TRIPLE-S MANAGEMENT CORP
Form 10-K
March 18, 2009

Table of Contents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2008

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from _____ to _____

COMMISSION FILE NUMBER 001-33865
Triple-S Management Corporation

Puerto Rico	**66-0555678**
(STATE OF INCORPORATION)	**(I.R.S. ID)**

1441 F.D. Roosevelt Avenue, San Juan, PR 00920
(787) 749-4949
Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Name of each exchange on which registered**
Class B common stock, $1.00 par value	New York Stock Exchange

Securities registered pursuant to Section 12(g) of the Act: Class A common stock, $1.00 par value

Indicate by check mark if the registrant is well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
o YES þ NO

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
o YES þ NO

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

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

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

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

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).
o YES þ NO

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are

affiliates) as of June 30, 2008 was approximately $263,095,550 for the Class B common stock (the only one that trade in the public market) and $15,928,809 for the Class A common stock (value at par value of $1.00 since it is not a publicly traded stock).

As of February 28, 2009, the registrant had 9,042,809 of its Class A common stock outstanding and 21,069,773 of is Class B common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive Proxy Statement to be delivered to shareholders in connection with the Annual Meeting of Shareholders to be held April 26, 2009 are incorporated by reference into Parts II and III of this Annual Report on Form 10-K.

Triple-S Management Corporation
FORM 10-K
For The Fiscal Year Ended December 31, 2008
INDEX

Table of Contents

Part I

Item 1. Business.

General Description of Business and Recent Developments

Triple-S Management Corporation (Triple-S , TSM , the Company , the Corporation , we , us or our) is the la managed care company in Puerto Rico, serving approximately one million members across all regions, and holds a leading market position covering approximately 30% of the population. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico and 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial, Medicare and Puerto Rico Health Reform (similar to Medicaid) (the Reform) markets.

We serve a full range of customer segments, from corporate accounts, federal and local government employees and individuals to Medicare recipients and Reform enrollees, with a wide range of managed care products. We market our managed care products through both an extensive network of independent agents and brokers located throughout Puerto Rico as well as an internal salaried sales force.

We also offer complementary products and services, including life insurance, accident and disability insurance and property and casualty insurance. We are a leading provider of life insurance policies in Puerto Rico.

A substantial amount of the premiums generated by our insurance subsidiaries are from customers within Puerto Rico. In addition, all of our long-lived assets, other than financial instruments, including the deferred policy acquisition costs and value of business acquired and the deferred tax assets, are located within Puerto Rico.

On December 4, 2008, we announced the signing of a non-binding letter of intent to acquire certain managed care assets of La Cruz Azul de Puerto Rico, Inc. In addition, we have requested the Blue Cross Blue Shield Association (BCBSA) to transfer to us and our managed care subsidiary the licensing rights to the Blue Cross brand in Puerto Rico and the Blue Cross Blue Shield brands in the U.S. Virgin Islands. The terms of the proposed acquisition are not yet finalized and are subject to change. The completion of the transaction is subject to a number of customary conditions including final due diligence, approvals from the Insurance Commissioner of Puerto Rico and the BCBSA, and the negotiation of definitive documentation. The Company intends to fund the acquisition with cash and expects to complete the acquisition by the second quarter of 2009.

On December 8, 2008, we announced the conversion of seven million issued and outstanding Class A shares into Class B shares effective immediately, in conjunction with the expiration of the lockup agreements signed by holders of Class A shares at the time of the Company s initial public offering. We also announced the immediate commencement of our $40 million share repurchase program, which will use available cash and was authorized by the Board of Directors in late October 2008. The share repurchase program will be conducted through open-market purchases and privately-negotiated transactions of Class B shares only, in accordance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended.

Effective February 16, 2009, Triple-S, Inc. (TSI), a manage care organization and Seguros Triple-S, Inc. (STS) , which is engaged in the underwriting of property and casualty insurance policies, change their name to Triple-S Salud, Inc. and Triple-S Propiedad, Inc., respectively.

In this Annual Report on Form 10-K, references to shares or common stock refer collectively to our Class A and Class B common stock, unless the context indicates otherwise. All share and per share amounts in this Annual Report on Form 10-K have been restated to reflect the 3,000-for-one common stock split effected by us on May 1, 2007.

Table of Contents

Industry Overview

Managed Care

In response to an increasing focus on health care costs by employers, the government and consumers, there has been a growth in alternatives to traditional indemnity health insurance, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). Through the introduction of these alternatives the managed care industry attempted to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver health care to plan members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of certain outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the medical system. In addition, providers may have incentives to achieve certain quality measures or may share medical cost risk. Members or their employers generally pay co-payments, coinsurance and deductibles when enrollees receive services. While the distinctions between the various types of plans have lessened over recent years, PPO products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization. An HMO plan may also require members to select one of the network primary care physicians to coordinate their care and approve any specialist or other services. The federal government provides hospital and medical insurance benefits to eligible persons aged 65 and over as well as to certain other qualified persons through the Medicare program, including the Medicare Advantage program. The federal government also offers prescription drug benefits to Medicare eligibles, both as part of the Medicare Advantage program and on a stand-alone basis, pursuant to Medicare Part D (also referred to as PDP stand-alone product). In addition, the government of the Commonwealth of Puerto Rico (the government of Puerto Rico) provides managed care coverage to the medically indigent population of Puerto Rico through the Reform program.

Recently, economic factors and greater consumer awareness have resulted in the increasing popularity of products that offer larger; more extensive networks, more member choice related to coverage, physicians and hospitals; greater access to preventive care and wellness programs; and a desire for greater flexibility for customers to assume larger deductibles and co-payments in return for lower premiums. We believe we are well-positioned to respond to these market preferences due to the breadth and flexibility of our product offering and size of our provider networks.

The BCBSA had 39 independent licensees as of December 31, 2008. We are licensed by BCBSA to use the Blue Shield name and mark in Puerto Rico. Most of the BCBSA licensees (known as BCBS plans or Member Plans) have the right to use the Blue Shield and Blue Cross names and marks in their designated geographic territories. We are not licensed to use the Blue Cross name and mark in Puerto Rico. La Cruz Azul de Puerto Rico has the right to use the Blue Cross mark in Puerto Rico**.** However, in December 2008, as part of our pending transaction with La Cruz Azul de Puerto Rico, Inc. we have asked the BCBSA to transfer to us and our managed care subsidiary the license for the Blue Cross name and mark in Puerto Rico, as well as the rights to use the Blue Shield and Blue Cross names and marks in the U.S. Virgin Islands. The number of members enrolled in Blue Cross Blue Shield (BCBS) plans has been steadily increasing, from 65.2 million in 1994 to 101.9 million at December 31, 2008, which represents 33.3% of the U.S. population. The BCBS plans work cooperatively in a number of ways that create significant market advantages, especially when competing for very large, multi-state employer groups. For example, all BCBS plans participate in the BlueCard program, which effectively creates a national Blue network. Each plan is able to take advantage of other BCBS plans broad provider networks and negotiated provider reimbursement rates where a member covered by a policy in one state or territory lives or travels outside of the state or territory in which the policy under which he or she is covered is written. The BlueCard program is a source of revenue for providing member services in Puerto Rico for individuals who are customers of other BCBS plans and at the same time provide us a significant network in the U.S. BlueCard also provides a significant competitive advantage to us because Puerto Ricans frequently travel to the continental United States.

Table of Contents

Life Insurance

Total annual premiums in Puerto Rico in 2007 for the life insurance market approximate $925 million. The main products in the market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are through independent agents. In recent years banks have established general agencies to cross sell many life products, such as term life and credit life.

Property and Casualty Insurance Segment

The total property and casualty market in Puerto Rico in terms of gross premiums written for 2007 was approximately $2.2 billion. Property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi peril, fire and allied lines and other general liabilities. Approximately 64% of the market is written by the top six companies in terms of market share, and approximately 82% of the market is written by companies incorporated under the laws of, and which operate principally in, Puerto Rico.

It is estimated that the Puerto Rican property and casualty insurance market has between $80 billion and $90 billion of insured value, while the industry has capital and surplus of approximately $1.5 billion. As a result, the market is highly dependent on reinsurance and some local carriers have diversified their operations outside Puerto Rico.

Puerto Rico s Economy

The economy of Puerto Rico is closely linked to that of the mainland United States, as most of the external factors that affect the Puerto Rico economy (other than the price of oil) are determined by the policies and results of the United States. These external factors include exports, direct investment, the amount of federal transfer payments, the level of interest rates, the rate of inflation, and tourist expenditures. During the fiscal year ended June 30, 2008, approximately 75% of Puerto Rico s exports went to the United States mainland, which was also the source of approximately 52% of Puerto Rico s imports. In the past, the economy of Puerto Rico has generally followed economic trends in the overall United States economy. However, in recent years economic growth in Puerto Rico has lagged behind growth in the United States.

The dominant sectors of the Puerto Rico economy in terms of production and income are manufacturing and services. The manufacturing sector has undergone fundamental changes over the years as a result of increased emphasis on higher wage, high technology industries, such as pharmaceuticals, biotechnology, computers, microprocessors, professional and scientific instruments, and certain high technology machinery and equipment. The services sector, including finance, insurance, real estate, wholesale and retail trade, and tourism, also plays a major role in the economy. It ranks second to manufacturing in contribution to the gross domestic product and leads all sectors in providing employment.

Preliminary figures for fiscal year 2008 show that gross national product increased from $58.6 billion (in current dollars) for fiscal 2007 to $60.8 billion (in current dollars) for fiscal 2008. Real gross national product, however, is projected to decline by 3.4% for fiscal year 2009. Personal income, both aggregate and per capita, has increased consistently each fiscal year from 1985 to 2008. In fiscal year 2008, aggregate personal income was $56.2 billion and personal income per capita was $14.2. Average total employment decreased from 1,263,000 in fiscal 2007 to 1,218,000 for fiscal 2008. The average unemployment rate increased from 10.4% in fiscal 2007 to 11.0% in fiscal 2008.

Future growth in the Puerto Rico economy will depend on several factors including the condition of the United States economy, the relative stability in the price of oil imports, the exchange value of the United States dollar, the level of interest rates and changes to existing tax incentive legislation. The major factors affecting the economy at this point are, among others, the high oil prices, the slowdown of economic activity in the U.S., the continuing economic uncertainty generated by the fiscal crisis affecting the government of Puerto Rico and the effects on economic activity of the implementation of a new sales tax that entered into effect on November 14, 2006. See Item 1A Risk Factors Risks Relating to Our Business The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region .

On March 12, 2009, the Government of Puerto Rico approved various temporary revenue raising measures, including a modification to the alternative minimum tax on corporations to limit deductions for expenses incurred outside Puerto Rico and a 5% surcharge on corporations, including insurance companies. These modifications and additional taxes

will apply for tax years beginning after December 31, 2008 and before January 1, 2012.

Table of Contents

Products and Services

Managed Care

We offer a broad range of managed care products, including HMOs, PPOs, Medicare Supplement, Medicare Advantage and Medicare Part D. Managed care products represented 89.2%, 87.7% and 88.6% of our consolidated premiums earned, net for the years ended December 31, 2008, 2007 and 2006. We design our products to meet the needs and objectives of a wide range of customers, including employers, individuals and government entities. Our customers either contract with us to assume underwriting risk or self-funded underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members access to providers is subject to referral or preauthorization requirements.

Managed care generally refers to a method of integrating the financing and delivery of health care within a system that manages the cost, accessibility and quality of care. Managed care products can be further differentiated by the types of provider networks offered, the ability to use providers outside such networks and the scope of the medical management and quality assurance programs. Our members receive medical care from our networks of providers in exchange for premiums paid by the individuals or their employers (or a government entity in case of the Medicare Advantage or Reform plan) and, in some instances, a cost-sharing payment between the employer and the member. We reimburse network providers according to pre-established fee arrangements and other contractual agreements.

We currently offer the following managed care plans:

Health Maintenance Organization (HMO). We offer HMO plans that provide our Reform and Medicare Advantage members with health care coverage for a fixed monthly premium in addition to applicable member co-payments. Health care services can include emergency care, inpatient hospital and physician care, outpatient medical services and supplemental services, such as dental, vision, behavioral and prescription drugs, among others. Members must select a primary care physician within the network to provide and assist in managing care, including referrals to specialists.

Preferred Provider Organization (PPO). We offer PPO managed care plans that provide our commercial and Medicare Advantage members and their dependent family members with health care coverage in exchange for a fixed monthly premium from our member or the member s employer. In addition, we provide our PPO members with access to a larger network of providers than our HMO. In contrast to our HMO product, we do not require our PPO members to select a primary care physician or to obtain a referral to utilize in-network specialists. We also provide coverage for PPO members who access providers outside of the network. Out-of-network benefits are generally subject to a higher deductible and coinsurance. We also offer national in-network coverage to our PPO members through the BlueCard program.

BlueCard. For our members who purchase our PPO and some of our Medicare Advantage products, we offer the BlueCard program. The BlueCard program offers these members in-network benefits through the networks of the other BCBS plans in the United States and certain U.S. territories. In addition, the BlueCard worldwide program provides our PPO members with coverage for medical assistance worldwide. We believe that the national and international coverage provided through this program allows us to compete effectively with large national insurers.

Medicare Supplement. We offer Medicare Supplement products, which provide supplemental coverage for many of the medical expenses that the Medicare Parts A and B programs does not cover, such as deductibles, coinsurance and specified losses that exceed the Federal program s maximum benefits.

Prescription Drug Benefit Plans. Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D in our Medicare Advantage plans as well as on a stand-alone basis. We also offer a Drug Discount Card for local government employees and individuals. As of December 31, 2008, we had enrolled approximately 22,000 members in the Drug

Table of Contents

Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2009.

Government Services. We servd as fiscal intermediary for the Medicare Part B program in Puerto Rico and the U.S. Virgin Islands, for which we received reimbursement of all direct costs and allocated overhead expenses, based on an approved budget by the Centers for Medicare and **Medicare Services (CMS) of the U.S. Department of Health and Human Services (HHS)**, until February 28, 2009. On September 12, 2008, CMS announced that First Coast Service Options (FCSO), a non-affiliated third party organization based in Jacksonville, Florida, was awarded the Medicare Administrative Contract (MAC) for Jurisdiction 9 (Florida, Puerto Rico and the U.S. Virgin Islands). FCSO selected TSI as a subcontractor in MAC Jurisdiction 9 to perform certain provider customer service functions, among others, in Puerto Rico, effective March 1, 2009. See Regulation Fiscal Intermediary included in this Item.

Administrative Services Only. In addition to our fully insured plans, we also offer our PPO products on a self-funded or ASO basis, under which we provide claims processing and other administrative services to employers. Employers choosing to purchase our products on an ASO basis fund their own claims but their employees are able to access our provider network at our negotiated discounted rates. We administer the payment of claims to the providers but we do not bear any insurance risk in connection with claims costs because we are reimbursed in full by the employer. For certain self-funded plans, we provide stop loss insurance pursuant to which we assume some of the medical risk for a premium. The administrative fee charged to self-funded groups is generally based on the size of the group and the scope of services provided.

Life Insurance

We offer a wide variety of life, accident and health and annuity products to all markets in Puerto Rico through our subsidiary Triple-S Vida, Inc. (TSV). Among these are group life and individual life insurance products. Life insurance premiums represented 5.5%, 6.0% and 5.7% of our consolidated premiums earned, net for the years ended December 31, 2008, 2007 and 2006. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases, credit and pre-need life products are marketed through independent agents. We are the principal company in Puerto Rico that offers guaranteed issue, funeral and cancer policies directly to people in their homes in the lower and middle income market segments. We also market our group life coverage through our managed care subsidiary s network of exclusive agents.

Property and Casualty Insurance

We offer a wide range of property and casualty insurance products through our subsidiary Seguros Triple-S, Inc. (STS). Property and casualty insurance premiums represented 5.5%, 6.5% and 5.9% of our consolidated premiums earned, net for the years ended December 31, 2008, 2007 and 2006. Our predominant lines of business are commercial multi-peril, commercial property mono-line, auto physical damage, auto liability and dwelling policies. The segment s commercial lines target small to medium size accounts. We generate a majority of our dwelling business through our strong relationships with financial institutions. During the year ended December 31, 2008, we generated our premiums in the property and casualty insurance segment primarily from the following lines of business:

Line of Business	Percentage of Total Segment Revenues for the Year Ended December 31, 2008
Commercial multi-peril	45%
Auto	22
Dwelling and commercial property mono-line	19
Other	14

Due to our geographical location, property and casualty insurance operations in Puerto Rico are subject to natural catastrophic activity, in particular hurricanes and earthquakes. As a result, local insurers, including us, rely on the international reinsurance market. The property and casualty insurance market is affected by the cost of reinsurance, which varies with the catastrophic experience. After 2005, the cost of reinsurance reported increases due to the severe

catastrophic losses occurred in that year. Because there were fewer

Table of Contents

severe catastrophic events in 2006 and 2007 reinsurance rates were lower in 2008. It is expected that 2009 will have a slight increase in reinsurance rates due to recent catastrophic events and investment losses reported by reinsurers.

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Our policy is to enter into reinsurance agreements with reinsurers considered to be financially sound. Over 90% of our reinsurers have an A.M. Best rating of A- or better, or an equivalent rating from other rating agencies. During the year ended December 31, 2008, 42.9% of the premiums written in the property and casualty insurance segment were ceded to reinsurers. Although these reinsurance arrangements do not relieve us of our direct obligations to our insureds, we believe that the risk of our reinsurers not paying balances due to us is low.

Marketing and Distribution

Our marketing activities concentrate on promoting our strong brand, quality care, customer service efforts, size and quality of provider networks, flexibility of plan designs, financial strength and breadth of product offerings. We distribute our products through several different channels, including our salaried and commission-based internal sales force, direct mail, independent brokers and agents and telemarketing staff. We also use our website to market our products.

Branding and Marketing

Our branding and marketing efforts include brand advertising , which focuses on the Triple-S name and the Blue Shield mark, acquisition marketing , which focuses on attracting new customers, and institutional advertising , which focuses on our overall corporate image. We believe that the strongest element of our brand identity is the Triple-S name. We seek to leverage what we believe to be the high name recognition and comfort level that many existing and potential customers associate with this brand. Acquisition marketing consists of business-to-business marketing efforts which are used to generate leads for brokers and our sales force as well as direct-to-consumer marketing which is used to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall company image. We believe these efforts support and further our competitive brand advantage. We will continue to utilize the Triple-S name and the Blue Shield mark for all managed care products and services in Puerto Rico.

Distribution

Managed Care Segment. We rely principally on our internal sales force and a network of independent brokers and agents to market our products. Individual policies and Medicare Advantage products are sold entirely through independent agents who exclusively sell our individual products, and group products are sold through our 70 person internal sales force as well as our approximately 360 independent brokers and agents. We believe that each of these marketing methods is optimally suited to address the specific needs of the customer base to which it is assigned. In the Reform sector, those notified by the government of Puerto Rico that they are eligible to participate in the Reform may enroll in the program at our branch offices.

Strong competition exists among managed care companies for brokers and agents with demonstrated ability to secure new business and maintain existing accounts. The basis of competition for the services of such brokers and agents are commission structure, support services, reputation and prior relationships, the ability to retain clients and the quality of products. We pay commissions on a monthly basis based on premiums paid. We believe that we have good relationships with our brokers and agents, and that our products, support services and commission structure are highly competitive in the marketplace.

Life Insurance Segment. In our life insurance segment, we offer our insurance products through our own network of brokers and independent agents, as well as group life insurance coverage through our managed care network of agents. We place a majority of our premiums (57% during the years ended December 31, 2008 and 2007) through direct selling to customers in their homes. TSV employs over 525 full-time active agents and managers and utilized approximately 600 independent agents and brokers. We pay commissions on a monthly basis based on premiums paid. In addition, TSV has over 200 agents that are licensed to sell certain of our managed care products.

Table of Contents

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is exclusively subscribed through 18 general agencies, including our insurance agency, Triple-S Insurance Agency, Inc. (formerly known as Signature Insurance Agency, Inc. (SIA)), where business is placed by independent insurance agents and brokers. SIA placed approximately 45% of our property and casualty insurance subsidiary, STS, total premium volume during the year ended December 31, 2008. During the each of the years ended December 31, 2007 and 2006, SIA placed approximately 52% of our subsidiary s total premium volume. The general agencies contracted by our property and casualty insurance subsidiary remit premiums net of their respective commission.

Customers

Managed Care

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2008:

Market Sector	Enrollment at December 31, 2008	Percentage of Total Enrollment
Commercial	592,723	49.6%
Reform	527,447	44.1
Medicare Advantage	75,280	6.3
Total	1,195,450	100.0%

Commercial Sector

The commercial accounts sector includes corporate accounts, U.S. federal government employees, individual accounts, local government employees, and Medicare Supplement.

Corporate Accounts. Corporate accounts consist of small (2 to 50 employees) and large employers (over 50 employees). Employer groups may choose various funding options ranging from fully insured to self-funded financial arrangements or a combination of both. While self-funded clients participate in our managed care networks, the clients bear the claims risk, except to the extent that such self-funded clients maintain stop loss coverage.

