ 42 $ 68 U. S. Treasury notes159 144 Corporate debt securities37 — Total restricted investments $ 238 $ 212 7. Property, Equipment, and Capitalized Software, Net Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Software developed for internal use is capitalized. Property and equipment are generally depreciated using the straight- line method over estimated useful lives ranging from three to seven years. Software is generally amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease, or over their useful lives from five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31. 5 to 40 years. As discussed in Note 2, " Significant Accounting Policies ", the Company recognized an impairment on property and equipment of $ 16 million associated with our reduction in leased space used in our business operations, in the quarter ended December 31, 2022. A summary of property, equipment, and capitalized software is as follows: December 31, 20222021 (In millions) Capitalized software $ 615 $ 547 Property and equipment221 237 Building and improvements41 37 Land5 1 Total cost882 822 Less: accumulated amortization- capitalized software (482) (427) Less: accumulated depreciation and amortization- property, equipment, building, and improvements (213) (205) Total accumulated depreciation and amortization (695) (632) ROU assets- finance leases72 206 Property, equipment, and capitalized software, net $ 259 $ 396 Molina Healthcare, Inc. 2022 Form 10- K | 67 The following table presents all depreciation and amortization recognized in our consolidated statements of income: Year Ended December 31, 202220212020 (In millions) Recorded in depreciation and amortization: Amortization of intangible assets $ 77 $ 49 $ 15 Amortization of capitalized software54 41 38 Amortization of finance leases28 25 19 Depreciation and amortization of property, equipment, building, and improvements17 16 16 Total depreciation and amortization recognized $ 176 $ 131 $ 88 8. Leases We are a party to operating and finance leases primarily for our corporate and health plan offices. Our operating leases have remaining lease terms up to 13 years, some of which include options to extend the leases for up to 10 years. As of December 31, 2022, the weighted average remaining operating lease term is 8 years. Our finance leases have remaining lease terms up to 16 years, some of which include options to extend the leases for up to 25 years. As of December 31, 2022, the weighted average remaining finance lease term is 13 years. As discussed in Note 2, " Significant

Accounting Policies ", the Company recognized $ 192 million of ROU asset impairments associated with our reduction in leased space used in our business operations in the quarter ended December 31, 2022. As of December 31, 2022, the weighted- average discount rate used to compute the present value of lease payments was 4. 4 % for operating lease liabilities, and 6. 3 % for finance lease liabilities. The components of lease expense for the years ended December 31, 2022, 2021, and 2020 are presented in the following table. Year Ended December 31, 202220212020 (In millions) Operating lease expense $ 31 $ 34 $ 28 Finance lease expense: Amortization of ROU assets $ 28 $ 25 $ 19 Interest on lease liabilities15 15 15 Total finance lease expense $ 43 $ 40 $ 34 Supplemental consolidated cash flow information related to leases follows: Year Ended December 31, 202220212020 (In millions) Cash used in operating activities: Operating leases $ 31 $ 33 $ 30 Finance leases15 15 15 Cash used in financing activities: Finance leases15 18 9 ROU assets recognized in exchange for lease obligations: Operating leases10 86 28 Finance leases18 18 7 Molina Healthcare, Inc. 2022 Form 10- K | 68 Supplemental information related to leases, including location of amounts reported in the accompanying consolidated balance sheets, follows: December 31, 20222021 (In millions) Operating leases: ROU assetsOther assets $ 43 $ 128 Lease liabilitiesAccounts payable and accrued liabilities (current) $ 41 $ 35 Other long- term liabilities (non- current) 77 99 Total operating lease liabilities $ 118 $ 134 Finance leases: ROU assetsProperty, equipment, and capitalized software, net $ 72 $ 206 Lease liabilitiesAccounts payable and accrued liabilities (current) $ 22 $ 15 Finance lease liabilities (non- current) 215 219 Total finance lease liabilities $ 237 $ 234 Maturities of lease liabilities as of December 31, 2022, were as follows: Operating FinanceLeasesLeases (In millions) 2023 $ 28 $ 34 202422 30 202518 26 202611 23 20279 24 Thereafter55 219 Subtotal- undiscounted lease payments143 356 Less imputed interest (25) (119) Total $ 118 $ 237 9. Goodwill and Intangible Assets, Net The following table presents the changes in the carrying amounts of goodwill by segment, for the periods presented. MedicaidMedicareOtherConsolidated (In millions) Balance, December 31, 2020 $ 489 $ 161 $ 42 $ 692 Acquisitions and measurement period adjustments280 8 2 290 Balance, December 31, 2021769 169 44 982 Acquisitions and measurement period adjustments130 3 — 133 Balance, December 31, 2022 $ 899 $ 172 $ 44 $ 1, 115 The changes in the carrying amounts of both goodwill and intangible assets, net, in 2022, were due to the Molina Healthcare, Inc. 2022 Form 10- K | 69 acquisitions and purchase price adjustments described in Note 4, " Business Combinations. " The following table provides the details of identified intangible assets, by major class, for the periods presented. December 31, 2022December 31, 2021CostAccumulatedAmortizationCarrying Amount CostAccumulatedAmortizationCarrying Amount (In millions) Contract rights and licenses $ 507 $ 279 $ 228 $ 426 $ 210 $ 216 Provider networks57 24 33 56 19 37 Trade names19 5 14 19 2 17 Total $ 583 $ 308 $ 275 $ 501 $ 231 $ 270 As of December 31, 2022, we estimate that our intangible asset amortization will be approximately $ 84 million in 2023, $ 67 million in 2024, $ 64 million in 2025, $ 25 million in 2026, and $ 13 million in 2027. 10. Medical Claims and Benefits Payable The following table provides the details of our medical claims and benefits payable as of the dates indicated. December 31, 202220212020 (In millions) Fee- for- service claims incurred but not paid (" IBNP ") $ 2, 597 $ 2, 486 $ 1, 647 Pharmacy payable206 219 157 Capitation payable94 82 70 Other631 576 528 Magellan Complete Care acquisition opening balance — — 294 Total $ 3, 528 $ 3, 363 $ 2, 696 " Other " medical claims and benefits payable include amounts payable to certain providers for which we act as an intermediary on behalf of various government agencies without assuming financial risk. Such receipts and payments do not impact our consolidated statements of income. Non- risk provider payables amounted to $ 228 million, $ 226 million and $ 235 million, as of December 31, 2022, 2021, and 2020, respectively. Molina Healthcare, Inc. 2022 Form 10- K | 70 The following tables present the components of the change in our medical claims and benefits payable for the periods indicated. Year Ended December 31, 2022Medicaid Medicare MarketplaceConsolidated (In millions) Medical claims and benefits payable, beginning balance $ 2, 580 $ 404 $ 379 $ 3, 363 Components of medical care costs related to: Current year22, 097 3, 390 1, 972 27, 459 Prior years (251) (32) (1) (284) Total medical care costs21, 846 3, 358 1, 971 27, 175 Payments for medical care costs related to: Current year19, 655 2, 944 1, 746 24, 345 Prior years1, 966 361 343 2, 670 Total paid21, 621 3, 305 2, 089 27, 015 Acquired balances, net of post- acquisition adjustments12 — — 12 Change in non- risk and other provider payables (2) (5) — (7) Medical claims and benefits payable, ending balance $ 2, 815 $ 452 $ 261 $ 3, 528 Year Ended December 31, 2021Medicaid Medicare MarketplaceConsolidated (In millions) Medical claims and benefits payable, beginning balance $ 2, 129 $ 392 $ 175 $ 2, 696 Components of medical care costs related to: Current year18, 321 2, 970 2, 652 23, 943 Prior years (182) (39) (18) (239) Total medical care costs18, 139 2, 931 2, 634 23, 704 Payments for medical care costs related to: Current year16, 284 2, 573 2, 291 21, 148 Prior years1, 601 340 139 2, 080 Total paid17, 885 2, 913 2, 430 23, 228 Acquired balances, net of post- acquisition adjustments205 (8) — 197 Change in non- risk and other provider payables (8) 2 — (6) Medical claims and benefits payable, ending balance $ 2, 580 $ 404 $ 379 $ 3, 363 Molina Healthcare, Inc. 2022 Form 10- K | 71 Year Ended December 31, 2020Medicaid Medicare MarketplaceConsolidated (In millions) Medical claims and benefits payable, beginning balance $ 1, 465 $ 267 $ 122 $ 1, 854 Components of medical care costs related to: Current year12, 545 2, 189 1, 205 15, 939 Prior years (84) (28) (7) (119) Total medical care costs12, 461 2, 161 1, 198 15, 820 Payments for medical care costs related to: Current year10, 940 1, 884 1, 047 13, 871 Prior years1, 176 233 98 1, 507 Total paid12, 116 2, 117 1, 145 15, 378 Acquired balances, net of post- acquisition adjustments215 79 — 294 Change in non- risk and other provider payables104 2 — 106 Medical claims and benefits payable, ending balance $ 2, 129 $ 392 $ 175 $ 2, 696 The amounts presented for " Components of medical care costs related to: Prior years " represent the amount by which our original estimate of medical claims and benefits payable at the beginning of the year varied from the actual liabilities, based on information (principally the payment of claims) developed since those liabilities were first reported. Our estimates of medical claims and benefits payable recorded at December 31, 2022, 2021 and 2020 developed favorably by approximately $ 284 million, $ 239 million and $ 119 million in 2022, 2021 and 2020, respectively. The favorable prior year development recognized in 2022 was primarily due to lower than expected utilization of medical services by our members and improved operating performance, mainly in the Medicaid segment. Consequently, the ultimate costs recognized in 2022, as claims payments were processed, were lower than our estimates in 2021. The favorable prior year development recognized in 2021 was primarily due to lower than expected utilization of medical services by our Medicaid members, and to a

lesser extent our Medicare and Marketplace members, and improved operating performance. Consequently, the ultimate costs recognized in 2021 were lower than our original estimates in 2020, which was not discernible until additional information was provided, and as claims payments were processed. The favorable prior year development recognized in 2020 was primarily due to lower than expected utilization of medical services by our Medicaid members, and improved operating performance. Consequently, the ultimate costs recognized in 2020 were lower than our original estimates in 2019, which was not discernible until additional information was provided, and as claims payments were processed. The following tables provide information about our consolidated incurred and paid claims development as of December 31, 2022, as well as cumulative claims frequency and the total of incurred but not paid claims liabilities. The pattern of incurred and paid claims development is consistent across each of our segments. The cumulative claim frequency is measured by claim event, and includes claims covered under capitated arrangements. Incurred Claims and Allocated Claims Adjustment ExpensesTotal IBNPCumulative number of reported claimsBenefit Year202020212022 (Unaudited) (Unaudited) (In millions) 2020 $ 16, 233 $ 16, 056 $ 16, 000 $ 27 138 202124, 167 23, 979 108 236 202227, 459 2, 453 264 $ 67, 438 $ 2, 588 Molina Healthcare, Inc. 2022 Form 10- K | 72 Cumulative Paid Claims and Allocated Claims Adjustment ExpensesBenefit Year202020212022 (Unaudited) (Unaudited) (In millions) 2020 $ 13, 871 $ 16, 004 $ 15, 973 202121, 148 23, 871 202224, 345 $ 64, 189 The following table represents a reconciliation of claims development to the aggregate carrying amount of the liability for medical claims and benefits payable. 2022 (In millions) Incurred claims and allocated claims adjustment expenses $ 67, 438 Less: cumulative paid claims and allocated claims adjustment expenses (64, 189) All outstanding liabilities before 20209 Non- risk and other provider payables270 Medical claims and benefits payable $ 3, 528 11. Debt Contractual maturities of debt, as of December 31, 2022, are illustrated in the following table. All amounts represent the principal amounts of the debt instruments outstanding. Total2023202420252026 2027Thereafter (In millions) 4. 375 % Notes due 2028 $ 800 $ — $ — $ — $ — $ — $ 800 3. 875 % Notes due 2030650 — — — — — 650 3. 875 % Notes due 2032750 — — — — — 750 Total $ 2, 200 $ — $ — $ — $ — $ — $ 2, 200 All our debt is held at the parent which is reported in the Other segment. The following table summarizes our outstanding debt obligations, all of which are non-current as of the dates reported below: December 31, 20222021 (In millions) Non- current long- term debt: 4. 375 % Notes due 2028 $ 800 $ 800 3. 875 % Notes due 2030650 650 3. 875 % Notes due 2032750 750 Less: unamortized debt issuance costs (24) (27) Total $ 2, 176 $ 2, 173 We are party to a credit agreement (the " Credit Agreement ") which includes a revolving credit facility (" Credit Facility ") of $ 1. 0 billion, among other provisions. The Credit Agreement has a term of five years, and all amounts outstanding will be due and payable on June 8, 2025. Borrowings under the Credit Agreement bear interest based, at our election, on a base rate or other defined rate, plus in each case, the applicable margin. In addition to interest Molina Healthcare, Inc. 2022 Form 10- K | 73 payable on the principal amount of indebtedness outstanding from time to time under the Credit Agreement, we are required to pay a quarterly commitment fee. The Credit Agreement contains customary non- financial and financial covenants. As of December 31, 2022, we were in compliance with all financial and non- financial covenants under the Credit Agreement and other long- term debt. As of December 31, 2022, no amounts were outstanding under the Credit Facility. Senior Notes Our senior notes are described below. Each of these notes are senior unsecured obligations of Molina and rank equally in right of payment with all existing and future senior debt, and senior to all existing and future subordinated debt of Molina. In addition, each of the notes contain customary non- financial covenants and change of control provisions. The indentures governing the senior notes contain cross- default provisions that are triggered upon default by us or any of our subsidiaries on any indebtedness in excess of the amount specified in the applicable indenture. 4. 375 % Notes due 2028. We have $ 800 million aggregate principal amount of senior notes (the " 4. 375 % Notes ") outstanding as of December 31, 2022, which are due June 15, 2028, unless earlier redeemed. Interest, at a rate of 4. 375 % per annum, is payable semiannually in arrears on June 15 and December 15. 3. 875 % Notes due 2030. We have $ 650 million aggregate principal amount of senior notes (the " 3. 875 % Notes due 2030 ") outstanding as of December 31, 2022, which are due November 15, 2030, unless earlier redeemed. Interest, at a rate of 3. 875 % per annum, is payable semiannually in arrears on May 15 and November 15. 3. 875 % Notes due 2032. We have $ 750 million aggregate principal amount of senior notes (the " 3. 875 % Notes due 2032 ") outstanding as of December 31, 2022, which are due May 15, 2032, unless earlier redeemed. Interest, at a rate of 3. 875 % per annum, is payable semiannually in arrears on May 15 and November 15. 12. Income Taxes Income tax expense for continuing operations consisted of the following: Year Ended December 31, 202220212020 (In millions) Current: Federal $ 297 $ 209 $ 281 State40 31 26 Total current337 240 307 Deferred: Federal (66) (17) (13) State — (7) (7) Foreign — — 1 Total deferred (66) (24) (19) Income tax expense $ 271 $ 216 $ 288 A reconciliation of the U. S. federal statutory income tax rate to the combined effective income tax rate for continuing operations is as follows: Year Ended December 31, 202220212020Statutory federal tax (benefit) rate21. 0 % 21. 0 % 21. 0 % State income provision (benefit), net of federal benefit3. 0 2. 2 1. 6 Nondeductible health insurer fee (" HIF ") — — 6. 1 Nondeductible compensation1. 8 1. 5 1. 1 Other (0. 3) — 0. 2 Effective tax expense rate25. 5 % 24. 7 % 30. 0 % Molina Healthcare, Inc. 2022 Form 10- K | 74 The effective tax rate was not impacted by the HIF in 2022 and 2021 given it was repealed for years after 2020. Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, foreign, and local tax laws. Deferred tax assets and liabilities are classified as non- current. Significant components of our deferred tax assets and liabilities as of December 31, 2022 and 2021 were as follows: December 31, 20222021 (In millions) Accrued expenses and reserve liabilities $ 96 $ 57 Other accrued medical costs24 23 Net operating losses9 13 Unearned premiums16 17 Lease financing obligation40 9 Unrealized losses49 2 Fixed assets and intangibles9 — Tax credit carryover5 5 Other5 4 Valuation allowance (18) (10) Total deferred income tax assets, net of valuation allowance 235 120 Fixed assets and intangibles — (1) Prepaid expenses (15) (13) Total deferred income tax liabilities (15) (14) Net deferred income tax asset $ 220 $ 106 At December 31, 2022, we had state net operating loss carryforwards of $ 95 million, which begin