U.S. Federal Government Employees. For more than 40 years, we have maintained our leadership in the provision of managed care to U.S. federal government employees in Puerto Rico. We provide our services to federal employees in Puerto Rico under the Federal Employees Health Benefits Program pursuant to a direct contract with the United States Office of Personnel Management (OPM). We are one of two companies in Puerto Rico that has such a contract with OPM. Every year, OPM allows other insurance companies to compete for this business, provided such companies comply with the applicable requirements for service providers. This contract is subject to termination in the event of noncompliance not corrected to the satisfaction of OPM.

Individual Accounts. We provide managed care services to individuals and their dependent family members who contract these services directly with us though our network of independent brokers. We provide individual and family contracts. We assume the risk of both medical and administrative costs in return for a monthly premium.

Local Government Employees. We provide managed care services to the local government employees of Puerto Rico through a government-sponsored program whereby the health plan assumes the risk of both medical and administrative costs for its members in return for a monthly premium. The government qualifies on an annual basis the managed care companies that participate in this program and sets the coverage, including benefits, co-payments and amount to be contributed by the government. Employees then select from one of the authorized companies and pays for the difference between the premium of the selected carrier and the amount contributed by the government.

Table of Contents

Medicare Supplement. We offer Medicare Supplement products, which provide supplemental coverage for many of the medical expenses that the basic Medicare program does not cover, such as deductibles, coinsurance and specified losses that exceed the Federal program s maximum benefits.

Reform Sector

In 1994, the government of Puerto Rico privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into geographical areas and by December 31, 2001, the Reform had been fully implemented in each of these areas. Each of the eight geographical areas is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2008, the Reform provided healthcare coverage to over 1.5 million people. Mental health and drug abuse benefits are currently offered to Reform beneficiaries by behavioral healthcare companies and are therefore not part of the benefits covered by us.

The Reform program is similar to the Medicaid program, a joint federal and state health insurance program for medically indigent residents of the state. The Medicaid program is structured to provide states the flexibility to establish eligibility requirements, benefits provided, payment rates, and program administration rules, subject to general federal guidelines.

The government of Puerto Rico has adopted several measures to control the increase of Reform expenditures, which represented approximately 5.3% of total government expenditures during its fiscal year ended June 30, 2008, including closer and continuous scrutiny of participants (members) eligibility, decreasing the number of areas in order to take advantage of economies of scale and establishing disease management programs. In addition, the government of Puerto Rico began a pilot project in 2003 within one of the eight geographical areas under which it contracted services on an ASO basis with an Independent Practice Associations (IPA), instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us under a fully-insured model until October 31, 2006. This region was awarded to us again on an ASO basis for a one year period beginning November 1, 2008. The two other regions that we currently serve remain with the fully-insured model; however, there can be no assurance that the government will not implement ASO programs in these regions in the future. If a similar ASO plan is adopted in any areas served by us during the contract period, we would not generate premiums in the Reform business but instead we would collect administrative service fees. On the other hand, the government has expressed its intention to evaluate different alternatives of providing health services to Reform beneficiaries.

The government of Puerto Rico has also implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in Medicare Advantage programs, such as the deductibles and co-payments of prescription drug benefits.

We provide managed care services to Reform members in the North and Southwest regions on a fully-insured basis and in the Metro-North region on an ASO basis. We have participated in the Reform program since 1995. The premium rates for each Reform contract are negotiated annually. If the contract renewal process is not completed by a contract s expiration date, the contract may be extended by the government, upon acceptance by us, for any subsequent period of time if deemed to be in the best interests of the beneficiaries and the government. The terms of a contract, including premiums, can be renegotiated if the term of the contract is extended. Each contract is subject to termination in the event of non-compliance by the insurance company not corrected or cured to the satisfaction of the government entity overseeing the Reform, or in the event that the government determines that there is an insufficiency of funds to finance the Reform. For additional information please see Item 1A Risk Factors We are dependent on a small number of government contracts to generate a significant amount of the revenues of our managed care business .

Medicare Advantage Sector

Medicare is a federal program administered by CMS that provides a variety of hospital and medical insurance benefits to eligible persons aged 65 and over as well as to certain other qualified persons. Medicare, with the approval of the Medicare Modernization Act, started promoting a managed care

Table of Contents

organizations (MCO) sponsored Medicare product that offers benefits similar or better than the traditional Medicare product, but where the risk is assumed by the MCOs. This program is called Medicare Advantage. We entered into the Medicare Advantage market in 2005 and have contracts with CMS to provide extended Medicare coverage to Medicare beneficiaries under our *Medicare Optimo*, *Medicare Selecto* and *Medicare Platino* policies. Under these annual contracts, CMS pays us a set premium rate based on membership that is adjusted for demographic factors and health status. In addition, for certain of our Medicare Advantage products the member will also pay an additional premium for additional benefits.

Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D through our Medicare Advantage plans as well as on a stand-alone basis. Our stand-alone prescription drug plan, called *FarmaMed*, was launched in 2006.

Life Insurance

Our life and health insurance customers consist primarily of individuals, who hold approximately 370,000 policies, and we insure approximately 1,600 groups.

Property and Casualty Insurance

Our property and casualty insurance segment targets small to medium size accounts with low to average exposures to catastrophic losses. Our dwelling insurance line of business aims for rate stability and seeks accounts with a very low exposure to catastrophic losses. Our auto physical damage and auto liability customer bases consist primarily of commercial accounts.

Underwriting and Pricing

Managed Care

We strive to maintain our market leadership by providing all of our managed care members with the best health care coverage at reasonable cost. Disciplined underwriting and appropriate pricing are core strengths of our business and we believe are an important competitive advantage. We continually review our underwriting and pricing guidelines on a product-by-product and customer group-by-group basis in order to maintain competitive rates in terms of both price and scope of benefits. Pricing is based on the overall risk level and the estimated administrative expenses attributable to the particular segment.

Our claims database enables us to establish rates based on our own experience and provides us with important insights about the risks in our service areas. We tightly manage the overall rating process and have processes in place to ensure that underwriting decisions are made by properly qualified personnel. In addition, we have developed and implemented a utilization review and fraud and abuse prevention program.

We have been able to maintain relatively high retention rates in the corporate accounts sector of our managed care business and since 2003 have maintained our overall market share. The retention rate in our corporate accounts, which is the percentage of existing business retained in the renewal process, has been over 90% in each of the last four years. In our managed care segment, the rates are set prospectively, meaning that a fixed premium rate is determined at the beginning of each contract year and revised at renewal. We renegotiate the premiums of different groups in the corporate accounts subsector as their existing annual contracts become due. We set rates for individual contracts based on the most recent semi-annual community rating. We consider the actual claims trend of each group when determining the premium rates for the following contract year. Rates in the Reform and Medicare sectors and for federal and local government employees are set on an annual basis through negotiations with the U.S. Federal and Puerto Rico governments, as applicable.

Life Insurance

Our individual life insurance business has been priced using mortality, morbidity, lapses and expense assumptions which approximate actual experience for each line of business. We review pricing

Table of Contents

assumptions on a regular basis. Individual insurance applications are reviewed by using common underwriting standards in use in the United States, and only those applications that meet these commonly used underwriting requirements are approved for policy issuance. Our group life insurance business is written on a group-by-group basis. We develop the pricing for our group life business based on mortality and morbidity experience and estimated expenses attributable to each particular line of business.

Property and Casualty Insurance

The property and casualty insurance sector has experienced soft market conditions in Puerto Rico in recent periods, principally as a result of the deregulation of commercial property rates since 2001. Lower reinsurance costs in 2006 and 2007 have also contributed to soft market conditions. Notwithstanding these conditions, our property and casualty segment has maintained its leadership position in the property insurance sector by following prudent underwriting and pricing practices.

Our core business is comprised of small and medium-sized accounts. We have attained positive results through attentive risk assessment and strict adherence to underwriting guidelines, combined with maintenance of competitive rates on above-par risks designed to maintain a relatively high retention ratio. Underwriting strategies and practices are closely monitored by senior management and constantly updated based on market trends, risk assessment results and loss experience. Commercial risks in particular are fully reviewed by our professionals.

Quality Initiatives and Medical Management

We utilize a broad range of focused traditional cost containment and advanced care management processes across various product lines. We continue to enhance our management strategies, which seek to control claims costs while striving to fulfill the needs of highly informed and demanding managed care consumers. One of these strategies is the reinforcement of population and case management programs, which empower consumers by educating them and engaging them in actively maintaining or improving their own health. Early identification of patients and inter-program referrals are the focus of these programs, which allow us to provide integrated service to our customers based on their specific conditions. The population management programs include programs which target asthma, congestive heart failure, hypertension and a prenatal program which focuses on preventing prenatal complications and promoting adequate nutrition. A medication therapy management program aimed at plan members who are identified as having a potential for high drug usage was also developed. In addition, we have had a contract with McKesson Health Solutions (McKesson) since 1998 pursuant to which they provide to us a 24-hour telephone-based triage program and health information services for all our sectors. McKesson also provides utilization management services for the Reform and Medicare sectors. We intend to expand to the Commercial sector the programs not currently offered in that sector. Other strategies include innovative partnerships and business alliances with other entities to provide new products and services such as an employee assistance program and the promotion of evidence-based protocols and patient safety programs among our providers. We also employ registered nurses and social workers to manage individual cases and coordinate healthcare services. We have implemented a hospital concurrent review program, the goal of which is to monitor the appropriateness of high admission rate diagnoses and unnecessary stays. These services and programs include pre-certification and concurrent review hospital discharge services for acute patients, as well as early referral of potential candidates for the population and case management programs.

In addition, we have developed and provide a variety of services and programs for the acute, chronic and complex populations. The services and programs seek to enhance quality by eliminating inappropriate hospitalizations or services. We also encourage the usage of formulary and generic drugs, instead of non-formulary therapeutic equivalent drugs, through benefit design and member and physician interactions and have implemented a three-tier formulary which offers three co-payment levels: the lowest level for generic drugs, a higher level for brand-name drugs and the highest level for brand-name drugs that are not on the formulary. We have also established an exclusive pharmacy network with discounted rates. In addition, through arrangements with our pharmacy benefit manager, we are able to obtain discounts and rebates on certain medications based on formulary listing and market share.

We have designed a comprehensive Quality Improvement Program (QIP). This program is designed with a strong emphasis on continuous improvement of clinical and service indicators, such as Health Employment

Table of Contents

Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. Our QIP also includes a Physician Incentive Program (PIP) and a Hospital Quality Incentive Program (HQIP), which are directed to support corporate quality initiatives, utilizing clinical and benchmark criteria developed by governmental agencies and professional organizations. The PIP encourages the participation of members on chronic care improvement programs and the achievement of specific clinical outcomes. The HQIP, a pilot of which began in 2008, encourages participating hospitals to achieve national benchmarks regarding fives core measures of CMS.

Information Systems

We have developed and implemented integrated and reliable information technology systems that we believe have been critical to our success. Our systems collect and process information centrally and support our core administrative functions, including premium billing, claims processing, utilization management, reporting, medical cost trending, as well as certain member and provider service functions, including enrollment, member eligibility verification, claims status inquiries, and referrals and authorizations.

We have substantially completed a system conversion process related to our property and casualty insurance business, which was begun in April 2005, at an estimated cost of $4.0 million.

In addition, we have selected Quality Care Solutions, Inc. to assess and implement new core business applications for our managed care segment. We completed this assessment in the fourth quarter of 2007 and plan to convert our managed care system over time by line of business, with the first line of business expected to be converted in the first half of 2010. We expect the managed care conversion process to be completed by 2012 at a total cost of approximately $64.0 million.

These new core business applications are intended to provide functionality and flexibility to allow us to offer new services and products and facilitate the integration of future acquisitions. They are also designed to improve customer service, enhance claims processing and contain operational expenses.

Provider Arrangements

Approximately 99% of member services are provided through one of our contracted provider networks and the remaining back-up percentage of member services are provided by out-of-network providers. Our relationships with managed care providers, physicians, hospitals, other facilities and ancillary managed care providers are guided by standards established by applicable regulatory authorities for network development, reimbursement and contract methodologies. As of December 31, 2008, we had provider contracts with 4,530 primary care physicians, 3,100 specialists and 63 hospitals.

It is generally our philosophy not to delegate full financial responsibility to our managed care providers in the form of capitation-based reimbursement. For certain ancillary services, such as behavioral health services, and primary services in the Reform business and *Medicare Optimo* product, we generally enter into capitation arrangements with entities that offer broad based services through their own contracts with providers. We attempt to provide market-based reimbursement along industry standards. We seek to ensure that providers in our networks are paid in a timely manner, and we provide means and procedures for claims adjustments and dispute resolution. We also provide a dedicated service center for our providers. We seek to maintain broad provider networks to ensure member choice while implementing effective management programs designed to improve the quality of care received by our members.

We promote the use of electronic claims billing to our providers. Approximately 90% of claims are submitted electronically through our fully automated claims processing system, and our first-pass rate , or the rate at which a claim is approved for payment after the first time it is processed by our system without human intervention, for physician claims has averaged 87% for the last two years.

In the Reform sector, we have a network of IPAs which provide managed care services to our Reform beneficiaries in exchange for a capitation fee. The IPA assumes the costs of certain primary care services provided and referred by its primary care physicians (PCPs), including procedures and in-patient services not related to risks assumed by us. We retain the risk associated with services provided to beneficiaries

Table of Contents

under this arrangement, such as: neonatal, obstetrical, AIDS, cancer, cardiovascular and dental services, among others. We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the non-hassle factor or reduction of non-value added administrative tasks when deciding whether to contract with a managed care plan. As a result of our established position in the Puerto Rican market, the strength of the Triple-S name and our association with the BCBA, we believe we have strong relationships with hospital and provider networks leading to a strong competitive position in terms of hospital count, number of providers and number of in-network specialists.

Hospitals. We generally contract for hospital services to be paid on an all-inclusive per diem basis, which includes all services necessary during a hospital stay. Negotiated rates vary among hospitals based on the complexity of services provided. We annually evaluate these rates and revise them, if appropriate.

Physicians. Fee-for-service is our predominant reimbursement methodology for physicians, except for the Reform sector. Our physician rate schedules applicable to services provided by in-network physicians are pegged to a resource-based relative value system fee schedule and then adjusted for competitive rates in the market. This structure is similar to reimbursement methodologies developed and used by the federal Medicare system and other major payers. Payments to physicians under the Medicare Advantage program are based on Medicare fees. In the Reform sector, we make payments to certain of our providers in the form of capitation-based reimbursement.

Services are provided to our members through our network providers with whom we contract directly. Members seeking medical treatment outside of Puerto Rico are served by providers in these areas through the BlueCard program, which offers access to the provider networks of the other BCBS plans.

Subcontracting. We subcontract our triage call center, utilization management, mental and substance abuse health services for federal government employees and other large ASO accounts, and pharmacy benefits management services through contracts with third parties.

In addition, we contract with a number of other ancillary service providers, including laboratory service providers, home health agency providers and intermediate and long-term care providers, to provide access to a wide range of services. These providers are normally paid on either a fee schedule or fixed per day or per case basis.

Competition

The insurance industry in Puerto Rico is highly competitive and is comprised of both local and foreign entities. The approval of the Gramm-Leach-Bliley Act of 1999, which applies to financial institutions domiciled in Puerto Rico, has opened the insurance market to new competition by allowing financial institutions such as banks to enter into the insurance business. Several banks in Puerto Rico have established subsidiaries that operate as insurance agencies.

Managed Care

The managed care industry is highly competitive, both nationally and in Puerto Rico. Competition continues to be intense due to aggressive marketing, business consolidations, a proliferation of new products and increased quality awareness and price sensitivity among customers. Industry participants compete for customers based on the ability to provide a total value proposition which we believe includes quality of service and flexibility of benefit designs, access to and quality of provider networks, brand recognition and reputation, price and financial stability.

We believe that our competitive strengths, including our leading presence in Puerto Rico, our Blue Shield license, the size and quality of our provider network, the broad range of our product offerings, our strong complementary businesses and our experienced management team, position us well to satisfy these competitive requirements.

Competitors in the managed care segment include national and local managed care plans. We currently have approximately 1,200,000 members enrolled in our managed care segment at December 31, 2008,

Table of Contents

representing approximately 30% of the population of Puerto Rico. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 22% for the year ended December 31, 2007. We offer a variety of managed care products, and are the leader by market share in almost every sector, as measured by the share of premiums written. Our main competitors are Aveta Inc. (or MMM Healthcare) and Medical Card Systems Inc., and Humana Inc.

Life Insurance

We are one of the leading providers of life insurance products in Puerto Rico. In 2007, we were the second largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 11%. In the life insurance segment we are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines. In the life insurance sector, excluding annuities, we were the largest company with a market share of approximately 16%, and our main competitors are Cooperativa de Seguros de Vida de Puerto Rico, Massachusetts Mutual, and Axa Equitable Life. In the cancer sector, we were the second largest company with a market share of approximately 17%, and our main competitors are AFLAC (sector leader), Trans-Oceanic Life Insurance Company and Universal Life Insurance Company.

Property & Casualty Insurance

The property and casualty insurance market in Puerto Rico is extremely competitive. In addition, soft market conditions have prevailed during last three years in Puerto Rico. In the local market, such conditions mostly affected commercial risks, precluding rate increases and even provoking lower premiums on both renewals and new business. Property and casualty insurance companies tend to compete for the same accounts through more favorable price and/or policy terms and better quality of services. We compete by reasonably pricing our products and providing efficient services to producers, agents and clients. We believe that our knowledgeable, experienced personnel are also an incentive for our customers to conduct business with us.

In 2007, we were the fifth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 8%. Our nearest competitors in the property and casualty insurance market in Puerto Rico in 2007 was American International Insurance Company of Puerto Rico. The market leaders in the property and casualty insurance market in Puerto Rico in 2006 were Universal Insurance Group, Cooperativa de Seguros Múltiples de Puerto Rico and MAPFRE Corporation.

Blue Shield License

We have the exclusive right to use the Blue Shield name and mark for the sale, marketing and administration of managed care plans and related services in Puerto Rico. We believe that the Blue Shield name and mark are valuable brands of our products and services in the marketplace. The license agreements, which have a perpetual term (but which are subject to termination under circumstances described below), contain certain requirements and restrictions regarding our operations and our use of the Blue Shield name and mark.

Upon the occurrence of any event causing the termination of our license agreements, we would cease to have the right to use the Blue Shield name and mark in Puerto Rico. We also would no longer have access to the BCBSA networks of providers and BlueCard Program. We would expect to lose a significant portion of our membership if we lose these licenses. Loss of these licenses could significantly harm our ability to compete in our markets and could require payment of a significant fee to the BCBSA. Furthermore, if our licenses were terminated, the BCBSA would be free to issue a new license to use the Blue Shield name and marks in Puerto Rico to another entity, which would have a material adverse affect on our business, financial condition and results of operations. See Item 1A Risk Factors The termination or modification of our license agreements to use the Blue Shield name and mark could have an adverse effect on our business, financial condition and results of operations .

Events which could result in termination of our license agreements include, but are not limited to:

Table of Contents

failure to maintain our total adjusted capital at 200% of Health Risk-Based Capital Authorized Control Level, as defined by the National Association of Insurance Commissioners (NAIC) Risk Based Capital (RBC) Model Act;

failure to maintain liquidity of greater than one month of underwritten claims and administrative expenses, as defined by the BCBA, for two consecutive quarters;

failure to satisfy state-mandated statutory net worth requirements;

impending financial insolvency; and

a change of control not otherwise approved by the BCBSA or a violation of the BCBSA voting and ownership limitations on our capital stock.

The BCBSA license agreements and membership standards specifically permit a licensee to operate as a for-profit, publicly-traded stock company, subject to certain governance and ownership requirements.

Pursuant to our license agreements with BCBSA, at least 80% of the revenue that we earn from health care plans and related services in Puerto Rico, and at least 66.7% of the revenue that we earn from (or at least 66.7% of the enrollment for) health care plans and related services both in the United States and in Puerto Rico together, must be sold, marketed, administered, or underwritten through use of the Blue Shield name and mark. This may limit the extent to which we will be able to expand our health care operations, whether through acquisitions of existing managed care providers or otherwise, in areas where a holder of an exclusive right to the Blue Shield name and mark is already present. Currently, the Blue Shield name and mark is licensed to other entities in all markets in the continental United States, Hawaii, and Alaska.

Pursuant to the rules and license standards of the BCBSA, we guarantee our subsidiaries contractual and financial obligations to their respective customers. In addition, pursuant to the rules and license standards of the BCBSA, we have agreed to indemnify the BCBSA against any claims asserted against it resulting from our contractual and financial obligations.

Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the Blue Shield name and mark. The annual BCBSA fee for the year 2009 is $1,340,489. During the years ended December 31, 2008 and 2007, we paid fees to the BCBSA in the amount of $1,079,172 and $921,636, respectively. The BCBSA is a national trade association of 39 Member Plans, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as to provide certain coordination among the Member Plans. Each Member Plan is an independent legal organization and is not responsible for obligations of other Blue Cross Blue Shield Association Member Plans. With a few limited exceptions, we have no right to market products and services using the Blue Shield names and marks outside our Blue Shield licensed territory.

We do not have the authority to use the Blue Cross name and mark in Puerto Rico. However, in December 2008, as part of our pending transaction with La Cruz Azul de Puerto Rico, Inc. we have asked the BCBSA to transfer to the Company and our managed care subsidiary the license for the Blue Cross name and mark in Puerto Rico, as well as the rights to use the Blue Shield and Blue Cross names and marks in the U.S. Virgin Islands.

BlueCard. Under the rules and license standards of the BCBSA, other Member Plans must make available their provider networks to members of the BlueCard Program in a manner and scope as consistent as possible to what such member would be entitled to in his or her home region. Specifically, the Host Plan (located where the member receives the service) must pass on discounts to BlueCard members from other Member Plans that are at least as great as the discounts that the providers give to the Host Plan s local members. The BCBSA requires us to pay fees to any Host Plan whose providers submit claims for health care services rendered to our members who receive care in their service area. Similarly, we are paid fees for submitting claims and providing other services to members of other Member Plans who receive care in our service area.

Claim Liabilities

We are required to estimate the ultimate amount of claims which have not been reported, or which have been received but not yet adjudicated, during any accounting period. These estimates, referred to as claim liabilities, are recorded as liabilities on our balance sheet. We estimate claim reserves in accordance with

Table of Contents

Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes the professional guidelines and standards for actuaries to follow. A degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. For additional information regarding the calculation of claim liabilities, see Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Policies and Estimates Claim Liabilities .

Investments

Our investment philosophy is to maintain a largely investment-grade fixed income portfolio, provide adequate liquidity for expected liability durations and other requirements, and maximize total return through active investment management.

We evaluate the interest rate risk of our assets and liabilities regularly, as well as the appropriateness of investments relative to our internal investment guidelines. We operate within these guidelines by maintaining a diversified portfolio, both across and within asset classes.

Investment decisions are centrally managed by investment professionals based on the guidelines established by management and approved by our Investment and financing Committee. Our internal investment group is comprised of the CFO, a Treasurer, an investment officer, and a treasury operations officer. The internal investment group uses an external investment consultant and manages our short-term investments, fixed income portfolio and equity securities of Puerto Rican corporations that are classified as available for sale. In addition, we use GE Asset Management and State Street Global Advisor as portfolio managers for our trading securities.

The board of directors monitors and approves investment policies and procedures. The investment portfolio is managed following those policies and procedures, and any exception must be reported to our board of directors.

For additional information on our investments, see Item 7A Quantitative and Qualitative Disclosures About Market Risk Market Risk Exposure .

Trademarks

We consider our trademarks of Triple-S and SSS to be very important and material to all segments in which we are engaged. In addition to these, other trademarks used by our subsidiaries that are considered important have been duly registered with the Department of State of Puerto Rico and the United States Patent and Trademark Office. It is our policy to register all our important and material trademarks in order to protect our rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the Blue Shield name and mark in Puerto Rico. See Blue Shield License .

Regulation

The operations of our managed care business are subject to comprehensive and detailed regulation in Puerto Rico, as well as U.S. Federal regulation. Supervisory agencies include the Office of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance), the Health Department of the Commonwealth of Puerto Rico and the Administration for Health Insurance of the Commonwealth of Puerto Rico (ASES, for its Spanish acronym), which administers the Reform Program for the Commonwealth of Puerto Rico. Federal regulatory agencies that oversee our operations include CMS, the Office of the Inspector General (OIG) of HHS, the Office of Civil Rights of HHS, the U.S. Department of Justice, and the Office of Personnel Management (OPM). These government agencies have the right to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of the products and services we offer;
- assess fines, penalties and/or sanctions;
- monitor our solvency and adequacy of our financial reserves; and

Table of Contents

regulate our investment activities on the basis of quality, diversification and other quantitative criteria, within the parameters of a list of permitted investments set forth in applicable insurance laws and regulations.

Our operations and accounts are subject to examination and audits at regular intervals by these agencies. In addition, the U.S Federal and local governments continue to consider and enact many legislative and regulatory proposals that have impacted, or would materially impact, various aspects of the health care system. Some of the more significant current issues that may affect our managed care business include:

initiatives to provide greater access to coverage for uninsured and under-insured populations;

initiatives to increase healthcare regulation, including enhanced efforts to expand the tort liability improve quality of health plans care;

Reform and Medicare reform legislation;

local government plans and initiatives;

Reform and Medicare reform legislation; and

increased government concerns regarding fraud and abuse.; and

initiatives to increase health care regulation, including efforts to expand the tort liability of health plans.

On February 26, 2009, President Obama announced his proposed budget for fiscal year 2010, which supports his comprehensive health care reform agenda. The Obama health care reform plan is expected to address increasing access to health care coverage, reducing the cost of care, and improving the quality of care rendered. The health care reform plan is expected to be financed in large part by reduced expenditures for the Medicare program. The proposed budget projects a minimum savings on health care expenditures of $316 billion by the Federal government over the next decade in the Medicare program, including $176 billon of which will be realized through reduced payments to Medicare Advantage plans as a result of changes in the competitive bidding process for Medicare Advantage contracts. In addition, President Obama s proposed budget calls for premium increases for certain high-income Medicare beneficiaries. The U.S. Congress is continuing to develop legislative efforts directed toward patient protection, including proposed laws that could expose insurance companies to economic damages, and in some cases punitive damages, for making a determination denying benefits or for delaying members receipt of benefits as well as for other coverage determinations. Similar legislation has been proposed in Puerto Rico. Given the political process, it is not possible to determine whether any federal and/or local legislation or regulation will be enacted in 2009 or what form any such legislation might take. Other legislative or regulatory changes that may affect us are described below. While certain of these measures could adversely affect us, at this time we cannot predict the extent of this impact.

The Federal government and the government of Puerto Rico, including the Commissioner of Insurance, have adopted laws and regulations that govern our business activities in various ways. These laws and regulations may restrict how we conduct our business and may result in additional burdens and costs to us. Areas of governmental regulation include:

licensure;
policy forms, including plan design and disclosures;
premium rates and rating methodologies;
underwriting rules and procedures;
benefit mandates;
eligibility requirements;

security of electronically transmitted individually identifiable health information;
geographic service areas;
transactions resulting in a change of control;
member rights and responsibilities;
fraud and abuse;
sales and marketing activities;
quality assurance procedures;
privacy of medical and other information and permitted disclosures;
rates of payment to providers of care;

surcharges on payments to providers;

market conduct;

provider contract forms;

delegation of financial risk and other financial

Table of Contents

- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- special rules in contracts to administer government programs;
- transactions with affiliated entities;
- limitations on the ability to pay dividends;
- rates of payment to providers of care;
- arrangements in rates paid to providers of care;
- agent licensing;
- financial condition (including reserves);
- reinsurance;
- issuance of new shares of capital stock;
- corporate governance; and
- permissible investments.

These laws and regulations are subject to amendments and changing interpretations in each jurisdiction. Failure to comply with existing or future laws and regulations could materially and adversely affect our operations, financial condition and prospects.

Puerto Rico Insurance Laws

Our insurance subsidiaries are subject to the regulations and supervision of the Commissioner of Insurance. The regulations and supervision of the Commissioner of Insurance consist primarily of the approval of certain policy forms, the standards of solvency that must be met and maintained by insurers and their agents, and the nature of and limitations on investments, deposits of securities for the benefit of policyholders, methods of accounting, periodic examinations and the form and content of reports of financial condition required to be filed, among others. In general, such regulations are for the protection of policyholders rather than security holders.

Puerto Rico insurance laws prohibit any person from offering to purchase or sell voting stock of an insurance company with capital contributed by stockholders (a stock insurer) which constitutes 10% or more of the total issued and outstanding stock of such company or of the total issued and outstanding stock of a company that controls an insurance company, without the prior approval of the Commissioner of Insurance. The proposed purchaser or seller must disclose any changes proposed to be made to the administration of the insurance company and provide the Commissioner of Insurance with any information reasonably requested. The Commissioner of Insurance must make a determination within 30 days of the later of receipt of the petition or of additional information requested. The determination of the Commissioner of Insurance will be based on its evaluation of the transaction s effect on the public, having regard to the experience and moral and financial responsibility of the proposed purchaser, whether such responsibility of the proposed purchaser will affect the effectiveness of the insurance company s operations and whether the change of control could jeopardize the interests of insureds, claimants or the company s other stockholders. Our articles prohibit any institutional investor from owning 10% or more of our voting power, any person that is not an institutional investor from owning 5% or more of our voting power, and any person from beneficially owning shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest in us. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles.

Puerto Rico insurance laws also require that stock insurers obtain the Commissioner of Insurance s approval prior to any merger or consolidation. The Commissioner of Insurance cannot approve any such transaction unless it determines that such transaction is just, equitable, consistent with the law and no reasonable objection exists. The merger or consolidation must then be authorized by a duly approved resolution of the board of directors and ratified by the affirmative vote of two-thirds of all issued and outstanding shares of capital stock with the right to vote thereon. The reinsurance of all or substantially all of the insurance of an insurance company by another insurance company is also deemed to be a merger or consolidation.

Puerto Rico insurance laws further prohibit insurance companies and insurance holding companies, among other entities, from soliciting or receiving funds in exchange for any new issuance of its securities, other than through a stock dividend, unless the Commissioner of Insurance has granted a solicitation permit in respect of such transaction. The Commissioner of Insurance will issue the permit unless it finds that the

Table of Contents

funds proposed to be secured are excessive for the purpose intended, the proposed securities and their distribution would be inequitable, or the issuance of the securities would jeopardize the interests of policyholders or securityholders.

Puerto Rico insurance laws also limit insurance companies ability to reinsure risk. Insurance companies can only accept reinsurance in respect of the types of insurance which they are authorized to transact directly. Also, except for life and disability insurance, insurance companies cannot accept any reinsurance in respect of any risk resident, located, or to be performed in Puerto Rico which was insured as direct insurance by an insurance company not then authorized to transact such insurance in Puerto Rico. As a result, insurance companies can only reinsure their risks with insurance companies in Puerto Rico authorized to transact the same type of insurance or with a foreign insurance company that has been approved by the Commissioner of Insurance. Insurance companies cannot reinsure 75% or more of their direct risk with respect to any type of insurance without first obtaining the approval of the Commissioner of Insurance.

Privacy of Financial and Health Information

Puerto Rico law requires that managed care providers maintain the confidentiality of financial and health information. The Commissioner of Insurance has promulgated regulations relating to the privacy of financial information and individually identifiable health information. Managed care providers must periodically inform their clients of their privacy policies and allow such clients to opt-out if they do not want their financial information to be shared. However, the regulations related to the privacy of health information do not apply to managed care providers, such as us, who comply with the provisions of HIPAA. Also, Puerto Rico law requires that managed care providers provide patients with access to their health information within a specified time and that they not charge more than a predetermined amount for such access. The law imposes various sanctions on managed care providers that fail to comply with these provisions.

Managed Care Provider Services

Puerto Rico law requires that managed care providers cover and provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialized services. In addition, the Office of the Solicitor for the Beneficiaries of the Reform is authorized to review and supervise the operations of entities contracted by the Commonwealth of Puerto Rico to provide services under the Reform. The Solicitor may investigate and adjudicate claims filed by beneficiaries of the Reform against the various service providers contracted by the Commonwealth of Puerto Rico. See Business Customers Medicare Supplement Reform Sector included in this Item for more information.

Capital and Reserve Requirements

In addition to the capital and reserve requirements set forth below, the Commissioner of Insurance requires our managed care subsidiary to maintain minimum capital of $1.0 million, our life insurance subsidiary to maintain minimum capital of $2.5 million and our property and casualty insurance subsidiary to maintain minimum capital of $3.0 million. During 2008, the Commissioner of Insurance approved the requirement to use the National Association of Insurance Commissioners (NAIC) RBC Model Act (the RBC Model Act) by all local insurers in determining minimum capital level. This requirement goes into effect in 2009. In addition, our managed care subsidiary is subject to the capital and surplus licensure requirements of the BCBSA.

The capital and surplus requirements of the BCBSA are based on the RBC Model Act. These capital and surplus requirements are intended to assess capital adequacy taking into account the risk characteristics of an insurer s investments and products. The RBC Model Act set forth the formula for calculating the risk-based capital requirements, which are designed to take into account risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company s business.

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company s risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a

Table of Contents

comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the company s total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The company action level is triggered if a company s total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital. At the company action level, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250% and 200% of its risk-based capital is subject to a trend test. The trend test calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company s adjusted capital exceeds it risk-based capital) between the current year and the prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year. If a similar decrease in margin in the coming year would result in a risk-based capital ratio of less than 190%, then company action level regulatory action will occur.

The regulatory action level is triggered if a company s total adjusted capital is less than 150% but greater than or equal to 100% of its risk-based capital. At the regulatory action level, the regulatory authority will perform a special examination of the company and issue an order specifying corrective actions that must be followed. The authorized control level is triggered if a company s total adjusted capital is less than 100% but greater than or equal to 70% of its risk-based capital, at which level the regulatory authority may take any action it deems necessary, including placing the company under regulatory control. The mandatory control level is triggered if a company s total adjusted capital is less than 70% of its risk-based capital, at which level the regulatory authority must place the company under its control.

We and our insurance subsidiaries currently meet and exceed the minimum capital requirements of the Commissioner of Insurance and the BCBSA, as applicable. Regulation of financial reserves for insurance companies and their holding companies is a frequent topic of legislative and regulatory scrutiny and proposals for change. It is possible that the method of measuring the adequacy of our financial reserves could change and that could affect our financial condition.

In addition to its catastrophic reinsurance coverage, STS is required by local regulatory authorities to establish and maintain a reserve supported by a trust fund (the Trust) to protect policyholders against their dual exposure to hurricanes and earthquakes. The funds in the Trust are solely to be used to pay catastrophe losses whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust, and accordingly additions to the reserve, are determined by a rate (1% in 2008 and 2007), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2008 and 2007, we had $31.3 million and $29.1 million, respectively, invested in securities deposited in the Trust. The income generated by investment securities deposited in the Trust becomes part of the Trust fund balance and are therefore considered an addition to the reserve. For additional details see note 17 of the audited consolidated financial statements.

Dividend Restrictions

Puerto Rico insurance laws also restrict insurance companies ability to pay dividends, as they provide that such companies can only pay cash dividends from their available surplus funds derived from realized net profits and cannot pay dividends with funds derived from loans. Any violation of these provisions would subject us to a penalty under these laws.

Puerto Rico insurance laws are not directly applicable to us, as a holding company, since we are not an insurance company. However, we, together with our insurance subsidiaries, are subject to the provisions of the General Corporation Law of Puerto Rico (PRGCL), which contains certain restrictions on the declaration and payment of dividends by corporations organized pursuant to the laws of Puerto Rico. These provisions provide that Puerto Rico corporations may only declare dividends charged to their surplus or, in the absence of such surplus, net profits of the fiscal year in which the dividend is declared and/or the preceding fiscal year. The PRGCL also contains provisions regarding the declaration and payment of dividends and directors liability for illegal payments.

Table of Contents

Guaranty Fund Assessments

We are required by Puerto Rico law and by the BCBSA guidelines to participate in certain guarantee associations. See Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Other Contingencies Guarantee Association for additional information.

Federal Regulation

The Medicare Advantage and Medicare Part D Programs

Medicare is the health insurance program for retired United States citizens aged 65 and older, qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by CMS.

The original Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a $135 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often purchase Medicare supplement products, commonly known as Medigap , to cover deductibles, co-payments, and coinsurance.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, a Medicare beneficiary can choose any licensed physician and use the services of any hospital, healthcare provider, or facility that has signed a participation agreement and meets applicable certification requirements with Medicare. CMS reimburses providers if Medicare covers the service and the service is medically necessary and other applicable coverage criteria. There is currently no fee-for-service coverage for certain preventive services, including annual physicals and well visits, eyeglasses, hearing aids, dentures and most dental services.

As an alternative to the traditional fee-for-service Medicare program, in geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage (MA) program, Medicare beneficiaries may choose to receive Medicare Parts A and B benefits from a managed care plan. The current Medicare managed care program was established in 1997 when Congress created a Medicare Part C, formerly known as Medicare+Choice and now known as Medicare Advantage. Pursuant to Medicare Part C, Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a fixed monthly payment per member from CMS. The monthly payment amounts from CMS to each MA plan are based on the plan s enrolled beneficiaries demographics, including each member s county of residence, as adjusted for each member s health risk characteristics**.** Individuals who elect to participate in the Medicare Advantage program often receive greater benefits than traditional fee-for-service Medicare beneficiaries, such as additional preventive services, and dental and vision benefits, which are included in some of our Medicare Advantage plans. Medicare Advantage plans typically have lower deductibles and co-payments than traditional fee-for-service Medicare, and plan members do not need to purchase supplemental Medigap policies. In exchange for these enhanced benefits, members are generally required to use only the services and provider network provided by the Medicare Advantage plan. Many Medicare Advantage plans have no additional premiums. In some geographic areas, however, and for plans with open access to providers, members may be required to pay a monthly premium.

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans members. Under the Balanced Budget Act of 1997 (BBA), as amended by SCHIP Benefits Improvement Act of 2000 (BIPA), CMS gradually phased in a risk adjustment payment methodology that based CMS monthly payments to plans on various clinical and demographic factors. CMS required all managed care companies to capture, collect and submit the necessary diagnosis code

Table of Contents

information to CMS twice a year for reconciliation with CMS s internal database. Payments to Medicare Advantage plans are also supplemented by a budget neutrality factor, which are scheduled to be phase out by 2011.

As of January 1, 2006 CMS uses a new rate calculation system for Medicare Advantage plans for Parts A and B services. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on the county level payment rates for MA plans prior to 2006, which were at least as high as CMS s historic per capita fee-for-service payments, was relabeled as the benchmark amount, or bidding target. Local Medicare Advantage plans annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the standard bid is less than the benchmark for that year, Medicare will pay the plan its bid amount, risk adjusted based on its risk scores, plus a rebate equal to 75% of the actual amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans are required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits. CMS will have the right to audit the use of these proceeds. The remaining 25% of the excess amount will be retained in the statutory Medicare trust fund. If a Medicare Advantage plan s bid is greater than the benchmark, the plan receives the benchmark as payment from Medicare and charges a premium to enrollees equal to the difference between the bid amount and the benchmark, which is expected to make such plans less competitive. CMS generally updates benchmarks each year. Medicare payments are also based on certain patient demographics and health risk characteristics. Regional MA plans are paid in a manner similar to local plans, described above, but take into account the weighted average of the average county rate and average plan bid. Currently TSI bids are below the CMS benchmark for all of our products.

The 2003 Medicare Modernization Act

In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act (MMA).

As part of the MMA, every Medicare beneficiary is able to select a voluntary prescription drug plan through Medicare Part D. Medicare Part D plans are private companies like ours that have contracted with the federal government to offer and run a Medicare Part D benefit plan under terms and conditions dictated by CMS in 34 geographic regions. Medicare Part D also replaced the Medicaid Prescription Drug Coverage for beneficiaries eligible for participation under both the Medicare and Medicaid programs, or dual-eligibles. The Medicare Part D prescription drug benefit payments to plans are determined through a competitive bidding process, and enrollee premiums also are tied to plan bids. The bids reflect the plan s expected costs for a Medicare beneficiary of average health; CMS adjusts payments to plans based on enrollees health and other factors. The program is largely subsidized by the federal government and is additionally supported by risk-sharing between Medicare Part D plans and the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs, as described below. The government payment amount to plans is based on the national weighted average monthly bid for basic Part D coverage, adjusted for member demographics and risk factor payments. The beneficiary will be responsible for the difference between the government subsidy and his or her plan s bid, together with the amount of his or her plan s supplemental premium (before rebate allocations), subject to the co-pays, deductibles and late enrollment penalties, if applicable, described below. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. Medicare also subsidizes 80% of drug spending above an enrollee s catastrophic threshold.

The Medicare Part D benefits are available to Medicare Advantage plan enrollees as well as Medicare fee-for-service enrollees. Medicare Advantage plan enrollees who elect to participate may pay a monthly premium for this Medicare Part D prescription drug benefit (MA-PD) while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan (PDP) from a list of CMS-approved PDPs available in their area. Any Medicare Advantage Member enrolling in a stand-alone PDP, however, will automatically be disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare for Medicare Parts A and B coverage. Under the standard Part D drug coverage for 2009, beneficiaries enrolled in a stand-alone PDP will pay a $295 deductible, co-insurance payments equal to 25% of the drug costs between $295 and the initial annual coverage limit of $2,700 and all drug

Table of Contents

costs between $2,700 and $6,153, which is commonly referred to as the Part D doughnut hole or coverage gap . After the beneficiary has incurred $4,350 in out-of-pocket drug expenses, the MMA provides catastrophic stop loss coverage that will cover approximately 95% of the beneficiaries remaining out-of-pocket drug costs for that year. MA-PDs are not required to match these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to this standard drug coverage benefit design. Medicare Part D plans also may offer supplemental drug coverage for additional benefits not subsidized by Medicare programs payments. The deductible, co-pay and coverage amounts are adjusted by CMS on an annual basis. We are required as a Medicare Advantage coordinated care plan to offer qualified Part D prescription drug coverage of our MA plan service areas. We currently offer prescription drug benefits through our Medicare Advantage plans and also offer a stand-alone PDP. Among the options in Medicare Advantage, we offer four MA-PD plans with no initial deductible, one of which has generic coverage with a $5 co-payment during the doughnut hole period. On the PDP side, we currently offer three plans, two of which have no initial deductible and one of which has generic coverage with a $5 co-payment during the doughnut hole period.