expiring in 2036. At December 31, 2022, we had foreign net operating loss carryforwards of $ 8 million, which expire in 2032. At December 31, 2022, we had foreign tax credit carryovers of $ 5 million, which expire in 2030. We evaluate the need for a valuation allowance taking into consideration the ability to carry back and carry forward tax credits and losses, available tax planning strategies and future income, including reversal of temporary differences. We have determined that as of December 31, 2022, $ 18 million of deferred tax assets did not satisfy the recognition criteria. Therefore, we increased our valuation allowance by $ 8 million, from $ 10 million at December 31, 2021, to $ 18 million as of December 31, 2022. We recognize tax benefits only if the tax position is more likely than not to be sustained. We are subject to income taxes in the United States, Puerto Rico, and numerous state jurisdictions. Significant judgment is required in evaluating our tax positions and determining our provision for income taxes. During the ordinary course of business, there are many transactions and calculations for which the ultimate tax determination is uncertain. We establish reserves for tax- related uncertainties based on estimates of whether, and the extent to which, additional taxes will be due. These reserves are established when we believe that certain positions might be challenged despite our belief that our tax return positions are fully supportable. We adjust these reserves in light of changing facts and circumstances, such as the outcome of tax audits. The provision for income taxes includes the impact of reserve provisions and changes to reserves that are considered appropriate. Molina Healthcare, Inc. 2022 Form 10- K | 75 The roll forward of our unrecognized tax benefits is as follows: Year Ended December 31, 202220212020 (In millions) Gross unrecognized tax benefits at beginning of period $ (15) $ (20) $ (20) Settlements — 5 — Lapse in statute of limitations10 — — Gross unrecognized tax benefits at end of period $ (5) $ (15) $ (20) The total amount of unrecognized tax benefits at December 31, 2022, 2021 and 2020 that, if recognized, would affect the effective tax rates is $ 5 million, $ 15 million, and $ 20 million, respectively. We expect that during the next 12 months it is reasonably possible that unrecognized tax benefit liabilities may decrease by $ 5 million due to resolution of a state refund claim. The state refund claim will not result in a cash payment for income taxes if our claim is denied. Our continuing practice is to recognize interest and / or penalties related to unrecognized tax benefits in income tax expense. Amounts accrued for the payment of interest and penalties as of December 31, 2022, 2021 and 2020 were insignificant. We may be subject to examination by the IRS for calendar years after 2018. With a few exceptions, which are immaterial in the aggregate, we no longer are subject to state, local, and Puerto Rico tax examinations for years before 2018. On August 16, 2022, the Inflation Reduction Act was signed into law. The Inflation Reduction Act includes various tax provisions, which are effective for the tax years beginning on or after January 1, 2023. We do not expect such tax provisions to have a material impact on our consolidated financial results. 13. Stockholders' Equity Stock Purchase Programs In November 2022, our board of directors authorized the purchase of up to $ 500 million, in the aggregate, of our common stock. This new program supersedes the stock purchase program previously approved by our board of directors in September 2021, as described below. This new program will be funded with cash on hand and extends through December 31, 2023. Under this program, pursuant to a Rule 10b5- 1 trading plan, we purchased approximately 590, 000 shares for $ 200 million in the fourth quarter of 2022 (average cost of $ 339. 06 per share). No shares have been purchased in 2023. In September 2021, our board of directors authorized the purchase of up to $ 500 million, in the aggregate, of our common stock. This program was funded with cash on hand. Under this program, pursuant to a Rule 10b5- 1 trading plan, we purchased approximately 658, 000 shares for $ 200 million in the second quarter of 2022 (average cost of $ 304. 13 per share). Share- Based Compensation In connection with our employee stock plans, approximately 755, 000 shares and 429, 000 shares of common stock were issued, net of shares used to settle employees' income tax obligations, during the years ended December 31, 2022, and 2021, respectively. Total share- based compensation expense is reported in " General and administrative expenses " in the accompanying consolidated statements of income, and summarized below. Year Ended December 31, 202220212020 (In millions) PretaxChargesNet- of- TaxAmountPretaxChargesNet- of- TaxAmountPretaxChargesNet- of- TaxAmountRSAs and PSUs (defined below) $ 97 $ 90 $ 66 $ 62 $ 47 $ 44 Employee stock purchase plan and stock options 6 6 6 6 10 9 Total $ 103 $ 96 $ 72 $ 68 $ 57 $ 53 Molina Healthcare, Inc. 2022 Form 10- K | 76 At December 31, 2022, we had employee equity incentives outstanding under our 2019 Equity Incentive Plan (the " 2019 EIP "). The 2019 EIP provides for awards, in the form of restricted stock awards (" RSAs "), performance units (" PSUs "), stock options, and other stock — or cash — based awards, to eligible persons who perform services for us. The 2019 EIP provides for the issuance of up to 2. 9 million shares of our common stock. Stock- based awards. RSAs and PSUs are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to four years from the date of grant. PSUs vest in their entirety at the end of three- year performance periods, if their performance conditions are met. We generally recognize expense for RSAs and PSUs on a straight- line basis. Activity for stock- based awards in the year ended December 31, 2022, is summarized below. RSAsWeightedAverageGrant DateFair ValuePSUsWeightedAverageGrant DateFair ValueUnvested balance, December 31, 2021539, 117 $ 169. 39 275, 050 $ 129. 99 Granted237, 590 312. 27 271, 270 214. 94 Vested (224, 345) 156. 21 (219, 674) 137. 54 Forfeited (41, 257) 224. 96 (13, 816) 249. 09 Unvested balance, December 31, 2022511, 105 $ 237. 10 312, 830 $ 193. 09 As of December 31, 2022, total unrecognized compensation expense related to unvested RSAs and PSUs was $ 74 million, and $ 31 million, respectively, which we expect to recognize over a remaining weighted- average period of 2. 0 years, and 0. 7 years, respectively. This unrecognized compensation cost assumes an estimated forfeiture rate of 9. 2 % for non- executive employees as of December 31, 2022, based on actual forfeitures over the last 4 years. The total grant date fair value of awards granted and vested is presented in the following table. Year Ended December 31, 202220212020 (In millions) Granted: RSAs $ 74 $ 65 $ 44 PSUs43 — 23 Total granted $ 117 $ 65 $ 67 Vested: RSAs $ 70 $ 53 $ 22 PSUs69 71 1 Total vested $ 139 $ 124 $ 23 Stock Options. Stock option awards generally have an exercise price equal to the fair market value of our common stock on the date of grant, vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant. Stock option activity for the year ended December 31, 2022, is summarized below. Number of SharesWeighted Average Exercise PriceAggregate Intrinsic ValueWeighted Average Remaining Contractual term (Per share) (In millions) (Years) Stock options outstanding as of December 31, 2021395, 000 $ 65. 59 Exercised (390, 000) 66. 01 Stock