Dual-Eligible Beneficiaries. A dual-eligible beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Reform, because of economic status. Health plans that serve dual-eligible beneficiaries receive premium from CMS and the government of Puerto Rico for dual-eligible members. The government of Puerto Rico has implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. All qualified Reform participants were eligible to move to the government-sponsored plan beginning in January 2006, and as of December 31, 2006 approximately 61,000 such participants from areas served by us did so. During the years ended December 31, 2007 and 2008, mostly those members newly-qualified for Medicare benefits moved to the government sponsored plan. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dual-eligible members. The MMA provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, as of January 1, 2006 dual-eligible individuals receive their drug coverage from the Medicare program rather than the Reform program. Companies offering stand-alone PDPs with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within the applicable region.

Sales and Marketing. The marketing and sales activities of our insurance and managed care subsidiaries are closely regulated by CMS and ASES. For example, our sales and marketing materials must be approved in advance by the applicable regulatory authorities, and they often impose other regulatory restrictions on our marketing activities.

Annual Enrollment and Lock-in In order for an MA organization to accept an enrollment request, a valid request must be made during an election period. There are four types of election periods during which individuals may make enrollment requests: Annual, Initial Coverage, Special and the Open Enrollment Period. During the Annual Enrollment Period, MA eligible individuals may enroll in or disenroll from an MA plan. It occurs November 15 through December 31 of every year. The Initial Coverage Enrollment Period is the period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan. The initial enrollment period begins 3 months before the individual s entitlement to both Medicare Part A and Part B and ends on the later of the last day of the month preceding entitlement to both Medicare Part A and Part B or the last day of the individual s Part B initial enrollment period. The initial enrollment period for Part B is the seven (7) month period that begins 3 months before the month an individual meets the eligibility requirements for Part B, and ends 3 months after the month of eligibility. In addition, MA eligible individuals may make one open enrollment period election from January 1st through March 31st. During the Open Enrollment Period the change enrollment requests must be made to enroll in the same type of plan. An individual who is enrolled in an MA-PD plan may elect another MA-PD plan or disenroll from the MA-PD by enrolling in a PDP. To effectuate this enrollment request, the individual must elect an MA-PD plan or enroll in a PDP. An individual enrolled in a PDP may elect an MA-PD. An individual who is enrolled in an MA plan and who does not have Part D coverage may elect another MA plan that does not include Part D coverage or may elect to disenroll from the MA plan.

Table of Contents

An individual enrolled in Original Medicare but not in a PDP may elect an MA plan that does not provide Part D coverage but, may not elect an MA-PD plan during this period. After these defined enrollment periods end, generally only Medicare beneficiaries who permanently relocate to another service area, leave the service area for six months, dual-eligible beneficiaries, institutionalized beneficiaries and employer MA plan retirees will be permitted to enroll in or change health plans during that plan year pursuant to special election period rules. Eligible beneficiaries who fail to timely enroll in a Part D plan will be subject to the penalties described above if they later decide to enroll in a Part D plan.

Fiscal Intermediary. As set forth in the MMA, the Federal government, through CMS, replaced the current Title 18 fiscal intermediary (Fl) and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation under the new Medicare Administrative Contractor (MAC) contracting authority. CMS has six years, between 2006 and 2011, to complete the transition of Medicare fee-for-service claims processing activities from the FI s and carriers to the MAC s. On September 12, 2008, CMS announced that First Coast Service Options (FCSO), a non-affiliated third party organization based in Jacksonville, Florida, was awarded the Medicare Administrative Contract (MAC) for Jurisdiction 9 (Florida, Puerto Rico and the U.S. Virgin Islands). FCSO selected our subsidiary, TSI as a subcontractor in MAC Jurisdiction 9 to perform certain provider customer service functions, among others, in Puerto Rico, effective March 1, 2009.

Fraud and Abuse Laws. The federal anti-kickback provisions of the Social Security Act and its regulations prohibit the payment, solicitation, offering or receipt of any form of remuneration (including kickbacks, bribes, and rebates) in exchange for the referral of federal healthcare program patients or any item or service that is reimbursed by any federal health care program. In addition, the federal regulations include certain safe harbors that describe relationships that have been determined by CMS not to violate the federal anti-kickback laws. Relationships that do not fall within one of the enumerated safe harbors are not a per se violation of the law, but will be subject to enhanced scrutiny by regulatory authorities. Failure to comply with the anti-kickback provisions may result in civil damages and penalties, criminal sanctions, and administrative remedies, such as exclusion from the applicable federal health care program.

Federal False Claims Act. Federal regulations also strictly prohibit the presentation of false claims or the submission of false information to the federal government. Under the federal False Claims Act, any person or entity that has knowingly presented or caused to be presented a false or fraudulent request for payment from the federal government or who has made a false statement or used a false record in the submission of a claim may be subject to treble damages and penalties of up to $11,000 per claim. The federal government has taken the position that claims presented in relationships that violate the anti-kickback statute may also be considered to be violations of the federal False Claims Act. Furthermore, the federal False Claims Act permits private citizen whistleblowers to bring actions on behalf of the federal government for violations of the Act and to share in the settlement or judgment that may result from the lawsuit.

HIPAA and Gramm-Leach-Bliley Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorizes HHS to issue standards for administrative simplification, as well as privacy and security of medical records and other individually identifiable health information. The regulations under the HIPAA Administrative Simplification section impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors. HIPAA Administrative Simplification section requirements apply to self-funded group plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically (covered entities). Regulations adopted to implement HIPAA Administrative Simplification also require that business associates acting for or on behalf of HIPAA-covered entities be contractually obligated to meet HIPAA standards. The regulations of the Administrative Simplification section establish significant criminal penalties and civil sanctions for noncompliance.

HHS has released rules mandating the use of new standard formats with respect to certain health care transactions (e.g. health care claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules requiring the use of standardized code sets and

Table of Contents

unique identifiers by employers and providers. Our managed care subsidiary believes that it is in material compliance with all relevant requirements.

HHS also sets standards relating to the privacy of individually identifiable health information. In general, these regulations restrict the use and disclosure of medical records and other individually identifiable health information held by health plans and other affected entities in any form, whether communicated electronically, on paper or orally, subject only to limited exceptions. In addition, the regulations provide patients new rights to understand and control how their health information is used. HHS has also published security regulations designed to protect member health information from unauthorized use or disclosure. Our managed care subsidiary is currently in material compliance with these security regulations.

The American Recovery and Reinvestment Act of 2009 (H.R. 1, S. 1) (the Stimulus), signed by President Obama on February 17, 2009, contains several provisions that expand the scope and enforcement of HIPAA. Most of the Stimulus provisions that affect and expand HIPAA will not become effective until February 17, 2010 or thereafter, and the Secretary of HHS is required to promulgate regulations interpreting and clarifying the aspects of the Stimulus pertaining to HIPAA. We will monitor the implementation of the Stimulus and the regulations promulgated thereunder, and we will modify our policies and operations to comply with these amendments. See Item 1 Regulation Legislative Initiatives for additional information.

Other federal legislation includes the Gramm-Leach-Bliley Act, which applies to financial institutions domiciled in Puerto Rico. The Gramm-Leach-Bliley Act generally placed restrictions on the disclosure of non-public information to non-affiliated third parties, and required financial institutions including insurers, to provide customers with notice regarding how their non-public personal information is used, including an opportunity to opt out of certain disclosures. The Gramm-Leach-Bliley Act also gives banks and other financial institutions the ability to affiliate with insurance companies, which has led to new competitors in the insurance and health benefits fields in Puerto Rico.

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA) a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor (DOL). ERISA regulates certain aspects of the relationships between us, the employers who maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

Other Government Programs

We participate in the Health Reform of the government of Puerto Rico (the Reform) to provide health coverage to medically indigent citizens in Puerto Rico. See Business Customers Reform Sector .

Legislative and Regulatory Initiatives

Puerto Rico Initiatives

The Commissioner of Insurance is currently evaluating the adoption of Rule No. 83, titled Norms and Procedures to Regulate Insurance and Health Maintenance Holding Company Systems and the Criteria to Evaluate the Change of Control . The most recent draft of Rule No. 83 contains certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. Rule No. 83 would generally require insurance companies and HMOs within an insurance holding company system to register with the Commissioner of Insurance if they are domiciled in the Commonwealth and to file with the Commissioner of Insurance certain reports describing capital structure, ownership, financial condition, certain intercompany transactions and general business operations. In addition, Rule No. 83 would require prior notice, reporting and regulatory approval of certain material transactions and intercompany transfers

Table of Contents

of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other restrictions, Rule No. 83 would restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, Rule No. 83 would restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. According to Rule No. 83, no person may make an offer to acquire or to sell the issued and outstanding voting stock of an insurance company, which constitutes 10% or more of the issued and outstanding stock of an insurance company, or of the total stock issued and outstanding of a holding company of an insurance company, without (i) filing the appropriate documentation with the Commissioner of Insurance and (ii) obtaining the prior approval of the Commissioner of Insurance. This requirement is similar to that contained in the Insurance Code and referred to under Regulation Puerto Rico Insurance Laws .

Federal Initiatives

On February 26, 2009, President Obama announced his proposed budget for fiscal year 2010, which supports his comprehensive health care reform agenda. The Obama health care reform plan is expected to address increasing access to health care coverage, reducing the cost of care, and improving the quality of care rendered. The health care reform plan is expected to be financed in large part by reduced expenditures for the Medicare program. The proposed budget projects a minimum savings on health care expenditures of $316 billion by the Federal government over the next decade in the Medicare program, including $176 billon of which will be realized through reduced payments to Medicare Advantage plans as a result of changes in the competitive bidding process for Medicare Advantage contracts. In addition, President Obama s proposed budget calls for premium increases for certain high-income Medicare beneficiaries.

Consistent with President Obama s plan, Congress has previously supported financing health care reform by reducing Medicare Advantage subsidies. On August 1, 2007, the U.S. House of Representatives passed the Children s Health and Medicare Protection Act of 2007 (H.R. 3162), which, among other things, would amend the Social Security Act to improve the federal government s children s health insurance program and make other changes under the Medicare and Medicaid programs. H.R. 3162 includes provisions that would gradually reduce Medicare Advantage payments over a four-year period to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program by 2011, consistent with the recommendations contained in MedPac s 2007 annual report to Congress on Medicare payment policy H.R. 3162 was referred to the Senate on September 4, 2007 for consideration; however, Congress did not enact H.R. 3162. Instead, Congress enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007 in order to protect physician payment reductions through June 30, 2008. This legislation did not include any payment reductions to Medicare Advantage plans, but it included several provisions affecting Medicare Advantage plans, including: (i) extended the statutory authority to allow existing special needs plans (SNPs) to continue to operate through December 31, 2009; (ii) placed a moratorium on approval of new SNPs; and (iii) removed $1.5 billion from the stabilization fund for regional preferred provider organizations in 2012, which would have no impact on plans in Puerto Rico. In its 2009 annual report to Congress, MedPac projected Medicare Advantage payments are likely to exceed payments for comparable Medicare fee-for-service spending in 2009 by 14%, and restated its support financial neutrality between payment rates for traditional Medicare fee-for-service and Medicare Advantage programs, as contained in H.R. 3162. As of the date of this Annual Report on Form 10-K, the U.S. Congress has not enacted H.R. 3162, or any other legislation that includes the MedPac recommendations for gradual reductions in Medicare Advantage payments. We cannot provide assurances if, when or to what degree Congress may enact H.R. 3162 or similar legislation, including the MedPac recommendations, but any reduction in Medicare Advantage rates could have a material adverse effect on our revenue, financial position, results of operations or cash flow.

The Stimulus contains several provisions that expand the scope and enforcement of HIPAA. In general, the Stimulus makes the following additions to and expansions of HIPAA: (i) business associates will be directly subject to certain provisions of HIPAA; (ii) covered entities and business associates must report breaches of unencrypted protected health information to the affected individuals and the Secretary of HHS; (iii) covered entities will have greater responsibilities with respect to the accounting of disclosures of protected health information; (iv) individuals will have greater access to their protected health information and increased ability to request restrictions on the disclosure of

their protected health information; (v) there

Table of Contents

will be additional restrictions and prohibitions on the ability of covered entities and business associates to sell protected health information for marketing purposes; (vi) the civil and criminal penalties for violations of HIPAA will be increased; and (vii) State Attorneys General have the authority to file suit in federal district court for alleged violations of HIPAA. The authority granted to State Attorneys General to prosecute HIPAA violations took effect as of February 17, 2009. However, the remaining Stimulus provisions that affect and expand HIPAA will not become effective until February 17, 2010 or thereafter. The Stimulus requires the Secretary of HHS to promulgate regulations interpreting and clarifying the aspects of the Stimulus pertaining to HIPAA. We are a covered entity under HIPAA, and therefore, we will monitor the implementation of the Stimulus and the regulations promulgated thereunder, and modify our policies and operations to remain HIPAA compliant.

President Obama and the U.S. Congress are considering a number of proposals to decrease the number of Americans who are uninsured or under-insured for health care, to decrease the costs of health care, and to improve the quality of care**.** We cannot provide assurances if, when or to what degree Congress may act on any of the proposals and do not know whether any proposal which may be enacted into law will change the way health insurance benefits are structured, sold or administered in the future.

Financial Information About Segments

Operating revenues (with intersegment premiums/service revenues shown separately), operating income and total assets attributable to the reportable segments are set forth in note 27 to the audited consolidated financial statements for the years ended December 31, 2008, 2007 and 2006.

Employees

As of February 28, 2009, we had 2,269 full-time employees and 301 temporary employees. Our managed care subsidiary has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 45% of our managed care subsidiary s 725 regular employees. The collective bargaining agreement expires on July 31, 2012. The Corporation considers its relations with employees to be good.

Available Information

We are an accelerated filer (as defined in Rule 12b-2 of the Securities Exchange Act of 1934, as amended) and are required, pursuant to Item 101 of Regulation S-K, to provide certain information regarding its website and the availability of certain documents filed with or furnished to the United States Securities and Exchange Commission (the SEC). Our Internet website is www.triplesmanagement.com. We make available free of charge, or through our Internet website, our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, and any amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934 as soon as reasonably practicable after we electronically file such material with or furnish it to the SEC. We also include on our Internet website our Corporate Governance Guidelines, our Standards of Ethical Business Conduct and the charter of each standing committee of our Board of Directors. In addition, we intend to disclose on our Internet website any amendments to, or waivers from, our Standards of Ethical Business Conduct that are required to be publicly disclosed pursuant to rules of the SEC and the New York Stock Exchange (NYSE). The SEC maintains an internet site (www.sec.gov) that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. The website addresses listed above are provided for the information of the reader and are not intended to be an active link. We will provide free of charge copies of our filings to any shareholder that requests them at the following address: Triple-S Management Corporation; Office of the Secretary of the Board; PO Box 363628; San Juan, P.R. 00936-3628.

Special Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K contains forward-looking statements, as such term is defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that include

Table of Contents

information about possible or assumed future sales, results of operations, developments, regulatory approvals or other circumstances and may be found in the Items of this Annual Report on Form 10-K entitled Item 1 Business , Item 1A Risk Factors , Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations and elsewhere in this Annual Report on Form 10-K. Statements that use the terms believe , expect , plan , intend , estimate , anticipate , project , may , will , shall , should and similar expressions, whether in the positive or ne intended to identify forward-looking statements.

All forward-looking statements in this Annual Report on Form 10-K reflect our current views about future events and are based on assumptions and subject to risks and uncertainties. Consequently, actual results may differ materially from those anticipated in these forward-looking statements as a result of various factors, including all the risks discussed in Item 1A Risk Factors and elsewhere in this Annual Report on Form 10-K.

In addition, we operate in a highly competitive, constantly changing environment that is significantly influenced by very large organizations that have resulted from business combinations, aggressive marketing and pricing practices of competitors and regulatory oversight. The following is a summary of factors, the results of which, either individually or in combination, if markedly different from our planning assumptions, could cause our results to differ materially from those expressed in any forward-looking statements contained in this Annual Report on Form 10-K:

- trends in health care costs and utilization rates;
- ability to secure sufficient premium rate increases;
- competitor pricing below market trends of increasing costs;
- re-estimates of our policy and contract liabilities;
- changes in government regulation of managed care, life insurance or property and casualty insurance;
- significant acquisitions or divestitures by major competitors;
- introduction and use of new prescription drugs and technologies;
- a downgrade in our financial strength ratings;
- litigation or legislation targeted at managed care, life insurance or property and casualty insurance companies;
- ability to contract with providers consistent with past practice;
- ability to successfully implement our disease management and utilization management programs;
- volatility in the securities markets and investment losses and defaults;
- general economic downturns, major disasters and epidemics.

The foregoing list should not be construed to be exhaustive. We believe the forward-looking statements in this Annual Report on Form 10-K are reasonable; however, there is no assurance that the actions, events or results anticipated by the forward-looking statements will occur or, if any of them do, what impact they will have on our results of operations or financial condition. In view of these uncertainties, you should not place undue reliance on any forward-looking statements, which are based on our current expectations. Further, forward-looking statements speak only as of the date they are made, and, other than as required by applicable law, including the securities laws of the United States, we do not intend to update or revise any of them in light of new information or future events.

Item 1A. Risk Factors

We must deal with several risk factors during the normal course of business. You should carefully consider the following risks and all other information set forth on this Annual Report on Form 10-K. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that are currently deemed immaterial may also impair our business operations. The occurrence of any of the following risks could materially affect our business, financial condition, operating results, and cash flows.

Table of Contents

Risks Relating to our Capital Stock

Certain of our current and former providers may bring materially dilutive claims against us.

Beginning with our founding in 1959 and until 1994, we encouraged, and at times required, the doctors and dentists that comprised our provider network to acquire our shares. Between approximately 1985 and 1994, our predecessor managed care subsidiary, Seguros de Servicios de Salud de Puerto Rico, Inc. (SSS) generally entered into an agreement with each new physician or dentist who joined our provider network to sell the provider shares of SSS at a future date (each agreement, a share acquisition agreement). These share acquisition agreements were necessary because there were not enough authorized shares of SSS available during this period and afterwards for issuance to all new providers. Each share acquisition agreement committed SSS to sell, and each new provider to purchase, five $40-par-value shares of SSS at $40 per share after SSS had increased its authorized share capital in compliance with the Puerto Rico Insurance Code and was in a position to issue new shares. Despite repeated efforts in the 1990s, SSS was not successful in obtaining shareholder approval to increase its share capital, other than in connection with the Corporation s reorganization in 1999, when SSS was merged into a newly-formed entity having authorized capital of 25,000 $40-par-value shares, or twice the number of authorized shares of SSS. SSS s shareholders did not, however, authorize the issuance of the newly formed entity s shares to providers or any other third party. In addition, subsequent to the reorganization, our shareholders did not approve attempts to increase our share capital in 2002 and 2003. Notwithstanding the fact that TSI and its predecessor, SSS, were never in a position to issue new shares to providers as contemplated by the share acquisition agreements because shareholder approval for such issuance was never obtained, and the fact that SSS on several occasions in the 1990s offered providers the opportunity to purchase shares of its treasury stock and such offers were accepted by very few providers, providers who entered into share acquisition agreements may claim that the share acquisition agreements entitled them to acquire our or TSI s shares at a subscription price equivalent to that provided for in the share acquisition agreements. SSS entered into share acquisition agreements with approximately 3,000 providers, the substantial majority of whom never came to own shares of SSS. Such share acquisition agreements provide for the purchase and sale of approximately 15,000 shares of SSS. If we or TSI were required to issue a significant number of shares in respect of these agreements, the interest of our existing shareholders would be substantially diluted. As of the date of this Annual Report on Form 10-K, only one judicial claim to enforce any of these agreements has been commenced. Additionally, we have received inquiries with respect to less than 700 shares under share acquisition agreements. The share numbers set forth in this paragraph reflect the number of SSS shares provided for in the share acquisition agreements. Those agreements do not include anti-dilution protections and we do not believe that the amounts of any claims under the agreements with SSS should be multiplied to reflect our 3,000-for-one stock split. We cannot provide assurances, however, that claimants will not successfully seek to increase the size of their claims by reference to the stock split.

We have been advised by our counsel that, on the basis of a reasoned analysis, while the matter is not free from doubt and there are no applicable controlling precedents, we should prevail in any litigation of these claims because, among other defenses, the condition precedent to SSS s obligations under the share acquisition agreements never occurred, and any obligation it may, or we may be deemed to, have had under the share acquisition agreements should be understood to have expired prior to our corporate reorganization, which took effect in 1999, although the share acquisition agreements do not expressly provide for any expiration.

We believe that we should prevail in any litigation with respect to these matters; however, we cannot predict the outcome of any such litigation, including with respect to the magnitude of any claims that may be asserted by any plaintiff, and the interests of our shareholders could be materially diluted to the extent that claims under the share acquisition agreements are successful.

Heirs of certain of our former shareholders may bring materially dilutive claims against us.

For much of our history, we and our predecessor entity have restricted the ownership or transferability of our shares, including by reserving to us or our predecessor a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, we and our

Table of Contents

predecessor, consistent with the requirements of our and our predecessor s bylaws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, former shareholders heirs who were not eligible to own or be transferred shares because they were not physicians or dentists at the time of their purported inheritance (non-medical heirs), may claim an entitlement to our shares or to damages with respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 former shareholders whose non-medical heirs may claim to have inherited up to 10,500,000 shares after giving effect to the 3,000-for-one stock split. As of the date of this Annual Report on Form 10-K, four judicial claim seeking the return of or compensation for 81 shares (prior to giving effect to the 3,000-for-one stock split) had been brought by non-medical heirs of former shareholders whose shares were repurchased upon their death. These heirs purport to represent as a class all non-medical heirs of deceased shareholders whose shares we repurchased. In addition, we have received inquiries from non-medical heirs with respect to less than 700 shares (or 2,100,000 shares after giving effect to the 3,000-for-one stock split).

We believe that we should prevail in litigation with respect to these matters; however, we cannot predict the outcome of any such litigation regarding these non-medical heirs. The interests of our existing shareholders could be materially diluted to the extent that any such claims are successful.

The dual class structure may not successfully protect against significant dilution of your shares of Class B common stock.

We designed our dual class structure of capital stock to offset the potential impact on the value of our Class B common stock attributable to any issuance of shares of common stock for less than market value in respect of a successful claim against us under any share acquisition agreement or by a non-medical heir. We believe that this mechanism will effectively protect investors in our shares of Class B common stock against any potential dilution attributable to the issuance of any shares in respect of such claims at below market prices. We cannot, however, provide any assurances that this mechanism will be effective under all circumstances.

While we expect to prevail against any such claims brought against us and, to the extent that we do not prevail, would expect to issue Class A common stock in respect of any such claim, there can be no assurance that the claimants in any such lawsuit will not seek to acquire Class B common stock. The issuance of a significant number of shares of Class B common stock, if followed by a material further issuance of shares of common stock to separate claimants, could impair the effectiveness of the anti-dilution protections of the Class B common stock. In addition, we cannot provide any assurances that the anti-dilution protections afforded our Class B common stock will not be challenged by share acquisition providers and/or non-medical heir claimants to the extent that these protections limit the percentage ownership of us that may be acquired by such claimants. We believe that such a challenge should not prevail, but cannot provide any assurances of the outcome.

In the event that claimants acquire shares of our managed care subsidiary, TSI, at less than fair value, we will not be able to prevent dilution of the value of the Class B shareholders ownership interest in us to the extent that the net value received by such claimants exceeds the value of our outstanding shares of Class A common stock. Finally, the anti-dilution protection afforded by the dual class structure may cease to be of further effect five years following the completion of our initial public offering, at which time all remaining shares of Class A common stock may, at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted into shares of Class B common stock even if we have not resolved all claims against us by such time.

Future sales of our Class B common stock, or the perception that such future sales may occur, may have an adverse impact on its market price.

Sales of a substantial number of shares of our common stock in the public market, or the perception that large sales could occur, could cause the market price of our Class B common stock to decline. Either of these limits our future ability to raise capital through an offering of equity securities. There are 22,104,989 shares of Class B common stock and 9,042,809 shares of Class A common stock outstanding as of December 31, 2008. Our Class A common stock is no longer subject to contractual lockup; thus, such shares are freely tradable without restriction or further registration under the Securities Act by persons

Table of Contents

other than our affiliates within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the New York Stock Exchange (NYSE) and will not be fungible with our listed shares of Class B common stock. In addition, at any time following the fifth anniversary of our initial public offering, or such earlier date after the first anniversary of the initial public offering as all claims with respect to which anti-dilution protections are afforded to shares of Class B common stock have been resolved, all or any portion of our shares of Class A common stock may at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock.

Risks Related to Our Business

Our inability to contain managed care costs may adversely affect our business and profitability.

Substantially all of our managed care revenue is generated by premiums consisting of monthly payments per member that are established by contracts with our commercial customers, the government of Puerto Rico (for the Reform program) or the CMS (for our Medicare Advantage and PDP plans), all of which are typically renewable on an annual basis. If our medical expenses exceed our estimates, except in very limited circumstances or as a result of risk score adjustments for member acuity, we will be unable to increase the premiums we receive under these contracts during the then-current terms. As a result, our profitability in any year depends, to a significant degree, on our ability to adequately predict and effectively manage our medical expenses related to the provision of managed care services through underwriting criteria, medical management, product design and negotiation of favorable provider contracts with hospitals, physicians and other health care providers. The aging of the population and other demographic characteristics and advances in medical technology continue to contribute to rising health care costs. Government-imposed limitations on Medicare and Reform reimbursement have also caused the private sector to bear a greater share of increasing health care costs. Also, we have in the past and may in the future enter into new lines of business in which it may be difficult to estimate anticipated costs. Numerous factors affecting the cost of managed care, including changes in health care practices, inflation, new technologies such as genetic laboratory screening for diseases including breast cancer, electronic recordkeeping, the cost of prescription drugs, clusters of high cost cases, changes in the regulatory environment including the implementation of HIPAA amendments under the Stimulus, as well as others, such as implementation of President Obama s health care reform plan, may adversely affect our ability to predict and manage managed care costs, as well as our business, financial condition and results of operations.

Our inability to implement increases in premium rates on a timely basis may adversely affect our business and profitability.

In addition to the challenge of managing managed care costs, we face pressure to contain premium rates. Our customers may move to a competitor at policy renewal to obtain more favorable premiums. Future Medicare and Reform premium rate levels may be affected by continuing government efforts to contain medical expense or other federal budgetary constraints. In particular, the government of Puerto Rico has adopted several measures to control Reform expenditures, such as closer and continuous scrutiny of participants eligibility, redesign of benefits, co-payments, deductibles, and requiring the establishment of disease management programs. Changes in the Medicare and Reform programs, including with respect to funding, may lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits, or reductions in the number of persons enrolled in or eligible for Medicare and the Reform. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

Our profitability may be adversely affected if we are unable to maintain our current provider agreements and to enter into other appropriate agreements.

Our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other managed care providers. We face heavy competition from other managed care plans to enter into contracts with hospitals, physicians and other providers in our provider networks. Consolidation in our industry, both on the provider side and on the managed care side, only exacerbates this competition.

Table of Contents

Currently certain providers are pressing for legislation that would allow them to negotiate service fees by group. The failure to maintain or to secure new cost-effective managed care provider contracts may result in a loss in membership or higher medical costs. In addition, our inability to contract with providers could adversely affect our business.

A reduction in the enrollment in our managed care programs could have an adverse effect on our business and profitability.

A reduction in the number of enrollees in our managed care programs could adversely affect our business, financial condition and results of operations. Factors that could contribute to a reduction in enrollment include: failure to obtain new customers or retain existing customers; premium increases and benefit changes; our exit from a specific market; reductions in workforce by existing customers; negative publicity and news coverage; failure to maintain the Blue Shield license; and any general economic downturn that results in business failures.

We are dependent on a small number of government contracts to generate a significant amount of the revenues of our managed care business.

Our managed care business participates in government contracts that generate a significant amount of our consolidated premiums earned, net, as follows:

Reform: We participate in the government of Puerto Rico Health Reform Program to provide health coverage to medically indigent citizens in Puerto Rico. Our results of operations have depended to a significant extent on our participation in the Reform program. During each of the years ended December 31, 2008, 2007 and 2006, the Reform program has accounted for 20.1%, 22.1% and 30.2%, respectively , of our consolidated premiums earned, net. During the 2008 period, we were the sole Reform provider in two of the eight Reform regions in Puerto Rico on a fully insured basis. One region was awarded to us on an ASO basis for a one year period beginning November 1, 2008. Since we obtained our first Reform contract in 1995, we have been the sole provider for two to three regions each year. The contract for each geographical area is subject to termination in the event of any non-compliance by the insurance company which is not corrected or cured to the satisfaction of the government entity overseeing the Reform, or on 90 days prior written notice in the event that the government determines that there is an insufficiency of funds to finance the Reform. These contracts have one-year terms and expire on June 30 of each year, except for the Metro-North region contract. Upon the expiration of the contract for a geographical area, the government of the Commonwealth of Puerto Rico usually commences an open bidding process for such area. During the year ended December 31, 2006, this region accounted for 10.7% of our consolidated premiums earned, net and 7.4% of our consolidated operating income. We intend to continue to participate in the Reform program, but we may not be able to retain the right to service a particular geographical area in which we currently operate after the expiration of our current or any future contracts.

Medicare: We provide services through our Medicare Advantage health plans pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if any of these contracts are terminated, our business would be materially impaired. During each of the years ended December 31, 2008, 2007 and 2006, contracts with CMS represented 25.9%, 17.2% and 11.3% of our consolidated premiums earned, net, respectively, and 12.4%, 34.6% and 46.0% of our consolidated operating income, respectively. The Medicare business may in the future represent a greater percentage of our results.

Commercial: Our managed care subsidiary is a qualified contractor to provide managed care coverage to federal government employees within Puerto Rico. Such coverage is provided pursuant to a contract with the OPM that is subject to termination in the event of noncompliance not corrected to the satisfaction of the OPM. During each of the years ended December 31, 2008, 2007 and 2006 premiums generated under this contract represented 7.3%, 8.2% and 7.5% of our consolidated premiums earned, net, respectively. The operating income generated under this contract represented 1.1% of our consolidated operating income, during each of

the years ended December 31, 2008, 2007 and 2006.

Table of Contents

If any of these contracts is terminated for any reason, including by reason of any noncompliance by us, or not renewed or replaced by a comparable contract, our premiums would be materially adversely affected. The further loss or non-renewal of either of our fully insured Reform contracts could have a material adverse effect on our operating results and could result in the downsizing of certain personnel, the cancellation of lease agreements of certain premises and of certain contracts, and severance payments, among others.

A change in our managed care product mix may impact our profitability.

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than ASO products and those managed care products where employer groups retain the risk, such as self-funded financial arrangements. There has been a trend in recent years among our Commercial customers of moving from fully-insured plans to ASO, or self-funded arrangements. In addition, the government of Puerto Rico began a pilot project in 2003 in one of the eight geographical areas under which it contracted for Reform services on an ASO basis for certain members instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region. This region was awarded to us again on an ASO basis for a one year period beginning November 1, 2008. There can be no assurance that the government will not implement such a program in areas served by us. As of December 31, 2008, and as a result of us being awarded the Metro-North region contract on an ASO basis, 69.5% of our managed care customers had fully insured arrangements and 30.5% had ASO arrangements, as compared to approximately 83.5% and 16.5%, respectively, as of December 31, 2007. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

Our failure to accurately estimate incurred but not reported claims would affect our reported financial results.

A portion of the claim liabilities recorded by our insurance segments represents an estimate of amounts needed to pay and adjust anticipated claims with respect to insured events that have occurred, including events that have not yet been reported to us. These amounts are based on estimates of the ultimate expected cost of claims and on actuarial estimation techniques. Judgment is required in actuarial estimation to ascertain the relevance of historical payment and claim settlement patterns under each segment s current facts and circumstances. Accordingly, the ultimate liability may be in excess of or less than the amount provided. We regularly compare prior period liabilities to re-estimated claim liabilities based on subsequent claims development; any difference between these amounts is adjusted in the operations of the period determined. Additional information on how each reportable segment determines its claim liabilities, and the variables considered in the development of this amount, is included elsewhere in this Annual Report on Form 10-K under Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operation Critical Accounting Policies . Actual experience will likely differ from assumed experience, and to the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

The termination or modification of our license agreements to use the Blue Shield name and mark could have a material adverse effect on our business, financial condition and results of operations.

We are a party to a license agreement with the BCBSA which entitle us to the exclusive use of the Blue Shield name and mark in Puerto Rico. We believe that the Blue Shield name and mark are valuable identifiers of our products and services in the marketplace. The termination of this license agreement or changes in the terms and conditions of a license agreement could adversely affect our business, financial condition and results of operations.

Our license agreement with the BCBSA contains certain requirements and restrictions regarding our operations and our use of the Blue Shield name and mark. Failure to comply with any of these requirements and restrictions could result in a termination of a license agreement. The standards under a license agreement may be modified in certain instances by the BCBSA. From time to time there have been proposals considered by the BCBSA to modify the terms of a license agreement to restrict various potential business activities of licensees. To the extent that such amendments to the license agreement are adopted

Table of Contents

in the future, they could have a material adverse effect on our future expansion plans or results of operations.

Upon any event causing termination of the license agreements, we would no longer have the right to use the Blue Shield name and mark in Puerto Rico. Furthermore, the BCBSA would be free to issue a license to use the Blue Shield name and mark in Puerto Rico to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Accordingly, termination of a license agreement could have a material adverse effect on our business, financial condition and results of operations.

In addition, the BCBSA requires us to comply with certain specified levels of risk based capital (RBC). RBC is designed to identify weakly capitalized companies by comparing each company s adjusted surplus to its required surplus (the RBC ratio). Although we are currently in compliance with these requirements, we may be unable to continue to comply in the future. Failure to comply with these requirements could result in the revocation or loss of our BCBS license.

Upon termination of a license agreement, the BCBSA would impose a Re-establishment Fee upon us, which would allow the BCBSA to re-establish a Blue Shield presence in the vacated service area with another managed care company. The fee is currently $89.02 per licensed enrollee. If the re-establishment fee were applied to our total Blue Shield enrollees as of December 31, 2008, we would be assessed approximately $106.4 million by the BCBSA. See Item 1 Business Blue Shield License for more information.

Our ability to manage our exposure to underwriting risks in our life insurance and property and casualty insurance businesses depends on the availability and cost of reinsurance coverage.

Reinsurance is the practice of transferring part of an insurance company s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. In the year ended December 31, 2008, 42.9%, or $72.1 million, of the premiums written in the property and casualty insurance segment and 7.6%, or $7.6 million, of the premiums written in the life insurance segment were ceded to reinsurers. In the year ended December 31, 2007, 40.4%, or $69.1 million, of the premiums written in the property and casualty insurance segment and 9.0%, or $8.8 million, of the premiums written in the life insurance segment were ceded to reinsurers. The availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or to obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

It is also possible that the losses we experience on insured risks for which we have obtained reinsurance will exceed the coverage limits of the reinsurance. See Large scale natural disasters may have a material adverse effect on our business, financial condition and results of operation . If the amount of our reinsurance coverage is insufficient, our insurance losses could increase substantially.

If our reinsurers do not pay our claims or do not pay them in a timely manner, we may incur losses.

We are subject to loss and credit risk with respect to the reinsurers with whom we deal. In accordance with general industry practices, our property and casualty and life insurance subsidiaries annually purchase reinsurance to lessen the impact of large unforeseen losses and mitigate sudden and unpredictable changes in our net income and shareholders equity. Reinsurance contracts do not relieve us from our obligations to policyholders. In the event that all or any of the reinsurance companies are unable to meet their obligations under existing reinsurance agreements or pay on a timely basis, we will continue to be liable to our policyholders notwithstanding such defaults or delays. If our reinsurers are not capable of fulfilling their

Table of Contents

financial obligations to us, our insurance losses would increase, which would negatively affect our financial condition and results of operations.

A downgrade in our A.M. Best rating or our inability to increase our A.M. Best rating could affect our ability to write new business or renew our existing business in our property and casualty segment.

Ratings assigned by A.M. Best are an important factor influencing the competitive position of the property and casualty insurance companies in Puerto Rico. In 2008, A.M. Best maintained our property and casualty insurance subsidiary s rating of A- (the fourth highest of A.M. Best s 16 financial strength ratings) and changed the outlook to stable. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary s rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings.

Significant competition could negatively affect our ability to maintain or increase our profitability.

Managed Care

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of managed care companies. In addition, the managed care market in Puerto Rico, other than the Medicare Advantage market, is mature. According to the U.S. Census Bureau, Puerto Rico s population grew by 0.3% between July 2007 and 2008, less than half the national population rate growth of 0.9% during the same period. As a result, in order to increase our profitability we must increase our membership in the new Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically. In Puerto Rico, several managed care plans and other entities were awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans and entered that market in 2006 and 2007. We anticipate that these other plans will aggressively market their benefits to our current and our prospective members. Although we believe that we market an attractive offering, there are no assurances that we will be able to compete successfully with these other plans for new members, or that our current members will not choose to terminate their relationship with us and enroll in these other plans. Concentration in our industry also has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. The parent companies of some of our competitors are larger and have greater financial and other resources than we do. We may have difficulty competing with larger managed care companies, which can create downward price pressures on premium rates. We may not be able to compete successfully against current and future competitors. Competitive pressures faced by us may adversely affect our business, financial condition and results of operations. In addition, our rights under the BCBSA license only extend to the use of the Blue Shield name and mark in Puerto Rico. The exclusive right to use the Blue Cross name and mark in Puerto Rico is currently held by La Cruz Azul de Puerto Rico

Future legislation at the federal and local levels also may result in increased competition in our market. While we do not anticipate that any of the current legislative proposals of which we are aware would increase the competition we face, future legislative proposals, if enacted, might do so.

Complementary Products

The property and casualty insurance market in Puerto Rico is extremely competitive. Due to the relatively low level of economic growth in Puerto Rico, there are few new sources of business in this segment. As a result, property and casualty insurance companies compete for the same accounts through aggressive

Table of Contents

pricing, more favorable policy terms and better quality of services. We also face heavy competition in the life and disability insurance market.

We believe these trends will continue. There can be no assurance that these competitive pressures will not adversely affect our business, financial condition and results of operations.

As a holding company, we are largely dependent on rental payments, dividends and other payments from our subsidiaries, although the ability of our regulated subsidiaries to pay dividends or make other payments to us is subject to the regulations of the Commissioner of Insurance, including maintenance of minimum levels of capital, as well as covenant restrictions in their indebtedness.

We are a holding company whose assets include, among other things, all of the outstanding shares of common stock of our subsidiaries, including our regulated insurance subsidiaries. We principally rely on rental income and dividends from our subsidiaries to fund our debt service, dividend payments and operating expenses, although our subsidiaries do not declare dividends every year. We also benefit to a lesser extent from income on our investment portfolio.

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. See Our insurance subsidiaries are subject to minimum capital requirements. Our failure to meet these requirements could subject us to regulatory action . These regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed. Our subsidiaries ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, if any, business and other legal restrictions. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries have a superior claim to such subsidiaries assets. Our subsidiaries may not be able to pay dividends or otherwise contribute or distribute funds to us in an amount sufficient for us to meet our financial obligations. In addition, from time to time, we may find it necessary to provide financial assistance, either through subordinated loans or capital infusions to our subsidiaries.

In addition, we are subject to RBC requirements by the BCBSA. See The termination or modification of our license agreements to use the Blue Shield name and mark could have a material adverse effect on our business, financial condition and results of operations .

Our results may fluctuate as a result of many factors, including cyclical changes in the insurance industry.

Results of companies in the insurance industry, and particularly the property and casualty insurance industry, historically have been subject to significant fluctuations and uncertainties. The industry s profitability can be affected significantly by:

- rising levels of actual costs that are not known by companies at the time they price their products;
- volatile and unpredictable developments, including man-made and natural catastrophes;
- changes in reserves resulting from the general claims and legal environments as different types of claims arise and judicial interpretations relating to the scope of insurers liability develop; and
- fluctuations in interest rates, inflationary pressures and other changes in the investment environment, which affect returns on invested capital.

Historically, the financial performance of the insurance industry has fluctuated in cyclical periods of low premium rates and excess underwriting capacity resulting from increased competition, followed by periods of high premium rates and a shortage of underwriting capacity resulting from decreased competition. Fluctuations in underwriting capacity, demand and competition, and the impact on us of the other factors identified above, could have a negative impact on our results of operations and financial condition. We believe that underwriting capacity and price competition in the current market is increasing. This additional underwriting capacity may result in increased competition from other insurers seeking to expand the kinds or amounts of business they write or cause some insurers to seek to maintain market share at the expense of underwriting discipline. We may not be able to retain or attract customers in the future at prices we consider adequate.

Table of Contents

If we do not effectively manage the growth of our operations, we may not be able to achieve our profitability targets.