options outstanding, vested, and exercisable as of December 31, 20225, 000 33. 02 $ 1 0. 2 No stock options were granted in 2022, 2021, or 2020, and no stock options were exercised in 2020. As of December 31, 2022, there was no unrecognized compensation expense related to unvested stock options. Molina Healthcare, Inc. 2022 Form 10- K | 77 Employee Stock Purchase Plans (" ESPP ") Under our ESPP, eligible employees may purchase common shares at 85 % of the lower of the fair market value of our common stock on either the first or last trading day of each six- month offering period. Each participant is limited to a maximum purchase of $ 25, 000 (as measured by the fair value of the stock acquired) per year through payroll deductions. We estimate the fair value of the stock issued using a standard option pricing model. For the years ended December 31, 2022, 2021, and 2020, the inputs to this model were as follows: risk- free interest rates of approximately 0. 1 % to 2. 5 %; expected volatility of approximately 29 % to 54 %, dividend yields of 0 %, and an average expected life of 0. 5 years. 14. Employee Benefit Plans We sponsor defined contribution 401 (k) plans that cover substantially all employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount allowed by law. We match up to the first 4 % of compensation contributed by employees. Expense recognized in connection with our contributions to the 401 (k) plans amounted to $ 45 million, $ 41 million, and $ 28 million in the years ended December 31, 2022, 2021, and 2020, respectively. We also have a non- qualified deferred compensation plan for certain key employees. Under this plan, eligible participants may defer portions of their base salary and bonus to provide tax- deferred growth. The deferrals are distributable based upon termination of employment or other periods, as elected under the plan and were $ 26 million and $ 23 million as of December 31, 2022 and 2021, respectively. 15. Commitments and Contingencies Our health plans, which are generally operated by our respective wholly owned subsidiaries in those states in which our health plans operate, are subject to state laws and regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. The National Association of Insurance Commissioners (" NAIC "), has adopted rules which, if implemented by the states, set minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for healthcare coverage. The requirements take the form of risk- based capital (" RBC ") rules which may vary from state to state. Regulators in some states may also enforce capital requirements that require the retention of net worth in excess of amounts formally required by statute or regulation. All of the states in which our health plans operate, except California, Florida, Massachusetts and New York, have adopted the RBC rules. The minimum statutory capital requirements in these states is based on a percentage of annualized premium revenue, a percentage of annualized health care costs, a percentage of certain liabilities, or other financial ratios. The RBC rules, if adopted by California, Florida, Massachusetts or New York, could increase the minimum capital required for those states. Our Massachusetts health plan maintains a $ 35 million performance bond, effective through December 31, 2023, to partially satisfy minimum net worth requirements in that state. Statutes, regulations and informal capital requirements also restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent our subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. Based on current statutes and regulations, the net assets in these subsidiaries, which may not be transferable to us in the form of loans, advances, or cash dividends was approximately $ 3. 1 billion at December 31, 2022. Because of the statutory restrictions that inhibit the ability of our health plans to transfer net assets to us, the amount of retained earnings readily available to pay dividends to our stockholders is generally limited to cash, cash equivalents and investments held by the parent company — Molina Healthcare, Inc. Such cash, cash equivalents and investments amounted to $ 375 million and $ 348 million as of December 31, 2022 and 2021, respectively. As of December 31, 2022, our health plans had aggregate statutory capital and surplus of approximately $ 3. 3 billion, which was in excess of the required minimum aggregate statutory capital and surplus of approximately $ 2. 3 billion. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements. Molina Healthcare, Inc. 2022 Form 10- K | 78 We continue to monitor and assess the estimated operating and financial impact of the COVID- 19 pandemic and, as it evolves, we continue to process, assemble, and assess member utilization information. We believe that our cash resources, borrowing capacity available under the Credit Agreement, and cash flow generated from operations will be sufficient to withstand the financial impact of the pandemic, and will enable us to continue to support our operations, regulatory requirements, debt repayment obligations, and capital expenditures for the foreseeable future. The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Penalties associated with violations of these laws and regulations include significant fines and penalties, exclusion from participating in publicly funded programs, and the repayment of previously billed and collected revenues. We are involved in legal actions in the ordinary course of business including, but not limited to, various employment claims, vendor disputes and provider claims. Some of these legal actions seek monetary damages, including claims for punitive damages, which may not be covered by insurance. We review legal matters and update our estimates of reasonably possible losses and related disclosures, as necessary. We have accrued liabilities for legal matters for which we deem the loss to be both probable and reasonably estimable. These liability estimates could change as a result of further developments of the matters. The outcome of legal actions is inherently uncertain. An adverse determination in one or more of these pending matters could have an adverse effect on our consolidated financial position, results of operations, or cash flows. Kentucky RFP. On September 4, 2020, Anthem Kentucky Managed Care Plan, Inc. brought an action in Franklin County Circuit Court against the Kentucky Finance and Administration Cabinet, the Kentucky Cabinet for Health and Family Services, and all of the five winning bidder health plans, including our Kentucky health plan. On September 9, 2022, the Kentucky Court of Appeals ruled that, with regard to the earlier Circuit Court ruling granting Anthem relief, the Circuit Court should not have invalidated the 2020 procurement and thus should not have awarded a contract to Anthem. Anthem has sought discretionary review by the Kentucky Supreme Court of the ruling by the Court of Appeals. Pending further Court order, our Kentucky health plan will continue to operate for the foreseeable future under its current Medicaid contract. Professional Liability Insurance We carry medical professional liability insurance for healthcare services

rendered in the primary care institutions that we manage. In addition, we carry managed care errors and omissions insurance for all managed care services that we provide. 16. Segments Molina Healthcare, Inc. 2022 Form 10- K | 79 service margin. The service margin is equal to service revenue minus cost of service revenue. We do not report total assets by segment since this is not a metric used to assess segment performance or allocate resources. The following table presents total revenue by segment. Inter- segment revenue was insignificant for all periods presented. Year Ended December 31, 202220212020 (In millions) Total revenue: Medicaid $ 25, 783 $ 21, 231 $ 15, 217 Medicare3, 824 3, 379 2, 529 Marketplace2, 296 3, 091 1, 677 Other71 70 — Consolidated $ 31, 974 $ 27, 771 $ 19, 423 The following table reconciles margin by segment to consolidated income before income tax expense: Year Ended December 31, 202220212020 (In millions) Margin: Medicaid $ 2, 981 $ 2, 322 $ 1, 804 Medicare437 430 351 Marketplace290 399 324 Other11 14 — Total margin3, 719 3, 165 2, 479 Add: other operating revenues (1) 1, 020 846 1, 124 Less: other operating expenses (2) (3, 566) (2, 991) (2, 525) Operating income1, 173 1, 020 1, 078 Less: other expenses, net110 145 117 Income before income tax expense $ 1, 063 $ 875 $ 961 (1) Other operating revenues include premium tax revenue, health insurer fees reimbursed, Marketplace risk corridor judgment, investment income and other revenue. (2) Other operating expenses include general and administrative expenses, premium tax expenses, health insurer fees, depreciation and amortization, impairment, and other costs. Molina Healthcare, Inc. 2022 Form 10- K | 80 17. Condensed Financial Information of Registrant The condensed balance sheets as of December 31, 2022 and 2021, and the related condensed statements of income, comprehensive income and cash flows for each of the three years in the period ended December 31, 2022 for our parent company Molina Healthcare, Inc. (the " Registrant "), are presented below. Condensed Balance Sheets December 31, 20222021 (In millions, except per- share data) ASSETSCurrent assets: Cash and cash equivalents $ 329 $ 274 Investments46 74 Due from affiliates143 74 Prepaid expenses and other current assets106 142 Total current assets624 564 Property, equipment, and capitalized software, net224 349 Goodwill and intangible assets, net731 699 Investments in subsidiaries4, 142 3, 772 Deferred income taxes37 (18) Advances to related parties and other assets78 68 Total assets $ 5, 836 $ 5, 434 LIABILITIES AND STOCKHOLDERS' EQUITYCurrent liabilities: Accounts payable, accrued liabilities and other $ 448 $ 378 Total current liabilities448 378 Long- term debt2, 176 2, 173 Finance lease liabilities215 219 Other long- term liabilities33 34 Total liabilities2, 872 2, 804 Stockholders' equity: Common stock, $ 0. 