Our growth strategy includes enhancing our market share in Puerto Rico, entering new geographic markets, introducing new insurance products and programs, further developing our relationships with independent agencies or brokers and pursuing acquisition opportunities. Our strategy is subject to various risks, including risks associated with our ability to:

identify profitable new geographic markets to enter;

operate in new geographic areas, as we have very limited experience operating outside Puerto Rico;

obtain licenses in new geographic areas in which we wish to market and sell our products;

successfully implement our underwriting, pricing, claims management and product strategies over a larger operating region;

properly design and price new and existing products and programs and reinsurance facilities for markets in which we have no direct experience;

identify, train and retain qualified employees;

identify, recruit and integrate new independent agencies and brokers and expand the range of Triple-S products carried by our existing agents and brokers;

develop a network of physicians, hospitals and other managed care providers that meets our requirements and those of applicable regulators; and

augment our internal monitoring and control systems as we expand our business.

We also may encounter difficulties in the implementation of our growth strategies. For instance, our BCBSA license entitles us to use the Blue Shield name and mark only in Puerto Rico. We currently are not able to use the Blue Shield name and mark in areas outside Puerto Rico. In addition, we may enter into markets or product lines in which we have little or no prior experience. For example, we plan to expand our operations outside Puerto Rico and to expand our property and casualty insurance segment through the establishment of an auto preferred rate insurance company, which will write personal auto policies at discounted rates.

Any such risks or difficulties could limit our ability to implement our growth strategies or result in diversion of senior management time and adversely affect our financial results.

We face intense competition to attract and retain employees and independent agents and brokers.

We are dependent on retaining existing employees, attracting and retaining additional qualified employees to meet current and future needs and achieving productivity gains. Our life insurance subsidiary, TSV, has historically experienced a very high level of turnover in its home service agents, through which it places a majority of its premiums, and we expect this trend to continue. Our inability to retain existing employees or attract additional employees could have a material adverse effect on our business, financial condition and results of operations.

In addition, in order to market our products effectively, we must continue to recruit, retain and establish relationships with qualified independent agents and brokers. We may not be able to recruit, retain and establish relationships with agents and brokers. Independent agents and brokers are typically not exclusively dedicated to us and may frequently also market our competitors managed care products. We face intense competition for the services and allegiance of independent agents and brokers. If such agents and brokers do not help us to maintain our current customer accounts or establish new accounts, our business and profitability could be adversely affected.

Our investment portfolios are subject to varying economic and market conditions.

We have exposure to market risk and credit risk in our investment activities. The fair values of our investments vary from time to time depending on economic and market conditions. Fixed maturity securities expose us to interest rate risk. Equity securities expose us to equity price risk. Interest rates are highly sensitive to many factors, including governmental monetary policies and domestic and international economic and political conditions. These and other factors also affect the equity securities owned by us.

Table of Contents

The outlook of our investment portfolio depends on the future direction of interest rates, fluctuations in the equity securities market and in the amount of cash flows available for investment. For additional information, see Management s Discussion and Analysis of Financial Condition and Results of Operations Quantitative and Qualitative Disclosures About Market Risk for an analysis of our exposure to interest and equity price risks and the procedures in place to manage these risks. Our investment portfolios may lose money in future periods, which could have a material adverse effect on our financial condition.

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, real estate and equity investments, amongst others, which could generate higher returns on our investments. If we fail to comply with these laws and regulations, any investments exceeding regulatory limitations would be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital, and, in some instances, we may be required to sell those investments.

The securities and credit markets recently have been experiencing extreme volatility and disruption.

Adverse conditions in the U.S. and global capital markets can significantly and adversely affect the value of our investments in debt and equity securities, and other investments, our profitability and/or our financial position, and we do not expect these conditions to improve in the near future.

The global capital markets, including credit markets, have experienced extreme volatility, uncertainty and disruption during 2008 and the beginning of 2009. As an insurer, we have a substantial investment portfolio that is comprised particularly of debt securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S, financial markets, and volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments monetary policy, particularly the easing of U.S. monetary policy, can significantly and adversely affect the value of our investment portfolio, our profitability and/or our financial position by:

- Significantly reducing the value of the debt securities we hold in our investment portfolio, and creating net realized capital losses that reduces our operating results and/or net unrealized capital losses that reduce our shareholders equity.

- Reducing interest rates on high quality short-term debt securities and thereby materially reducing our net investment income and operating results.

- Making it more difficult to value certain of our investment securities, for example if trading becomes less frequent, which could lead to significant period-to-period changes in our estimates of the fair values of those securities and cause period-to-period volatility in our operating results and shareholders equity.

- Reducing our ability to issue other securities.

The volatility and disruption in the securities and credit markets has impacted our investment portfolio. We evaluate our investment securities for impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. For the purpose of determining gross realized gains and losses, the cost of investment securities is based upon specific identification. During 2008, we realized losses associated with other-than-temporary impairments of $16.5 million. Gross unrealized losses were $3.5 million and gross unrealized gains were $6.1 million at December 31, 2008. Given current market conditions, there is a continuing risk that further declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

We believe our cash balances, investment securities, operating cash flows, and funds available under our credit agreement, taken together, provide adequate resources to fund ongoing operating and regulatory requirements. However, continuing adverse securities and credit market conditions could significantly affect the availability of credit.

Table of Contents

The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region.
Substantially all of our business activity is with insureds located throughout Puerto Rico, and as such, we are subject to the risks associated with the Puerto Rico economy. Preliminary reports on the performance of the Puerto Rico economy for fiscal year 2008 indicate that real gross national product decreased 2.5% and the forecast for fiscal year 2009 projects a decline of 3.4%. The major factors affecting the economy are, among others, high oil prices, the slowdown of economic activity in the United States, the continuing economic uncertainty generated by the budgetary deficiency affecting the government of Puerto Rico and the effects on the economy of a recently implemented sales tax.
The Commonwealth of Puerto Rico government is currently facing a fiscal deficit which has been estimated at approximately $3.0 billion or over 30% of its annual budget. On March 9, 2009, the Governor signed the Special Lay on the Fiscal Emergency, which provides for additional revenue generation measures, sets forth a cost reduction plan, including a reduction in public-sector employment, and provides for a number of financial initiatives geared towards achieving a balanced budget in four years. Since the government is an important source of employment on the Island, theses measures could have the effect of intensifying the current recessionary cycle.
If economic conditions in Puerto Rico deteriorate, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, financial condition and results of operations.
We may not be able to retain our executive officers and significant employees, and the loss of any one or more of these officers and their expertise could adversely affect our business.
Our operations are highly dependent on the efforts of our senior executives, each of whom has been instrumental in developing our business strategy and forging our business relationships. While we believe that we could find replacements, the loss of the leadership, knowledge and experience of our executive officers could adversely affect our business. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the industries in which we operate have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. We do not currently maintain key-man life insurance on any of our executive officers.
The success of our business depends on developing and maintaining effective information systems.
Our business and operations may be affected if we do not maintain and upgrade our information systems and the integrity of our proprietary information. We are materially dependent on our information systems for all aspects of our business operations, including monitoring utilization and other factors, supporting our managed care management techniques, processing provider claims and providing data to our regulators, and our ability to compete depends on our ability to continue to adapt technology on a timely and cost-effective basis. Malfunctions in our information systems, communication and energy disruptions, security breaches or the failure to maintain effective and up-to-date information systems could disrupt our business operations, alienate customers, contribute to customer and provider disputes, result in regulatory violations and possible liability, increase administrative expenses or lead to other adverse consequences. The use of patient data by all of our businesses is regulated at federal and local levels. These laws and rules change frequently and developments require adjustments or modifications to our technology infrastructure.
Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. If we are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments on a timely basis, loss of members, difficulty in attracting new members, regulatory problems and increases in administrative expenses. We have substantially completed a system conversion process related to our property and casualty insurance business, which was begun in April 2005, at an estimated cost of $4.0 million. In addition, we selected Quality Care Solutions, Inc., a wholly owned subsidiary of Trizzetto, Inc, to assess and implement new core business applications for our managed care segment. We completed an initial assessment during 2007, with the first line of business expected to be converted in the first half of the 2010. We expect the managed care conversion process to be completed by 2012, at a total cost of approximately $64.0 million. If we are unsuccessful in implementing these improvements in a timely manner or if these improvements do not meet our customers requirements, we may not be able to recoup these costs and expenses and effectively compete in our industry.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other event or developments could result in compromises or breaches of our security system and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential

Table of Contents

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

We face risks related to litigation.

In addition to the litigation risks discussed above in Risks Relating to Our Capital Stock we are, or may be in the future, a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we may be subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include:

- claims relating to the denial of managed care benefits;
- medical malpractice actions;
- allegations of anti-competitive and unfair business activities;
- provider disputes over compensation and termination of provider contracts;
- disputes related to self-funded business;
- disputes over co-payment calculations;
- claims related to the failure to disclose certain business practices;
- claims relating to customer audits and contract performance; and
- claims by regulatory agencies or whistleblowers for regulatory non-compliance, including but not limited to fraud.

We are a defendant in various lawsuits, including a class action, some of which involve claims for substantial and/or indeterminate amounts and the outcome of which is unpredictable. While we are defending these suits vigorously, we will incur expenses in the defense of these suits. Any adverse judgment against us resulting in such damage awards could have an adverse effect on our cash flows, results of operations and financial condition. See "Item 3 Legal Proceedings .

Large-scale natural disasters may have a material adverse effect on our business, financial condition and results of operations.

Puerto Rico has historically been at a relatively high risk of natural disasters such as hurricanes and earthquakes. If Puerto Rico were to experience a large-scale natural disaster, claims incurred by our property and casualty insurance segment would likely increase and our properties may incur substantial damage, which could have a material adverse effect on our business, financial condition and results of operations.

Covenants in our secured term loan and note purchase agreements may restrict our operations.

We are a party to a secured loan with a commercial bank for an aggregate amount of $41.0 million, for which we had an outstanding balance of $24.3 million as of December 31, 2008. Also, we have an aggregate principal amount of $145.0 million of senior unsecured notes outstanding, consisting of $50.0 million aggregate principal amount of

6.30% notes due 2019, $60.0 million aggregate principal amount of 6.60% notes due 2020 and $35.0 million aggregate principal amount of 6.70% notes due 2021 (collectively, the notes). The secured term loan and the note purchase agreements governing the notes contain covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These covenants could restrict our operations. In addition, if we fail to make any required payment under our secured term loan or note purchase agreements governing the notes or to

Table of Contents

comply with any of the covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our secured term loan or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the secured term loan, cease to make further extensions of credit. If the indebtedness under our secured term loan or note purchase agreements is accelerated, we may be unable to repay or finance the amounts due and our business may be materially adversely affected.

We may incur additional indebtedness in the future. Covenants related to such indebtedness could also adversely affect our ability to pursue desirable business opportunities.

We may incur additional indebtedness in the future. Our debt service obligations may require us to use a portion of our cash flow to pay interest and principal on debt instead of for other corporate purposes, including funding future expansion. If our cash flow and capital resources are insufficient to service our debt obligations, we may be forced to seek extraordinary dividends from our subsidiaries, sell assets, seek additional equity or debt capital or restructure our debt. However, these measures might be prohibited by applicable regulatory requirements or unsuccessful or inadequate in permitting us to meet scheduled debt service obligations.

We may also incur future debt obligations that might subject us to restrictive covenants that could affect our financial and operational flexibility. Our breach or failure to comply with any of these covenants could result in a default under our secured term loan and note purchase agreements and the acceleration of amounts due thereunder. Indebtedness could also limit our ability to pursue desirable business opportunities, and may affect our ability to maintain an investment grade rating for our indebtedness.

We expect to pursue acquisitions in the future.

We may acquire additional companies if consistent with our strategic plan for growth. The following are some of the risks associated with acquisitions that could have a material adverse effect on our business, financial condition and results of operations:

- disruption of on-going business operations, distraction of management, diversion of resources and difficulty in maintaining current business standards, controls and procedures;
- difficulty in integrating information technology of acquired entity and unanticipated expenses related to such integration;
- difficulty in the integration of the new company s accounting, financial reporting, management, information, human resources and other administrative systems and the lack of control if such integration is delayed or not implemented;
- difficulty in the implementation of controls, procedures and policies appropriate for filers with the SEC at companies that prior to acquisition lacked such controls, policies and procedures;
- potential unknown liabilities associated with the acquired company;
- failure of acquired businesses to achieve anticipated revenues, earnings or cash flow;
- dilutive issuances of equity securities and incurrence of additional debt to finance acquisitions;
- other acquisition-related expenses, including amortization of intangible assets and write-offs; and
- competition with other firms, some of which may have greater financial and other resources, to acquire attractive companies.

In addition, we may not successfully realize the intended benefits of any acquisition or investment.

We could be subject to possible regulatory actions in connection with alleged illegal political contributions.

Miguel Vázquez-Deynes, who was president and chief executive officer of the Company from January 1990 to April 2002, prior to the time that we became an SEC registrant, stated during a radio interview in October 2007 that he had testified to a federal grand jury to having caused the Company to effect illegal political contributions totaling over $100,000 between 1996 and 2000. Mr. Vázquez-Deynes has stated

Table of Contents

publicly that the payments in question were made to Puerto Rico public relations firms for the purpose of concealing the fact that they exceeded the amounts permitted by applicable Puerto Rico election laws. Mr. Vázquez-Deynes testimony was given in connection with an ongoing investigation by the U.S. Attorney s Office for the District of Puerto Rico into illegal political contributions in Puerto Rico. The Puerto Rico Legislative Assembly, the Puerto Rico Department of Justice and the Puerto Rico Office of the Commissioner of Insurance subsequently launched separate investigations into the matters described by Mr. Vázquez-Deynes. The Company is cooperating fully with all requests made of it in connection with these investigations.

There may be, or could in the future be, other investigations by governmental authorities relating to these matters. The current and any such future investigations could result in actions against us or certain of our current or former employees. These actions could result in fines, penalties, sanctions, injunctions against future conduct, third party litigation or other actions that could have a material adverse effect on our business, financial condition, share price and reputation, including by impairing government contracts and adversely affecting our ability to obtain future contracts and participate in governmental payor programs.

Following the airing of Mr. Vázquez s allegations, the Company s board of directors hired outside counsel from Clifford Chance US, LLP, a law firm that had no prior relationship with the Company, to conduct an internal investigation into these allegations. The investigation was completed in February 2008 and concluded that any misconduct was limited to the matters alleged by Mr. Vázquez-Deynes and limited to the period when he was an officer of the Company. No current officer or director of the Company was found to have acted improperly. Our internal controls today are substantially more comprehensive than those in place during the period when these events took place and we believe these controls reduce the possibility of any similar event occurring in the future. Although we cannot predict the outcome of the government investigations described above, management does not currently believe that they will result in actions having a material adverse effect on the Company.

Table of Contents

Risks Relating to Taxation

If the Company is considered to be a controlled foreign corporation under the related person insurance income rules for U.S. federal income tax purposes, U.S. persons that own the Company s shares of Class B common stock could be subject to adverse tax consequences.

The Company does not expect that it will be considered a controlled foreign corporation under the related person insurance income rules (a RPII CFC) for U.S. federal income tax purposes. However, because RPII CFC status depends in part upon the correlation between an insurance company s shareholders and such company s insurance customers and the extent of such company s insurance business outside its country of incorporation, there can be no assurance that the Company will not be a RPII CFC in any taxable year. The Company does not intend to monitor whether or not it generates RPII or becomes an RPII CFC. If the Company were a RPII CFC in any taxable year, certain adverse tax consequences could apply to U.S. persons that own the Company s shares of Class B common stock.

If the Company is considered to be a passive foreign investment company for U.S. federal income tax purposes, U.S. persons that own the Company s shares of Class B common stock could be subject to adverse tax consequences.

The Company does not expect that it will be considered a "passive foreign investment company (a PFIC) for U.S. federal income tax purposes. However, since PFIC status depends upon the composition of a company s income and assets and the market value of its assets (including, among others, less than 25 percent owned equity investments and the Company s ability to use the proceeds from its initial public offering in a timely fashion) from time to time, there can be no assurance that the Company will not be considered a PFIC for any taxable year. The Company s belief that it is not a PFIC is based, in part, on the fact that the PFIC rules include provisions intended to provide an exception for bona fide insurance companies predominately engaged in an insurance business. However, the scope of this exception is not entirely clear and there are no administrative pronouncements, judicial decisions or Treasury regulations that provide guidance as to the application of the PFIC rules to insurance companies. If the Company were treated as a PFIC for any taxable year, certain adverse consequences could apply to certain U.S. persons that own the Company s shares of Class B common stock.

Risks Relating to the Regulation of Our Industry

Changes in governmental regulations, or the application thereof, may adversely affect our business, financial condition and results of operations.

Our business is subject to changing Federal and local legal, legislative and regulatory environments, including general business regulations and laws relating to taxation, privacy, data protection and pricing. Please refer to Item 1 Business Regulation . In addition, our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. Some of the more significant proposed regulatory changes that may affect our business are:

initiatives to provide greater access to coverage for uninsured and under-insured populations;

enhanced efforts to improve quality of health care;

Reform and Medicare reform legislation;

local government plans and initiatives;

increased government concerns regarding fraud and abuse; and

initiatives to increase health care regulation, including efforts to expand the tort liability of health plans.

On February 26, 2009, President Obama announced his proposed budget for fiscal year 2010, which supports his comprehensive health care reform agenda. The Obama health care reform plan is expected to address increasing access to health care coverage, reducing the cost of care, and improving the quality of care rendered. The Obama health care reform plan is expected to be financed in large part by reduced expenditures for the Medicare program. The proposed budget projects a minimum savings on health care

Table of Contents

expenditures of $316 billion by the Federal government over the next decade in the Medicare program, including $176 billon of which will be realized through reduced payments to Medicare Advantage plans as a result of changes in the competitive bidding process for Medicare Advantage contracts. In addition, President Obama s proposed budget calls for premium increases for certain high-income Medicare beneficiaries.

The U.S. Congress is developing legislation aimed at patient protection, including proposed laws that could expose insurance companies to damages, and in some cases punitive damages, for certain coverage determinations including the denial of benefits or delay in providing benefits to members. Similar legislation has been proposed in Puerto Rico. Congressional committees are currently considering MedPac recommendations to lower Medicare Advantage rates to ensure financial neutrality with the traditional Medicare program**.** We cannot provide any assurance if, when or to what degree Congress may act on any of the proposals and we do not know whether any proposal which may be enacted into law will change the way health insurance benefits are structured, sold or administered in the future. The enactment of laws that change the way health insurance benefits are structured, sold or administered could have a material adverse effect on the Company s business, financial conditions and results of operations.

Regulations imposed by the Commissioner of Insurance, among other things, influence how our insurance subsidiaries conduct business and solicit subscriptions for shares of capital stock, and place limitations on investments and dividends. Possible penalties for violations of such regulations include fines, orders to cease or change practices or behavior and possible suspension or termination of licenses. The regulatory powers of the Commissioner of Insurance are designed to protect policyholders, not shareholders. While we cannot predict the terms of future regulation, the enactment of new legislation could affect the cost or demand of insurance policies, limit our ability to obtain rate increases in those cases where rates are regulated, otherwise restrict our operations, limit the expansion of our business, expose us to expanded liability or impose additional compliance requirements. In addition, we may incur additional operating expenses in order to comply with new legislation and may be required to revise the ways in which we conduct our business.

Future regulatory actions by the Commissioner of Insurance or other governmental agencies could have a material adverse effect on the profitability or marketability of our business, financial condition and results of operations.

We may be subject to regulatory and investigative proceedings, which may find that our policies, procedures and contracts do not fully comply with complex and changing healthcare regulations.

The Commissioner of Insurance, as well as other Federal and Puerto Rico government authorities, including but not limited to CMS, the OIG, the Office of the Civil Rights of HHS, the U.S. Department of Justice, and the OPM, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations. We may become the subject of regulatory or other investigations or proceedings brought by these authorities, and our compliance with and interpretation of applicable laws and regulations may be challenged. In addition, our regulatory compliance may also be challenged by private citizens under the whistleblower provisions of applicable laws. The defense of any such challenge could result in substantial cost and a diversion of management s time and attention. Thus, any such challenge could have a material adverse effect on our business, regardless of whether it ultimately is successful. If we fail to comply with any applicable laws, or a determination is made that we have failed to comply with these laws, our financial condition and results of operations could be adversely affected.

An adverse review, audit or an investigation could result in one or more of the following:

- recoupment of amounts we have been paid pursuant to our government contracts;
- mandated changes in our business practices;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key employees;
- loss of our right to participate in Medicare, the Reform or other federal or local programs; damage to our reputation;
- increased difficulty in marketing our products and services;

Table of Contents

inability to obtain approval for future services or geographic expansions; and

loss of one or more of our licenses to act as an insurance company, preferred provider or managed care organization or other licensed entity or to otherwise provide a service.

Our failure to maintain an effective corporate compliance program may increase our exposure to civil damages and penalties, criminal sanctions and administrative remedies, such as program exclusion, resulting from an adverse review. Any adverse review, audit or investigation could reduce our revenue and profitability and otherwise adversely affect our operating results.

As a Medicare Advantage program participant, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties, and our Medicare Advantage contracts may be terminated.

The laws and regulations governing Medicare Advantage program participants are complex, subject to interpretation and can expose us to penalties for non-compliance. If we fail to comply with these laws and regulations, we could be subject to criminal fines, civil penalties or other sanctions, including the termination of our Medicare Advantage contracts.

The revised rate calculation system for Medicare Advantage and the payment system for the Medicare Part D established by the MMA could reduce our profitability.

Effective January 1, 2006, a revised rate calculation system based on a competitive bidding process was instituted for Medicare Advantage managed care plans, including our *Medicare Selecto* and *Medicare Optimo* plans. The statutory payment rate was relabeled as the benchmark amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. If the accepted bid is less than the benchmark, Medicare pays the plan its bid plus a rebate of 75% of the amount by which the benchmark exceeds the bid. However, these rebates can only be used to enhance benefits or lower premiums and co-pays for plan members. If the bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid and the benchmark, which could affect our ability to attract enrollees. CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability.

Furthermore, President Obama s proposed budget expects to save over $175 billion over a ten year period based on reductions in subsidies to Medicare Advantage plans by changes in the competitive bidding process.

In addition, the Medicare Part D prescription drug benefit payments to plans are determined through a competitive bidding process, and enrollee premiums also are tied to plan bids. The bids reflect the plan s expected costs for a Medicare beneficiary of average health; CMS adjusts payments to plans based on enrollees health and other factors. The program is largely subsidized by the federal government and is additionally supported by risk-sharing between Medicare Part D plans and the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs. The government payment amount to plans is based on the national weighted average monthly bid for basic Part D coverage, adjusted for member demographics and risk factor payments. The beneficiary will be responsible for the difference between the government payment amount and his or her plan s bid, together with the amount of his or her plan s supplemental premium (before rebate allocations), subject to the co-pays, deductibles and late enrollment penalties, if applicable. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. Medicare also subsidizes 80% of drug spending above an enrollee s catastrophic threshold.

We face the risk of reduced or insufficient government funding and we may need to terminate our Medicare Advantage and/or Part D contracts with respect to unprofitable markets, which may have a material adverse effect on our financial position, results of operations or cash flows. In addition, as a result of the competitive bidding process, our ability to participate in the Medicare Advantage and/or the Part D programs is effected by the pricing and design of our competitors bids. Moreover, we may in the future be required to reduce benefits or charge our members an additional premium in order to maintain our current

Table of Contents

level of profitability, either of which could make our health plans less attractive to members and adversely affect our membership.

CMS s risk adjustment payment system and budget neutrality factors make our revenue and profitability difficult to predict and could result in material retroactive adjustments to our results of operations.

CMS has implemented a risk adjustment payment system for Medicare Advantage plans to improve the accuracy of payments and establish incentives for such plans to enroll and treat less healthy Medicare beneficiaries. CMS phased in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS for reconciliation with CMS s internal database. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. In addition, our own risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare payment revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of recording diagnosis code information, which has an impact on our risk scores. Payments to Medicare Advantage plans are also adjusted by a "budget neutrality factor that was implemented in 2003 by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. However, this adjustment is schedule to be gradually being phased out by 2011. Furthermore, MedPac continues to recommend that Congress enact legislation that reduces Medicare Advantage payment to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program. As of the date of this Annual Report on Form 10-K, Congress has not enacted legislation that contains the MedPac recommendations. However, we cannot provide assurance if, when or to what degree Congress may enact legislation including the MedPac recommendations, but any reduction in Medicare Advantage rates could have a material adverse effect on our revenue, financial position, results of operations or cash flow.

If during the open enrollment season our Medicare Advantage members enroll in another Medicare Advantage plan, they will be automatically disenrolled from our plan, possibly without our immediate knowledge.

Pursuant to the MMA, members enrolled in one insurer s Medicare Advantage program will be automatically unenrolled from that program if they enroll in another insurer s Medicare Advantage program. If our members enroll in another insurer s Medicare Advantage program during the open enrollment season, we may not discover that such member has been unenrolled from our program until such time as we fail to receive reimbursement from the CMS in respect of such member, which may occur several months after the end of the open season. As a result, we may discover that a member has unenrolled from our program after we have already provided services to such individual. Our profitability would be reduced as a result of such failure to receive payment from CMS if we had made related payments to providers and were unable to recoup such payments from them.

If we are deemed to have violated the insurance company change of control statutes in Puerto Rico, we may suffer adverse consequences.

We are subject to change of control statutes applicable to insurance companies. These statutes regulate, among other things, the acquisition of control of an insurance company or a holding company of an insurance company. Under these statutes, no person may make an offer to acquire or to sell the issued and outstanding voting stock of an insurance company, which constitutes 10% or more of the issued and outstanding stock of an insurance company, or of the total stock issued and outstanding of a holding company of an insurance company, or solicit or receive funds in exchange for the issuance of new shares of our or our insurance subsidiaries capital stock, without the prior approval of the Commissioner of Insurance. Our amended and restated articles of incorporation (the articles) prohibit any institutional investor from owning 10% or more of our voting power and any person that is not an institutional investor from owning 5% or more of our voting power. We cannot, however, assure you that ownership of our securities will remain below these thresholds. To the extent that a person, including an institutional

Table of Contents

investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles. If the Commissioner of Insurance determines that a change of control has occurred, we could be subject to fines and penalties, and in some instances the Commissioner of Insurance would have the discretion to revoke our operating licenses.

We are also subject to change of control limitations pursuant to our BCBSA license agreements. The BCBSA ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for an institutional investor and less than 5% for a non-institutional investor, both as defined in our articles. In addition, no person may beneficially own shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest, whether voting or non-voting, in our company. This provision in our articles cannot be changed without the prior approval of the BCBSA and the vote of holders of at least 75% of our common stock.

Our insurance subsidiaries are subject to minimum capital requirements. Our failure to meet these standards could subject us to regulatory actions.

Puerto Rico insurance laws and the regulations promulgated by the Commissioner of Insurance, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by our insurance subsidiaries to us. Although we are currently in compliance with these requirements, there can be no assurance that we will continue to comply in the future. Failure to maintain required levels of capital or to otherwise comply with the reporting requirements of the Commissioner of Insurance could subject our insurance subsidiaries to corrective action, including government supervision or liquidation, or require us to provide financial assistance, either through subordinated loans or capital infusions, to our subsidiaries to ensure they maintain their minimum statutory capital requirements.

We are also subject to minimum capital requirements pursuant to our BCBSA license agreements. See The termination or modification of our license agreements to use the Blue Shield name and mark could have an adverse effect on our business, financial condition and results of operations .

We are required to comply with laws governing the transmission, security and privacy of health information.

Certain implementing regulations of HIPAA require us to comply with standards regarding the formats for electronic transmission, and the privacy and security of certain health information within our company and with third parties, such as managed care providers, business associates and our members. While we have agreements in place with our business associates we have limited control over their operations regarding the privacy and security of protected heath information. The HIPAA regulations also provide access rights and other rights for health plan beneficiaries with respect to their health information. These regulations include standards for certain electronic transactions, including encounter and claims information, health plan eligibility and payment information. Compliance with HIPAA is enforced by HHS s Office for Civil Rights for privacy, CMS for security and electronic transactions, and by the U.S. Department of Justice for criminal violations, and by States Attorneys General once the HIPAA amendments under the Stimulus are implemented. Further, the Gramm-Leach-Bliley Act imposes certain privacy and security requirements on insurers that may apply to certain aspects of our business as well.

We continue to implement and revise our health information policies and procedures to monitor and ensure our compliance with these laws and regulations, including the HIPAA amendments under the Stimulus. Furthermore, Puerto Rico s ability to promulgate its own laws and regulations (including those issued in response to the Gramm-Leach-Bliley Act), such as Act No. 194 of August 25, 2000, also known as the Patient s Rights and Responsibilities Act, including those more stringent than HIPAA, and uncertainty regarding many aspects of such state requirements, make compliance with applicable health information laws more difficult. For these reasons, our total compliance costs may increase in the future.

Puerto Rico insurance laws and regulations and provisions of our articles and bylaws could delay, deter or prevent a takeover attempt that shareholders might consider to be in their best interests and may make

Table of Contents

it more difficult to replace members of our board of directors and have the effect of entrenching management.
Puerto Rico insurance laws and the regulations promulgated thereunder, and our articles and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.
Our license agreements with the BCBSA require that our articles contain certain provisions, including ownership limitations. See If we are deemed to have violated the insurance company change of control provisions in Puerto Rico insurance laws, we may suffer adverse consequences .
Other provisions included in our articles and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. In particular, our articles and bylaws:

- permit our board of directors to issue one or more series of preferred stock;
- divide our board of directors into three classes serving staggered three-year terms;
- limit the ability of shareholders to remove directors;
- impose restrictions on shareholders ability to fill vacancies on our board of directors;
- impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and
- impose restrictions on shareholders ability to amend our articles and bylaws.

See also If we are deemed to have violated the insurance company change of control provisions in Puerto Rico insurance laws, we may suffer adverse consequences .
Puerto Rico insurance laws and the regulations promulgated by the Commissioner of Insurance may also delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, the Commissioner of Insurance must review any merger, consolidation or new issue of shares of capital stock of an insurer or its parent company and make a determination as to the fairness of the transaction. Also, a director of an insurer must meet certain requirements imposed by Puerto Rico insurance laws.
These voting and other restrictions may operate to make it more difficult to replace members of our board of directors and may have the effect of entrenching management regardless of their performance.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own a seven story (including the basement floor) building located at 1441 F.D. Roosevelt Avenue, in San Juan, Puerto Rico, and two adjacent buildings, as well as the adjoining parking lot. In addition, we own five floors of a fifteen-story building located at 1510 F.D. Roosevelt Avenue, in Guaynabo, Puerto Rico. The properties are subject to liens under our credit facilities. See Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operation Liquidity and Capital Resources .
In addition to the properties described above, we or our subsidiaries are parties to operating leases that are entered into in the ordinary course of business.

Table of Contents

We believe that our facilities are in good condition and that the facilities, together with capital improvements and additions currently underway, are adequate to meet our operating needs for the foreseeable future. The need for expansion, upgrading and refurbishment of facilities is continually evaluated in order to keep facilities aligned with planned business growth and corporate strategy.

Item 3. Legal Proceedings.

As of December 31, 2008, the Company is a defendant in various lawsuits arising in the ordinary course of business. We are also defendants in various other claims and proceedings, some of which are described below. Furthermore, the Commissioner of Insurance, as well as other Federal and Puerto Rico government authorities, regularly make inquiries and conduct audits concerning the Corporation s compliance with applicable insurance and other laws and regulations. Management believes that the aggregate liabilities, if any, arising from all such claims, assessments, audits and lawsuits will not have a material adverse effect on the consolidated financial position or results of operations of the Corporation. However, given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could have a material adverse effect on our financial condition, operating results and/or cash flows. Where the Corporation believes that a loss is both probable and estimable, such amounts have been recorded. In other cases, it is at least reasonably possible that the Corporation may incur a loss related to one or more of the mentioned pending lawsuits or investigations, but the Corporation is unable to estimate the range of possible loss which may be ultimately realized, either individually or in the aggregate, upon their resolution.

Additionally, we may face various potential litigation claims that have not to date been asserted, including claims from persons purporting to have contractual rights to acquire shares of the Corporation on favorable terms or to have inherited such shares notwithstanding applicable transfer and ownership restrictions. See Item 1A Risk Factors Risks Relating to our Capital Stock .

Hau et al Litigation (formerly known as Jordan et al)

On April 24, 2002, Octavio Jordán, Agripino Lugo, Ramón Vidal, and others filed a suit against the Corporation, TSI and others in the Court of First Instance for San Juan, Superior Section (the Court), alleging, among other things, violations by the defendants of provisions of the Puerto Rico Insurance Code, antitrust violations, unfair business practices, RICO violations, breach of contract with providers, and damages in the amount of $12 million. Following years of complaint amendments, motions practice and interim appeals up to the level of the Puerto Rico Supreme Court, the plaintiffs amended their complaint on June 20, 2008 to allege with particularity the same claims initially asserted but on behalf of a more limited group of plaintiffs, and increase their claim for damages to approximately $207 million. At a status conference held on August 18, 2008, the parties informed the Court that they had reached an agreement to try to simplify the case. Based on the agreement, which was approved by the Court, the defendants sent a letter to the plaintiffs on September 19, 2008 explaining the reasons why the allegations of the amended complaint should be dismissed. We are currently waiting for the plaintiffs to reply.

Thomas Litigation

On May 22, 2003, Kenneth A. Thomas, M.D. and Michael Kutell, M.D. filed a putative class action suit against the Blue Cross Blue Shield Association and substantially all of the other Blue Cross and Blue Shield plans in the United States, including TSI. The complaint alleges that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to doctors so that they are not paid in a timely manner for the covered medically necessary services they render. TSI, along with the other defendants, moved to dismiss the complaint on multiple grounds, including but not limited an arbitration right and the applicability of the McCarran Ferguson Act. The parties announced a Settlement Agreement on April 27, 2007 and on April 19, 2008, the Court granted final approval of the settlement. A small group of physicians filed an appeal of the settlement that is pending in the Eleventh Circuit. The Company recorded an accrual for the settlement that is included within accounts payable and accrued liabilities in the accompanying consolidated financial statements.

Table of Contents

Colón Litigation

On October 15, 2007, José L. Colón-Dueño, a former holder of one share of TSI predecessor stock, filed suit against TSI and the Puerto Rico Commissioner of Insurance (the Commissioner) in the Court of First Instance for San Juan, Superior Section. The sale of that share to Mr. Colón-Dueño was voided in 1999 pursuant to an order issued by the Commissioner in which the sale of 1,582 shares to a number of TSI shareholders was voided. The Puerto Rico Court of Appeals upheld the order on March 31, 2000. The plaintiff requests that the court direct TSI to return his share of stock and pay damages in excess of $500,000 and attorney s fees. TSI, however, had appealed the Commissioner s order before the Puerto Rico Court of Appeals, which upheld the order on March 31, 2000. Therefore, management plans to vigorously contest this lawsuit because, among other reasons, the Commissioner s order is final and cannot be collaterally attacked in this litigation.

Puerto Rico Center for Municipal Revenue Collection

On March 1, 2006 and March 3, 2006, respectively, the Puerto Rico Center for Municipal Revenue Collection (CRIM) imposed a real property tax assessment of approximately $1.3 million and a personal property tax assessment of approximately $4.0 million upon TSI for fiscal years 1992-1993 through 2002-2003. During that time, TSI qualified as a tax-exempt entity under Puerto Rico law pursuant to rulings issued by the Puerto Rico tax authorities. In imposing the tax assessments, CRIM revoked the tax rulings retroactively, based on its contention that a for-profit corporation such as TSI is not entitled to such an exemption. On March 28, 2006 and March 29, 2006, respectively, TSI challenged the real and personal property tax assessments in the Court of First Instance for San Juan, Superior Section. The court granted summary judgment affirming the real property and personal property tax assessments on October 29, 2007 and December 5, 2007, respectively.

After unsuccessfully filing motions for reconsideration in both cases, TSI appealed the court s decisions before the Puerto Rico Court of Appeals on November 29, 2007 and February 21, 2008, respectively. TSI also requested a consolidation of both cases, which the Court of Appeals approved on April 17, 2008. On May 27, 2008, TSI submitted a motion to the Court of Appeals requesting the Court to take notice of a recent decision of the Puerto Rico Supreme Court that addresses administrative law issues involving other parties and which TSI believes confirms its position that the rulings issued by the Puerto Rico tax authorities may not be revoked on a retroactive basis. On June 30, 2008 the Court of Appeals confirmed the summary judgment issued by the Court of First Instance in both property tax cases. On September 29, 2008, TSI timely filed a certiorari petition with the Puerto Rico Supreme Court, which is currently pending. Management believes that these municipal tax assessments are improper and expects to prevail in this litigation.

Dentists Association Litigation

On February 11, 2009, the Puerto Rico Dentists Association (Colegio de Cirujanos Dentistas de Puerto Rico, or CCD) filed a complaint in the Puerto Rico Court of First Instance for San Juan against 24 health plans operating in Puerto Rico that offer dental health coverage. The Company, TSI, and Triple-C, Inc., a Company subsidiary, were included as defendants. This litigation purports to be a class action filed on behalf of Puerto Rico dentists who are similarly situated; however, the complaint does not include a single dentist as a class representative nor a definition of the intended class.

The complaint alleges that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to dentists so that they are not paid in a timely and complete manner for the covered medically necessary services they render. The complaint also alleges, among other things, violations to the Puerto Rico Insurance Code, antitrust laws, the Puerto Rico racketeering statute, unfair business practices, breach of contract with providers, and damages in the amount of $150 million. In addition, the complaint claims that the Puerto Rico Insurance Companies Association (ACODESE for its Spanish acronym) is the hub of an alleged conspiracy concocted by the member plans to defraud dentists.

There are numerous available defenses to oppose both the request for class certification and the merits. The Company intends to vigorously defend this claim.

Claims by Heirs of Former Shareholders

The Company and TSI are also defending four individual lawsuits and one purported class action, all filed in state court, from persons who claim to have inherited a total of 90 shares of the Company or one of its

Table of Contents

predecessors (before giving effect to the 3,000-for-one stock split). While each case presents unique facts, the lawsuits generally allege that the redemption of the shares by the Company pursuant to transfer and ownership restrictions contained in the Company s (or its predecessor s) articles of incorporation and bylaws was improper. On February 18, 2009, the Court of First Instance for San Juan, Superior Section, issued an order granting our motion to dismiss the purported class action suit, on grounds that the claim was time barred under the Puerto Rico Securities Act. Motions to dismiss are pending in a majority of the remaining cases and discovery has begun in all of them. Management believes all these claims are time barred under one or more statutes of limitations, and intends to vigorously defend against them.

Item 4. Submissions of Matters to a Vote of Security Holders.

None.

Part II

Item 5. Market for Registrant s Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities.

Market Information

There is no established public trading market for our Class A common stock. Our Class B common stock is listed and began trading on the New York Stock Exchange (the NYSE) on December 7, 2007 under the trading symbol GTS . Prior to this date our Class B common stock had no established public trading market.

The following table presents high and low sales prices for the periods in which our Class B common stock was publicly traded:

	High	Low
2007		
Fourth quarter (beginning December 7, 2007)	$21.20	$14.78
2008		
First quarter	$21.69	$16.83
Second quarter	19.94	16.34
Third quarter	18.05	15.19
Fourth quarter	16.43	6.55

On February 27, 2009 the closing price of our Class B common stock on the NYSE was $11.51.

Holders

As of February 27, 2009, there were 9,042,809 and 21,069,773 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A and Class B common stock as of February 5, 2009 was 1,922 and 4,357, respectively.

Dividends

Subject to the limitations under Puerto Rico corporation law and any preferential dividend rights of outstanding preferred stock, of which there is currently none outstanding, holders of common stock are entitled to receive their pro rata share of such dividends or other distributions as may be declared by our board of directors out of funds legally available therefore.

Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Our subsidiaries are subject to regulatory surplus requirements and additional regulatory requirements, which may restrict their ability to declare and pay dividends or distributions to us. We are required to maintain minimum capital of $1.0 million for our managed care subsidiary, $2.5 million for our life insurance subsidiary and $3.0

Table of Contents

million for our property and casualty insurance subsidiary. In addition, our secured term loan restricts our ability to pay dividends if a default thereunder has occurred and is continuing. Please refer to Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources Restriction on Certain Payments by the Corporation s Subsidiaries .

In March 2007, we declared and paid dividends amounting to approximately $2.4 million. In January 2006 we declared and paid dividends amounting to $6.2 million. We did not declare any dividends in prior years.

We do not expect to pay any cash dividends for the foreseeable future. We currently intend to retain future earnings, if any, to finance operations and expand our business. The ultimate decision to pay a dividend, however, remains within the discretion of our board of directors and may be affected by various factors, including our earnings, financial condition, capital requirements, level of indebtedness, statutory and contractual limitations and other considerations our board of directors deems relevant.

Securities Authorized for Issuance Under Equity Compensation Plan

The information required by this item is incorporated by reference to the section Compensation Discussion and Analysis included in our definitive Proxy Statement.

Recent Sales of Unregistered Securities

Not applicable.

Purchases of Equity Securities by the Issuer

The following table presents information related to our repurchases of common stock for the period indicated:

(Dollar amounts in millions, except per share data)	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs[1]	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs
December 1, 2008 to December 31, 2008	1,181,500	$ 11.75	1,181,500	$ 26.1

[1] In October 2008, the Board of Directors authorized a $40.0 million share repurchase program, which commenced on December 8, 2008.

Performance Graph

The following graph compares the cumulative total return to shareholders on our Class B common stock for the period from December 7, 2007, the date our Class B common stock began trading on the NYSE, through December 31, 2008, with the cumulative total return over such period of (i) the Standard and Poor s 500 Stock Index (the S&P 500 Index) and (ii) the Morgan Stanley Healthcare Payor Index (the MSHP Index). For illustrative purposes, the graph assumes an investment of $100 on December 7, 2007 in each of our Class B common stock, the S&P 500 Index and the MSHP Index. The performance graph is not necessarily indicative of future performance.