001 par value; 150 million shares authorized; outstanding: 58 million shares at each of December 31, 2022 and December 31, 2021 — — Preferred stock, $ 0. 001 par value; 20 million shares authorized, no shares issued and outstanding — — Additional paid- in capital328 236 Accumulated other comprehensive loss (160) (5) Retained earnings2, 796 2, 399 Total stockholders' equity2, 964 2, 630 Total liabilities and stockholders' equity $ 5, 836 $ 5, 434 Molina Healthcare, Inc. 2022 Form 10- K | 81 Condensed Statements of Income Year Ended December 31, 202220212020 (In millions) Revenue: Administrative services fees $ 1, 826 $ 1, 496 $ 1, 208 Investment income and other revenue8 11 13 Total revenue1, 834 1, 507 1, 221 Expenses: General and administrative expenses1, 721 1, 424 1, 089 Depreciation and amortization141 98 67 Impairment138 — — Other — 5 24 Total operating expenses2, 000 1, 527 1, 180 Operating (loss) income (166) (20) 41 Interest expense110 120 102 Other expenses, net — 25 15 Total other expenses, net110 145 117 Loss before income tax benefit and equity in net earnings of subsidiaries (276) (165) (76) Income tax benefit (42) (21) (5) Net loss before equity in net earnings of subsidiaries (234) (144) (71) Equity in net earnings of subsidiaries1, 026 803 744 Net income $ 792 $ 659 $ 673 Condensed Statements of Comprehensive Income Year Ended December 31, 202220212020 (In millions) Net income $ 792 $ 659 $ 673 Other comprehensive (loss) income: Unrealized investment (loss) income (204) (55) 44 Less: effect of income taxes (49) (13) 11 Other comprehensive (loss) income, net of tax (155) (42) 33 Comprehensive income $ 637 $ 617 $ 706 Molina Healthcare, Inc. 2022 Form 10- K | 82 Condensed Statements of Cash Flows Year Ended December 31, 202220212020 (In millions) Operating activities: Net cash provided by operating activities $ 119 $ 60 $ 67 Investing activities: Capital contributions to subsidiaries (159) (440) (107) Dividends received from subsidiaries668 564 635 Purchases of investments (29) (27) (188) Proceeds from sales and maturities of investments49 21 282 Purchases of property, equipment and capitalized software (86) (70) (74) Net cash paid in business combinations — (263) (1, 028) Change in amounts due to / from affiliates (69) 40 (68) Other, net3 (3) 3 Net cash provided by (used in) investing activities377 (178) (545) Financing activities: Common stock purchases (400) (128) (606) Common stock withheld to settle employee tax obligations (54) (53) (8) Contingent consideration liabilities settled (20) (20) — Proceeds from senior notes offering, net of issuance costs — 740 1, 429 Repayment of senior notes — (723) (338) Repayment of term loan facility — — (600) Proceeds from borrowings under term loan facility — — 380 Cash paid for partial termination of warrants — — (30) Cash paid for partial settlement of conversion option — — (27) Cash received for partial settlement of call option — — 27 Repayment of principal amount of convertible notes — — (12) Other, net33 1 2 Net cash (used in) provided by financing activities (441) (183) 217 Net increase (decrease) in cash and cash equivalents55 (301) (261) Cash and cash equivalents at beginning of period274 575 836 Cash and cash equivalents at end of period $ 329 $ 274 $ 575 Notes to Condensed Financial Information of Registrant Note A- Basis of Presentation The Registrant was incorporated in 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California health plan and as the parent company for three other state health plans. In June 2003, the employees and operations of the corporate entity were transferred from Molina Healthcare of California to the Registrant. The Registrant' s investment in subsidiaries is stated at cost plus equity in undistributed earnings of subsidiaries since the date of acquisition. The accompanying condensed financial information of the Registrant should be read in conjunction with the consolidated financial statements and accompanying notes. Note B- Transactions with Subsidiaries The Registrant provides certain centralized medical and administrative services to our subsidiaries pursuant to administrative services agreements that include, but are not limited to, information technology, product development Molina Healthcare, Inc. 2022 Form 10- K | 83 and administration, underwriting, claims processing, customer service, certain care management services, human resources, marketing, purchasing, risk management, actuarial, finance, accounting, compliance, legal and public relations. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the

states in which they operate. Charges in 2022, 2021, and 2020 for these services amounted to $ 1, 826 million, $ 1, 496 million, and $ 1, 208 million, respectively, and are included in operating revenue. The Registrant and its subsidiaries are included in the consolidated federal and state income tax returns filed by the Registrant. Income taxes are allocated to each subsidiary in accordance with an intercompany tax allocation agreement. The agreement allocates income taxes in an amount generally equivalent to the amount which would be expensed by the subsidiary if it filed a separate tax return. Net operating loss benefits are paid to the subsidiary by the Registrant to the extent such losses are utilized in the consolidated tax returns. Note C- Dividends and Capital Contributions When the Registrant receives dividends from its subsidiaries, such amounts are recorded as a reduction to the investments in the respective subsidiaries. For all periods presented, the Registrant made capital contributions to certain subsidiaries primarily to comply with minimum net worth requirements and to fund business combinations. Such amounts have been recorded as an increase in investment in the respective subsidiaries. Molina Healthcare, Inc. 2022 Form 10- K | 84 CONTROLS AND PROCEDURES MANAGEMENT' S EVALUATION OF DISCLOSURE CONTROLS AND PROCEDURES We maintain disclosure controls and procedures, as defined in Rule 13a- 15 (e) and Rule 15d- 15 (e) under the Securities Exchange Act of 1934, as amended (the " Exchange Act "), that are designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC' s rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to provide reasonable assurance that information required to be disclosed by us in reports we file or submit under the Exchange Act is accumulated and communicated to our management, including our principal executive officer and principal financial officer or persons performing similar functions, as appropriate, to allow timely decisions regarding required disclosure. In designing and evaluating the disclosure controls and procedures, management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, and management is required to apply its judgment in evaluating the cost- benefit relationship of any possible controls and procedures. Under the supervision and with the participation of our management, including our chief executive officer and our chief financial officer, we carried out an evaluation of the effectiveness of our disclosure controls and procedures as of the end of the period covered by this Form 10- K pursuant to Rule 13a- 15 (b) and Rule 15d- 15 (b) of the Exchange Act. Based on this evaluation, our chief executive officer and our chief financial officer concluded that our disclosure controls and procedures were effective as of December 31, 2022, at the reasonable assurance level. In addition, management concluded that our consolidated financial statements included in this Annual Report on Form 10- K are fairly stated in all material respects in accordance with U. S. generally accepted accounting principles (" GAAP ") for each of the periods presented herein. MANAGEMENT' S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING Management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a- 15 (f) under the Exchange Act. Our internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are being made only in accordance with authorizations of our management and directors; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on our financial statements. Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements prepared for external purposes in accordance with GAAP. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of the effectiveness of our internal control over financial reporting to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate. Management concluded that we maintained effective internal control over financial reporting as of December 31, 2022, based on criteria described in Internal Control- Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (" COSO "). Ernst & Young, LLP, the independent registered public accounting firm who audited our Consolidated Financial Statements included in this Form 10- K, has issued a report on our internal control over financial reporting, which is included herein. Changes in Internal Control over Financial Reporting There were no changes in our internal control over financial reporting (as defined in Rule 13a- 15 (f) of the Exchange Act) during the quarter ended December 31, 2022 , that have materially affected , or are reasonably likely to materially affect **us** , **including** our internal control over financial reporting. Molina Healthcare, Inc. 2022 Form 10- K | 85 REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM To the Stockholders and the Board of Directors of Molina Healthcare, Inc. Opinion on Internal Control Over Financial Reporting We have audited Molina Healthcare, Inc.' s internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control- Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the " COSO criteria "). In our opinion, Molina Healthcare, Inc. (the " Company ") maintained, in all material respects, effective internal control over financial reporting as of December 31, 2022, based on the COSO criteria. We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (" PCAOB "), the consolidated balance sheets of the Company as of December 31, 2022 and 2021, the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes and our report dated February 13, 2023, expressed an unqualified opinion thereon. Basis for Opinion The Company' s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management' s Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company' s internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent

with respect to the Company in accordance with the U. S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB. We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating **operations** effectiveness of internal control based on the assessed risk , **business strategy** and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion. Definition and Limitations of Internal Control Over Financial Reporting A company' s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company' s internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that , in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company' s assets that could have a material effect on the financial statements. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate. / s / Ernst & Young LLP Los Angeles, California February 13, 2023 Molina Healthcare, Inc. 2022 Form 10- K | 86 Opinion on the Financial Statements We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the " Company ") as of December 31, 2022 and 2021, the related consolidated statements of income, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2022, and the related notes (collectively referred to as the " consolidated financial statements "). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2022 and 2021, and the results of its operations **,** and its cash flows for **or** each of the three years in the period ended December 31, 2022, in conformity with U. S. generally accepted accounting principles. We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (" PCAOB "), the Company' s internal control over financial reporting as of December 31, 2022, based on criteria established in Internal Control- Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework), and our report dated February 13, 2023, expressed an unqualified opinion thereon. These financial statements are the responsibility of the Company ' s management. Our responsibility is to express an opinion on the Company ' s financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U. S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB. We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion. Critical Audit Matter The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates. Incurred but not paid (IBNP) claims reversesDescription of the matterAs of December 31, 2022, the Company' s liability for fee- for- service claims incurred but not paid (" IBNP "), comprised $ 2, 597 million of the $ 3, 528 million of Medical Claims and Benefits Payable. The Company' s IBNP liability is determined using actuarial methods that include a number of factors and assumptions, including completion factors, which seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns, and assumed health care cost trend factors, which represent an estimate of claims expense based on recent claims expense levels and healthcare cost levels. There is significant uncertainty inherent in determining management' s best estimate of completion and trend factors, which are used to calculate actuarial estimates of incurred but not paid claims. Molina Healthcare, Inc. 2022 Form 10- K | 87 How we addressed the matter in our auditWe obtained an understanding, evaluated the design, and tested the operating effectiveness of the Company' s controls over the process for estimating the IBNP liability. This included testing management review controls over completion and trend factor assumptions, and management' s review and approval of actuarial methods used to calculate IBNP liability, including the data inputs and outputs of those models. To test IBNP liability, our audit procedures included, among others, testing the completeness and accuracy of data used in the calculation by testing reconciliations of underlying claims and membership data recorded in source systems to the actuarial reserving calculations, and comparing a sample of claims to source documentation. With the assistance of EY actuarial specialists, we evaluated the Company' s selection and weighting of actuarial methods by comparing the weightings used in the current estimate to those used in prior periods and those used in the

industry for the specific types of insurance. To evaluate significant assumptions used by management in the actuarial methods, we compared assumptions to current and historical claims trends, to those used historically and to current industry benchmarks. We also compared management' s recorded IBNP liability to a range of reasonable IBNP estimates calculated independently by our EY actuarial specialists. Additionally, we performed a review of the prior period estimates using subsequent claims development, and we reviewed and evaluated management' s disclosures surrounding fee- for- service claims IBNP. We have served as the Company' s auditor since 2000. Molina Healthcare, Inc. 2022 Form 10- K | 88 OTHER INFORMATION None. DIRECTORS, EXECUTIVE OFFICERS, AND CORPORATE GOVERNANCE Information required by Item 10 of Part III will be included in our Proxy Statement relating to our 2023 Annual Meeting of Stockholders (the " 2023 Proxy Statement "), and is incorporated herein by reference. This information will be included in the following sections of the 2023 Proxy Statement: • PROPOSAL 1- Election of Directors • Information About Director Nominees • Information About Directors Continuing in Office • Additional Information About Directors • Corporate Governance and Board of Directors Matters • Information About the Executive Officers of the Company • Section 16 (a) Beneficial Ownership Reporting Compliance Information relating to our Code of Business Conduct and Ethics and compliance with Section 16 (a) of the Exchange Act will be set forth in the 2023 Proxy Statement and is incorporated herein by reference. To the extent permissible under NYSE rules, we intend to disclose amendments to our Code of Business Conduct and Ethics, as well as waivers of the provisions thereof, on our investor relations website under the heading " Investor Information — Corporate Governance " at molinahealthcare. com. EXECUTIVE COMPENSATION Information required by Item 11 of Part III will be included in the 2023 Proxy Statement in the section entitled " Executive Compensation, " and is incorporated herein by reference. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED SHAREHOLDER MATTERS Information required by Item 12 of Part III will be included in the 2023 Proxy Statement in the section entitled " Security Ownership of Certain Beneficial Owners and Management, " and is incorporated herein by reference. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE Information required by Item 13 of Part III will be included in the 2023 Proxy Statement in the sections entitled " Related Party Transactions, " and " Corporate Governance and Board of Directors Matters — Director Independence, " and is incorporated herein by reference. PRINCIPAL ACCOUNTANT FEES AND SERVICES Our independent registered public accounting firm is Ernst & Young LLP, Los Angeles, CA, Auditor Firm ID: 42. Information required by Item 14 of Part III will be included in the 2023 Proxy Statement in the section entitled " Fees Paid to Independent Registered Public Accounting Firm, " and is incorporated herein by reference. Molina Healthcare, Inc. 2022 Form 10- K | 89 EXHIBITS AND FINANCIAL STATEMENT SCHEDULES FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA (1) The consolidated financial statements are included in this report in the section entitled " Financial Statements and Supplementary Data. " (2) Financial Statement Schedules: Schedules for which provision is made in the applicable accounting regulations of the SEC are not required under the related instructions, are inapplicable, or the required information is included in the consolidated financial statements, and therefore have been omitted. Reference is made to the accompanying " Index to Exhibits. " Molina Healthcare, Inc. 2022 Form 10- K | 90 SIGNATURES Pursuant to the requirements of Section 13 or 15 (d) of the Securities Exchange Act of 1934, the undersigned registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized, on the 13th day of February, 2023. MOLINA HEALTHCARE, INC. By: / s / Joseph M. ZubretskyJoseph M. ZubretskyChief Executive Officer (Principal Executive Officer) Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 13, 2023. SignatureTitle / s / Joseph M. ZubretskyChief Executive Officer, President and DirectorJoseph M. Zubretsky (Principal Executive Officer) / s / Mark L. KeimChief Financial OfficerMark L. Keim (Principal Financial Officer) / s / Maurice S. HebertChief Accounting OfficerMaurice S. Hebert (Principal Accounting Officer) / s / Barbara L. BrasierDirectorBarbara L. Brasier / s / Daniel CoopermanDirectorDaniel Cooperman / s / Stephen H. LockhartDirectorStephen H. Lockhart / s / Steven J. OrlandoDirectorSteven J. Orlando / s / Ronna E. RomneyDirectorRonna E. Romney / s / Richard M. SchapiroDirectorRichard M. Schapiro / s / Dale B. WolfChairman of the BoardDale B. Wolf / s / Richard C. ZoreticDirectorRichard C. Zoretic Molina Healthcare, Inc. 2022 Form 10- K | 91 INDEX TO EXHIBITS The following exhibits, which are furnished with this Annual Report on Form 10- K (this " Form 10- K ") or incorporated herein by reference, are filed as part of this annual report. The agreements included or incorporated by reference as exhibits to this Form 10- K may contain representations and warranties by each of the parties to the applicable agreement. These representations and warranties were made solely for the benefit of the other parties to the applicable agreement and (i) were not intended to be treated as categorical statements of fact, but rather as a way of allocating the risk to one of the parties if those statements prove to be inaccurate; (ii) may have been qualified in such agreement by disclosures that were made to the other party in connection with the negotiation of the applicable agreement; (iii) may apply contract standards of " materiality " that are different from " materiality " under the applicable securities laws; and (iv) were made only as of the date of the applicable agreement or such other date or dates as may be specified in the agreement. The Company acknowledges that, notwithstanding the inclusion of the foregoing cautionary statements, it is responsible for considering whether additional specific disclosures of material information regarding material contractual provisions are required to make the statements in this Form 10- K not misleading. NumberDescriptionMethod of Filing3. 1Certificate of IncorporationFiled as Exhibit 3. 2 to registrant' s Registration Statement on Form S- 1 filed December 30, 20023. 2Certificate of Amendment to Certificate of IncorporationFiled as Appendix A to registrant' s Definitive Proxy Statement on Form DEF 14A filed March 25, 20133. 3Certificate of Amendment to Certificate of IncorporationFiled as Appendix A to registrant' s Definitive Proxy Statement on Form DEF 14A filed March 25, 20193. 4Sixth Amended and Restated Bylaws of Molina Healthcare, Inc. Filed as Exhibit 3. 3 to registrant' s Form 10- K filed February 19, 20194. 1Indenture, dated as of June 2, 2020, by and between Molina Healthcare, Inc. and U. S. Bank National Association, as TrusteeFiled as Exhibit 4. 1 to registrant' s Form 8- K filed June 2, 20204. 2Form of 4. 375 % Notes (included in Exhibit 4. 1). Filed as Exhibit 4. 2 to registrant' s Form 8- K filed June 2,

2020 (Included in Exhibit 4. 1 to registrant' s Form 8- K filed June 2, 2020) 4. 3Indenture, dated as of November 17, 2020, by and between Molina Healthcare, Inc. and U. S. Bank National Association, as TrusteeFiled as Exhibit 4. 1 to registrant' s Form 8- K filed November 17, 20204. 4Form of 3. 875 % Notes due 2030 (included in Exhibit 4. 3) Filed as Exhibit 4. 2 to registrant' s Form 8- K filed November 17, 2020 (Included in Exhibit 4. 1 to registrant' s Form 8- K filed November 17, 2020) 4. 5Indenture, dated as of November 16, 2021, by and between Molina Healthcare, Inc. and U. S. Bank National Association, as TrusteeFiled as Exhibit 4. 1 to registrant' s Form 8- K filed November 16, 20214. 6Form of 3. 875 % Notes due 2032 (included in Exhibit 4. 5) Filed as Exhibit 4. 2 to registrant' s Form 8- K filed November 16, 2021 (Included in Exhibit 4. 1 to registrant' s Form 8- K filed November 16, 2021) 4. 7Description of Registrant' s SecuritiesFiled as Exhibit 4. 9 to registrant' s Form 10- K filed February 16, 202110. 1Credit Agreement, dated as of June 8, 2020, by and among Molina Healthcare, Inc., as the Borrower, Truist Bank, as Administrative Agent, Issuing Bank and Swingline Lender, and the Lenders party theretoFiled as Exhibit 10. 1 to registrant' s Form 8- K filed June 8, 2020 * 10. 22019 Employee Stock Purchase PlanFiled as Appendix C to registrant' s Definitive Proxy Statement on Form DEF 14A filed March 25, 2019 * 10. 3Molina Healthcare, Inc. 2019 Equity Incentive PlanFiled as Appendix B to registrant' s Definitive Proxy Statement on Form DEF 14A filed March 25, 2019 * 10. 42019 Equity Incentive Plan- Form of Restricted Stock Award Agreement (Employee / Officer with No Employment Agreement) Filed as Exhibit 10. 1 to registrant' s Form 10- Q filed July 31, 2019 Molina Healthcare, Inc. 2022 Form 10- K | 92 NumberDescriptionMethod of Filing * 10. 52019 Equity Incentive Plan- Form of Performance Stock Unit Award Agreement (Employee / Officer with No Employment Agreement) Filed as Exhibit 10. 2 to registrant' s Form 10- Q filed July 31, 2019 * 10. 62019 Equity Incentive Plan- Form of Restricted Stock Award Agreement (Officer with Employment Agreement) Filed as Exhibit 10. 3 to registrant' s Form 10- Q filed July 31, 2019 * 10. 72019 Equity Incentive Plan- Form of Performance Stock Unit Award Agreement (Officer with Employment Agreement) Filed as Exhibit 10. 4 to registrant' s Form 10- Q filed July 31, 2019 * 10. 8Molina Healthcare, Inc. Second Amended and Restated Change in Control Severance PlanFiled as Exhibit 10. 14 to registrant' s Form 10- K filed February 16, 2021 * 10. 9Form of Indemnification AgreementFiled as Exhibit 10. 14 to registrant' s Form 10- K filed March 14, 2007 * 10. 10Molina Healthcare, Inc. Amended and Restated Deferred Compensation Plan (2022) Filed as Exhibit 10. 10 to registrant' s Form 10- K filed February 14, 2022 * 10. 11Employment Agreement with Jeff Barlow dated June 14, 2013Filed as Exhibit 10. 3 to registrant' s Form 8- K filed June 14, 2013 * 10. 12Change in Control Agreement with Jeff D. Barlow, dated as of September 18, 2012Filed as Exhibit 10. 16 to registrant' s Form 10- K filed February 28, 2013 * 10. 13Amended and Restated Employment Agreement, dated September 8, 2021, by and between Molina Healthcare, Inc. and Joseph M. ZubretskyFiled as Exhibit 10. 1 to registrant' s Form 8- K filed September 9, 2021 * 10. 14Amendment of Employment Agreement, dated February 16, 2022, by and between Molina Healthcare, Inc. and Joseph M. ZubretskyFiled as Exhibit 10. 1 to registrant' s Form 8- K filed February 16, 2022 10. 15Master Services Agreement for Information Technology Services, dated February 4, 2019, by and between Molina Healthcare, Inc. and Infosys LimitedFiled as Exhibit 10. 36 to registrant' s Form 10- K filed February 19, 201910. 16First Amendment, dated August 1, 2019, to the Master Services Agreement for Information Technology Services, dated February 4, 2019, by and between Molina Healthcare, Inc. and Infosys LimitedFiled as Exhibit 10. 1 to registrant' s Form 10- Q filed October 30, 2019 10. 17Change Request # 7 to the Master Services Agreement dated February 2, 2019, by and between Molina Healthcare, Inc. and Infosys LimitedFiled as Exhibit 10. 1 to registrant' s Form 10- Q filed October 27, 202221. 