The comparisons shown in the graph are based on historical data and the Corporation cautions that the stock price in the graph below is not indicative of, and is not intended to forecast, the potential future performance of our Class B common stock. Information used in the preparation of the graph was obtained from Bloomberg, a source we believe to be reliable, however, the Corporation is not responsible for any errors or omissions in such information.

Table of Contents

Table of Contents

Item 6. Selected Financial Data.

Statement of Earnings Data

	2008	2007	2006 (1)	2005	2004
(Dollar amounts in millions, except per share data)					
Years ended December 31,					
Premiums earned, net	$1,695.5	1,483.6	1,511.6	1,380.2	1,299.0
Administrative service fees	19.2	14.0	14.1	14.4	9.2
Net investment income	56.2	47.2	42.7	29.1	26.8
Total operating revenues	1,770.9	1,544.8	1,568.4	1,423.7	1,335.0
Net realized investments gains (losses)	(13.9)	5.9	0.8	7.2	11.0
Net unrealized investment gain (loss) on trading securities	(21.1)	(4.1)	7.7	(4.7)	3.0
Other income (loss), net	(2.5)	3.2	2.3	3.7	3.4
Total revenues	1,733.4	1,549.8	1,579.2	1,429.9	1,352.4
Benefits and expenses:					
Claims incurred	1,434.9	1,223.8	1,259.0	1,208.3	1,115.8
Operating expenses	251.9	237.5	236.1	181.7	171.9
Total operating costs	1,686.8	1,461.3	1,495.1	1,390.0	1,287.7
Interest expense	14.7	15.9	16.6	7.6	4.6
Total benefits and expenses	1,701.5	1,477.2	1,511.7	1,397.6	1,292.3
Income before taxes	31.9	72.6	67.5	32.3	60.1
Income tax expense	7.1	14.1	13.0	3.9	14.3
Net income	24.8	58.5	54.5	28.4	45.8
Basic net income per share (2):	$ 0.77	2.15	2.04	1.06	1.71
Diluted net income per share:	$ 0.77	2.15	2.04	1.06	1.71
Dividend declared per common share (3):	$	0.82	0.23		

Balance Sheet Data

December 31,	2008	2007	2006 (1)	2005	2004
Cash and cash equivalents	$ 46.1	240.2	81.6	49.0	35.1

Total assets	$1,548.5	1,659.5	1,345.5	1,137.5	919.7
Long-term borrowings	$ 169.3	170.9	183.1	150.6	95.7
Total stockholders equity	$ 485.9	482.5	342.6	308.7	301.4

Table of Contents

Additional Managed Care Data [4]

	2008	2007	2006 (1)	2005	2004
Additional Managed Care Data (4)					
Years ended December 31,					
Medical loss ratio	88.9%	87.1%	87.6%	90.3%	88.3%
Operating expense ratio	10.5%	11.2%	11.5%	10.8%	10.8%
Medical membership (period end)	1,195,450	977,190	979,506	1,252,649	1,236,108

(1) On January 31, 2006 we completed the acquisition of GA Life (now TSV). The results of operations and financial condition of GA Life are included in this table for the period following the effective date of the acquisition. See note 18 to the audited consolidated financial statements for the years ended December 31, 2008, 2007 and 2006.

(2) Further details of the calculation of basic earnings per share are set forth in notes 2 and 22 of the audited financial

consolidated financial statements for the years ended December 31, 2008, 2007 and 2006.

(3) Shareowners holding qualifying shares were excluded from dividend payment. See note 19 of the audited financial consolidated financial statements for the years ended December 31, 2008, 2007 and 2006.

(4) Does not reflect inter-segment eliminations.

Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations.

This financial discussion contains an analysis of our consolidated financial position and financial performance as of December 31, 2008 and 2007, and consolidated results of operations for 2008, 2007 and 2006. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

Overview

We are the largest managed care company in Puerto Rico in terms of membership, with 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the Commercial, Commonwealth of Puerto Rico Health Reform (the Reform) and Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plans (PDP)) markets. The Reform is a government of Puerto Rico-funded managed care program for the medically indigent, similar to the Medicaid program in the U.S. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico, serve approximately 1.2 million members across all regions of Puerto Rico and hold a leading market position covering approximately 30% of the population. For the years ended December 31, 2008 and 2007 respectively, our managed care segment represented approximately 89.2% and 87.7% of our total consolidated premiums earned, net, and approximately 62.6% and 68.7% of our operating income. We also have significant positions in the life insurance and property and casualty insurance markets. Our life insurance segment had a market share of approximately 11% (in terms of premiums written) as of December 31, 2007. Our property and casualty segment had a market share of approximately 8% (in terms of direct premiums) as of December 31, 2007.

We participate in the managed care market through our subsidiary, TSI. Our managed care subsidiary is a BCBSA licensee, which provides us with exclusive use of the Blue Shield brand in Puerto Rico. We offer products to the Commercial, including corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement, Reform and Medicare (including Medicare Advantage and PDP)

markets.

We participate in the life insurance market through our subsidiary, TSV, and in the property and casualty insurance market through our subsidiary, STS. TSV and STS represented approximately 5.5% each, of our consolidated premiums earned, net for the year ended December 31, 2008 and 14.9% and 15.6%, respectively, of our operating income for that period.

Table of Contents

The Commissioner of Insurance of the Commonwealth of Puerto Rico recognizes only statutory accounting practices for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Puerto Rico insurance laws and for determining whether its financial condition warrants the payment of a dividend to its stockholders. No consideration is given by the Commissioner of Insurance of the Commonwealth of Puerto Rico to financial statements prepared in accordance with U.S. generally accepted accounting principles (GAAP) in making such determinations. See note 25 to our audited consolidated financial statements.

Intersegment revenues and expenses are reported on a gross basis in each of the operating segments but eliminated in the consolidated results. Except as otherwise indicated, the numbers presented in this Annual Report on Form 10-K do not reflect intersegment eliminations. These intersegment revenues and expenses affect the amounts reported on the financial statement line items for each segment, but are eliminated in consolidation and do not change net income. The following table shows premiums earned, net and net fee revenue and operating income for each segment, as well as the intersegment premiums earned, service revenues and other intersegment transactions, which are eliminated in the consolidated results:

	Years ended December 31,		
(Dollar amounts in millions)	**2008**	**2007**	**2006**
Premiums earned, net:			
Managed care	$1,513.0	1,301.8	1,339.8
Life insurance	92.8	88.9	86.9
Property and casualty insurance	93.8	96.9	88.5
Intersegment premiums earned	(4.1)	(4.0)	(3.6)
Consolidated premiums earned, net	$1,695.5	1,483.6	1,511.6
Administrative service fees:			
Managed care	$ 22.5	17.2	16.9
Intersegment premiums earned	(3.3)	(3.2)	(2.8)
Consolidated administrative service fees	$ 19.2	14.0	14.1
Operating income:			
Managed care	$ 52.6	57.4	45.5
Life insurance	12.5	10.7	11.2
Property and casualty insurance	13.1	10.7	11.2
Intersegment premiums earned	5.9	4.7	5.4
Consolidated operating income	$ 84.1	83.5	73.3

We have one-year contracts with the government of Puerto Rico to be the Reform insurance carrier for two of the eight geographical regions into which Puerto Rico is divided for purposes of the Reform. In October 2006, the contract for the Metro-North region, for which we were the carrier, was awarded to another managed care company, effective November 1, 2006. This region was awarded to us again on an ASO basis for a one year period beginning November 1, 2008. The premiums earned, net of the Metro-North region during the years 2006 and 2005 amounted to $161.6 million and $200.9 million, respectively. The operating income of this region during the years 2006 and 2005 amounted to $5.4 million and $3.5 million, respectively.

Results of Operations

Revenue

General. Our revenue consists primarily of (i) premium revenue we generate from our managed care business, (ii) administrative service fees we receive for administrative services provided to self-insured employers (ASO), (iii) premiums we generate from our life insurance and property and casualty insurance businesses and (iv) investment income.

Table of Contents

Managed Care Premium Revenue. Our revenue primarily consists of premiums earned from the sale of managed care products to the Commercial market sector, including corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement, as well as to the Medicare Advantage (including PDP) and Reform sectors. We receive a monthly payment from or on behalf of each member enrolled in our commercial managed care plans (excluding ASO). We recognize all premium revenue in our managed care business during the month in which we are obligated to provide services to an enrolled member. Premiums we receive in advance of that date are recorded as unearned premiums.

Premiums are generally fixed by contract in advance of the period during which healthcare is covered. Our Commercial premiums are generally fixed for the plan year in the annual renewal process. Our Medicare Advantage contracts entitle us to premium payments from CMS on behalf of each Medicare beneficiary enrolled in our plans, generally on a per member per month (PMPM) basis. We submit rate proposals to CMS in June for each Medicare Advantage product that will be offered beginning January 1 of the subsequent year in accordance with the new competitive bidding process under the MMA. Retroactive rate adjustments are made periodically with respect to our Medicare Advantage plans based on the aggregate health status and risk scores of our plan participants.

Premium payments from CMS in respect of our Medicare Part D prescription drug plans are based on written bids submitted by us which include the estimated costs of providing the prescription drug benefits.

Administrative Service Fees. Administrative service fees include amounts paid to us for administrative services provided to self-insured employers. We provide a range of customer services pursuant to our administrative services only (ASO) contracts, including claims administration, billing, access to our provider networks and membership services. Administrative service fees are recognized in the month in which services are provided.

Other Premium Revenue. Other premium revenue includes premiums generated from the sale of life insurance and property and casualty insurance products. Premiums on life insurance policies are billed in the month prior to the effective date of the policy, with a one-month grace period, and the related revenue is recorded as earned during the coverage period. If the insured fails to pay within the one-month grace period, we may cancel the policy. We recognize premiums on property and casualty contracts as earned on a pro rata basis over the policy term. Property and casualty policies are subscribed through general agencies, which bill policy premiums to their clients in advance or, in the case of new business, at the inception date and remit collections to us, net of commissions. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheet as unearned premiums and is transferred to premium revenue as earned.

Investment Income and Other Income. Investment income consists of interest income and other income consists of net realized gains (losses) on investment securities. See note 2(e) to our audited consolidated financial statements.

Expenses

Claims Incurred. Our largest expense is medical claims incurred, or the cost of medical services we arrange for our members. Medical claims incurred include the payment of benefits and losses, mostly to physicians, hospitals and other service providers, and to policyholders. We generally pay our providers on one of three bases: (1) fee-for-service contracts based on negotiated fee schedules; (2) capitated arrangements, generally on a fixed PMPM payment basis, whereby the provider generally assumes some of the medical expense risk; and (3) risk-sharing arrangements, whereby we advance a capitated PMPM amount and share the risk of the medical costs of our members with the provider based on actual experience as measured against pre-determined sharing ratios. Claims incurred also include claims incurred in our life insurance and property and casualty insurance businesses. Each segment s results of operations depend in significant part on our ability to accurately predict and effectively manage claims. A portion of the claims incurred for each period consists of claims reported but not paid during the period, as well as a management and actuarial estimate of claims incurred but not reported during the period.

The medical loss ratio (MLR), which is calculated by dividing managed care claims incurred by managed care premiums earned, net is one of our primary management tools for measuring these costs and their

Table of Contents

impact on our profitability. The medical loss ratio is affected by the cost and utilization of services. The cost of services is affected by many factors, in particular our ability to negotiate competitive rates with our providers. The cost of services is also influenced by inflation and new medical discoveries, including new prescription drugs, therapies and diagnostic procedures. Utilization rates, which reflect the extent to which beneficiaries utilize healthcare services, significantly influence our medical costs. The level of utilization of services depends in large part on the age, health and lifestyle of our members, among other factors. As the medical loss ratio is the ratio of claims incurred to premiums earned, net it is affected not only by our ability to contain cost trends but also by our ability to increase premium rates to levels consistent with or above medical cost trends. We use medical loss ratios both to monitor our management of healthcare costs and to make various business decisions, including what plans or benefits to offer and our selection of healthcare providers.

Operating Expenses. Operating expenses include commissions to external brokers, general and administrative expenses, cost containment expenses such as case and disease management programs, and depreciation and amortization. The operating expense ratio is calculated by dividing operating expenses by premiums earned, net and administrative service fees. A significant portion of our operating expenses are fixed costs. Accordingly, it is important that we maintain or increase our volume of business in order to distribute our fixed costs over a larger membership base. Significant changes in our volume of business will affect our operating expense ratio and results of operations. We also have variable costs, which vary in proportion to changes in volume of business.

Membership

Our results of operation depend in large part on our ability to maintain or grow our membership. In addition to driving revenues, membership growth is necessary to successfully introduce new products, maintain an extensive network of providers and achieve economies of scale. Our ability to maintain or grow our membership is affected principally by the competitive environment and general market conditions.

In recent years, we have experienced a decrease in our fully insured commercial membership due to the highly aggressive pricing of our competitors, which has also affected our ability to increase premiums, and the shifting of Medicare eligibles from our Medicare Supplement program to Medicare Advantage plans offered by our competitors and, to a lesser extent, ourselves. Membership in our Reform program has also been affected by the shifting of Reform program members to such Medicare Advantage plans.

The Medicare Advantage program (including PDP) provided us a significant opportunity for growth in membership. We commenced offering Medicare Advantage products in 2005, with the introduction of our *Medicare Selecto* and *Medicare Optimo* plans. Membership enrolled in our Medicare Advantage programs increased by 71.4% in 2008; from 38,070 as of December 31, 2007 to 65,243 members as of December 31, 2008. In January 2006, we launched our stand-alone PDP plan, *FarmaMed*, which as of December 31, 2008 and 2007 had 10,037 and 11,175 members, respectively. We expect our Medicare Advantage enrollment to continue to grow, but not at the same pace as we have seen in the past.

The following table sets forth selected membership data as of the dates set forth below:

	As of December 31,		
	2008	**2007**	**2006**
Commercial [(1)]	592,723	574,251	580,850
Reform[(2)]	527,447	353,694	357,515
Medicare [(3)]	75,280	49,245	41,141
Total	1,195,450	977,190	979,506

(1) Commercial membership includes corporate

accounts, self-funded employers, individual accounts, Medicare Supplement, Federal government employees and local government employees.

(2) Includes rated and self-funded members.

(3) Includes Medicare Advantage as well as stand-alone PDP plan membership.

Table of Contents

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2008, 2007 and 2006.

(Dollar amounts in millions)	**2008**	**2007**	**2006**
Years ended December 31,			
Revenues:			
Premiums earned, net	$1,695.5	1,483.6	1,511.6
Administrative service fees	19.2	14.0	14.1
Net investment income	56.2	47.2	42.7
Total operating revenues	1,770.9	1,544.8	1,568.4
Net realized investment (losses) gains	(13.9)	5.9	0.8
Net unrealized investment gain (loss) on trading securities	(21.1)	(4.1)	7.7
Other income (expense), net	(2.5)	3.2	2.3
Total revenues	1,733.4	1,549.8	1,579.2
Benefits and expenses:			
Claims incurred	1,434.9	1,223.8	1,259.0
Operating expenses	251.9	237.5	236.1
Total operating costs	1,686.8	1,461.3	1,495.1
Interest expense	14.7	15.9	16.6
Total benefits and expenses	1,701.5	1,477.2	1,511.7
Income before taxes	31.9	72.6	67.5
Income tax expense	7.1	14.1	13.0
Net income	$ 24.8	58.5	54.5

Year ended December 31, 2008 compared with the year ended December 31, 2007

Operating Revenues

Consolidated premiums earned, net and administrative service fees increased by $217.1 million, or 14.5%, to $1.7 billion during the year ended December 31, 2008 compared to the year ended December 31, 2007. This increase was primarily due to an increase in the premiums earned, net in our managed care segment, principally due to a higher volume in the Medicare Advantage business and general increases in premium rates. The administrative service fees of the managed care segment also increased during the 2008 period mostly as the result of an increased member months enrollment that is mainly attributed to the contract for the Reform s Metro-North region, which began on November 1, 2008 on an ASO basis.

Consolidated net investment income presented an increase of $9.0 million, or 19.1%, to $56.2 million during the year ended December 31, 2008. This increase is attributed to a higher yield in 2008 as well as to a higher balance of invested assets.

Net Realized Investment Losses

Consolidated net realized investment losses of $13.9 million during the year ended December 31, 2008 are primarily the result of other-than-temporary impairments related to equity and fixed income securities amounting to $16.5 million due to other-than-temporary impairments in three equity mutual funds that replicate the Russell 1000, Standard & Poor s 500 and EAFE indexes as well as for certain perpetual preferred securities. The other-than-temporary impairments were offset in part by $2.6 million of net realized gains from the sale of fixed income and equity securities.

Net Unrealized Loss on Trading Securities and Other Income (Expense), Net

The combined balance of our consolidated net unrealized loss on trading securities and other income (expense), net was a loss of $23.6 million during the year ended December 31, 2008, an increase of $22.7

Table of Contents

million, as compared to the combined loss of $0.9 million in 2007. This increase is attributable to the net result of the unrealized loss on the trading portfolio, together with a decrease the fair value of the derivative component of our investment in structured notes linked to the Euro Stoxx 50 and Nikkei 225 stock indexes amounting to $4.7 million due to general market conditions. The unrealized loss experienced on trading securities represents a decrease of 36.67% and 35.78% in TSI and 36.82% in STS in the fair value of the portfolio, which is lower than the decrease experienced by the comparable indexes of 37.0% in the S&P 500 Index and 38.44% in the Russell 1000. The change in the fair value of the derivative component of these structured notes is included within other income (expense), net.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2008 increased by $211.1 million, or 17.2%, to $1.4 billion when compared to the claims incurred during the year ended December 31, 2007. This increase is principally due to increased claims in the managed care segment as a result of higher enrollment and utilization trends. The consolidated loss ratio increased by 2.1 percentage points, to 84.6% in the 2008 period, primarily due to higher utilization trends in the managed care segment for the period, particularly in the Medicare Advantage business.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2008 increased by $14.4 million, or 6.1%, to $251.9 million as compared to operating expenses during the 2007 period. This increase is primarily attributed to a higher volume of business, particularly in the Medicare business of our Managed Care segment. The consolidated operating expense ratio decreased by 1.2 percentage points, to 14.7%, during the 2008 period mainly due to the aforementioned increase in volume.

Income tax expense

The decrease in consolidated income tax expense during the year ended December 31, 2008 is primarily the result of the lower income before tax during the period. The consolidated effective tax rate for the 2008 period reflects an increase of 2.9 percentage points as compared to the 2007 period, from 19.4% in 2007 to 22.3% in 2008, due to a lower taxable income during 2008 as compared to the 2007 period.

Year ended December 31, 2007 compared with the year ended December 31, 2006

Operating Revenues

Consolidated premiums earned, net and administrative service fees decreased by $28.1 million, or 1.8%, to $1.5 billion during the year ended December 31, 2007 compared to the year ended December 31, 2006. This decrease was primarily due to a decrease in the premiums earned, net in our managed care segment, principally due to the decreased volume of the Reform business after the termination of the contract for the Metro-North region, offset in part by the growth of our Medicare Advantage business and the increases in premium rates of the Reform business during 2007.

Consolidated net investment income presented an increase of $4.5 million, or 10.5%, to $47.2 million during the year ended December 31, 2007. This increase is primarily the result of an increase of $3.5 million attributed to a higher yield in 2007, a higher balance of invested assets and the acquisition of GA Life effective January 31, 2006. Net investment income earned by GA Life during the month of January 2006 amounted to $1.0 million, which is not included in our consolidated financial statements.

Net Realized Investment Gains

Consolidated net realized investment gains increased by $5.1 million to $5.9 million during 2007. This increase is primarily the result of higher sales of investments in 2007, particularly in trading securities, in order to keep the portfolio within our established targets in each investment sector.

Net Unrealized Gain (Loss) on Trading Securities and Other Income, Net

The combined balance of our consolidated net unrealized loss on trading securities and other income, net was a loss of $0.9 million during the year ended December 31, 2007, a decrease of $10.9 million, as compared to the combined gain of $10.0 million in 2006. This decrease is attributable to the net result of

Table of Contents

the unrealized loss on the trading portfolio, offset in part by an increase in the fair value of the derivative component of our investment in structured notes linked to foreign stock indexes. This unrealized loss on trading securities is due to the sale of one equity portfolio which had a net unrealized gain at the time of sale. This sale had the effect of eliminating the unrealized gain that was offsetting unrealized losses in our trading portfolio.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2007 decreased by $35.2 million, or 2.8%, to $1.2 billion when compared to the claims incurred during the year ended December 31, 2006. This decrease is principally due to decreased claims in the managed care segment as a result of the decreased volume of the Reform business due to the termination of the contract for the Metro-North region, net of increased enrollment in the Medicare Advantage business. The consolidated loss ratio decreased by 0.8 percentage points, to 82.5% in the 2007 period. The lower loss ratio is mainly the result of an overall increase in premium rates, lower utilization trends and a change in the mix of business. During the year ended December 31, 2007, the weight in the