1List of SubsidiariesFiled herewith23. 1Consent of Independent Registered Public Accounting FirmFiled herewith31. 1Section 302 Certification of Chief Executive OfficerFiled herewith31. 2Section 302 Certification of Chief Financial OfficerFiled herewith32. 1Certificate of Chief Executive Officer pursuant to 18 U. S. C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes- Oxley Act of 2002Filed herewith32. 2Certificate of Chief Financial Officer pursuant to 18 U. S. C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes- Oxley Act of 2002Filed herewith101. INSInline XBRL Taxonomy Instance Document- the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the inline XBRL document. Filed herewith101. SCHInline XBRL Taxonomy Extension Schema DocumentFiled herewith101. CALInline XBRL Taxonomy Extension Calculation Linkbase DocumentFiled herewith101. DEFInline XBRL Taxonomy Extension Definition Linkbase DocumentFiled herewith101. LABInline XBRL Taxonomy Extension Label Linkbase DocumentFiled herewith101. PREInline XBRL Taxonomy Extension Presentation Linkbase DocumentFiled herewith104Cover Page Interactive Data file (formatted as Inline XBRL and embedded within Exhibit 101) Filed herewith Molina Healthcare, Inc. 2022 Form 10- K | 93 * Management contract or compensatory plan or arrangement required to be filed (and / or incorporated by reference) as an exhibit to this Annual Report on Form 10- K pursuant to Item 15 (b) of Form 10- K. * * Certain portions of this agreement have been omitted in accordance with Item 601 (b) (10) of Regulation S- K. A copy of any omitted portion will be furnished to the Securities and Exchange Commission upon request. Portions of this exhibit have been omitted pursuant to a request for confidential treatment filed with the Securities and Exchange Commission under Rule 24b- 2. The omitted confidential material has been filed separately. The location of the redacted confidential information is indicated in the exhibit as " [redacted] ". Molina Healthcare, Inc. 2022 Form 10- K | 94 EXHIBIT 21. 1 LIST OF SUBSIDIARIES NameJurisdiction of Incorporation2028 West Broadway, LLCDelawareMHAZ, Inc. * ArizonaMolina Healthcare Data Center, LLCNew MexicoMolina Healthcare of Arizona, Inc. ArizonaMolina Healthcare of CaliforniaCaliforniaMolina Healthcare of Florida, Inc. FloridaMolina Healthcare of Georgia, Inc. * GeorgiaMolina Healthcare of Illinois, Inc. IllinoisMolina Healthcare of Indiana, Inc. * IndianaMolina Healthcare of Iowa, Inc. * IowaMolina Healthcare of Kentucky, Inc. KentuckyMolina Healthcare of Louisiana, Inc. * LouisianaMolina Healthcare of Michigan, Inc. MichiganMolina Healthcare of Mississippi, Inc. MississippiMolina Healthcare of Nebraska, Inc. * NebraskaMolina Healthcare of Nevada, Inc. NevadaMolina Healthcare of New Mexico, Inc. New MexicoMolina Healthcare of New York, Inc. New YorkMolina Healthcare of Ohio, Inc. OhioMolina Healthcare of Oklahoma, Inc. * Oklahoma Molina Healthcare of Pennsylvania, Inc. * PennsylvaniaMolina Healthcare of Puerto Rico, Inc. Puerto Rico / NevadaMolina Healthcare of Rhode Island Holding Company, Inc. DelawareMolina Healthcare of Rhode Island, Inc. * Rhode IslandMolina Healthcare of

South Carolina, Inc. South CarolinaMolina Healthcare of Tennessee, Inc. * TennesseeMolina Healthcare of Texas, Inc. TexasMolina Healthcare of Texas Insurance CompanyTexasMolina Healthcare of Utah, Inc. UtahMolina Healthcare of Virginia, LLCVirginiaMolina Healthcare of Washington, Inc. WashingtonMolina Healthcare of Wisconsin, Inc. WisconsinMolina Healthcare of Wisconsin CMO, Inc. * WisconsinMolina Clinical Services, LLCDelawareMolina Care Connections, LLCTexasOccangate Reinsurance, Inc. UtahSWH Holdings, Inc. DelawareSenior Health Holdings, LLC DelawareSenior Health Holdings, Inc. DelawareAlphaCare Holdings, Inc. DelawareSenior Whole Health of New York, Inc. New YorkSenior Whole Health, LLC DelawareThe Management Group, LLCWisconsin * Non- operational entity Wholly owned subsidiary of Molina Healthcare of Rhode Island Holding Company, Inc. Wholly owned subsidiary of SWH Holdings, Inc. Wholly owned subsidiary of Senior Health Holdings, LLC Wholly owned subsidiary of Senior Health Holdings, Inc. Wholly owned subsidiary of AlphaCare Holdings, Inc. EXHIBIT 23. 1 CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM We consent to the incorporation by reference in the Registration Statement (Form S- 8 No. 333- 231385) pertaining to the Molina Healthcare, Inc. 2019 Equity Incentive Plan and 2019 Employee Stock Purchase Plan of our reports dated February 13, 2023, with respect to the consolidated financial statements of Molina Healthcare, Inc., and to the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in this Annual Report (Form 10- K) for the year ended December 31, 2022. / s / ERNST & YOUNG LLP Los Angeles, California EXHIBIT 31. 1 CERTIFICATION PURSUANT TO RULES 13a- 14 (a) / 15d- 14 (a) UNDER THE SECURITIES EXCHANGE ACT OF 1934, AS AMENDED I, Joseph M. Zubretsky, certify that: 1. I have reviewed the report on Form 10- Q for the period ended December 31, 2022, of Molina Healthcare, Inc.; 2. Based on my knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by the report; 3. Based on my knowledge, the financial statements, and other financial information included in the report, fairly present in all material respects the financial condition , results of operations and cash flows of the registrant as of, and for, the periods presented in the report; 4 . **Item** The registrant' s other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a- 15 (e) and 15d- 15 (e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a- 15 (f) and 15d- 15 (f) of the Securities Exchange Act of 1934, as amended), for the registrant and have: (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared; (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles; (c) Evaluated the effectiveness of the registrant' s disclosure controls and procedures and presented in the report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by the report based on such evaluation; and (d) Disclosed in the report any change in the registrant' s internal control over financial reporting that occurred during the registrant' s most recent fiscal quarter (the registrant' s fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant' s internal control over financial reporting; and 5. The registrant' s other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant' s auditors and to the audit committee of the registrant' s board of directors (or persons performing the equivalent functions): (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant' s ability to record, process, summarize and report financial information; and (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant' s internal control over financial reporting. Dated: February 13, 2023 / s / Joseph M. Zubretsky Joseph M. Zubretsky Chief Executive Officer, President and Director EXHIBIT 31. 2 I, Mark L . **PROPERTIES** Keim, certify that: 4. The registrant' s other certifying officers and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Rule 13a- 15 (e) and 15d- 15 (e) of the Securities Exchange Act of 1934, as amended), and internal control over financial reporting (as defined in Rules 13a- 15 (f) and 15d- 15 (f) of the Securities Exchange Act of 1934, as amended), for the registrant and have: 5. The registrant' s other certifying officers and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant' s auditors and to the audit committee of the registrant' s board of directors (or persons performing the equivalent functions): Dated: February 13, 2023 / s / Mark L. Keim Mark L. Keim Chief Financial Officer and Treasurer EXHIBIT 32. 1 CERTIFICATE PURSUANT TO 18 U. S. C. SECTION 1350, AS ADOPTED PURSUANT TO SECTION 906 OF THE SARBANES- OXLEY ACT OF 2002 In connection with the report of Molina Healthcare, Inc. (the " Company ") on Form 10- Q for the period ended December 31, 2022 (the " Report "), I, Joseph M. Zubretsky, Chief Executive Officer of the Company, certify, pursuant to 18 U. S. C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes- Oxley Act of 2002, that: (1) The Report fully complies with the requirements of Section 13 (a) or 15 (d) of the Securities Exchange Act of 1934, as amended; and (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company. Dated: February 13, 2023 / s / Joseph M. ZubretskyJoseph M. ZubretskyChief Executive Officer, President and Director EXHIBIT 32. 2 In connection with the report of Molina Healthcare, Inc. (the " Company ") on Form 10- Q for the period ended December 31, 2022 (the " Report "), I, Mark L. Keim, Chief Financial Officer of the Company, certify, pursuant to 18 U. S. C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes- Oxley Act of 2002, that: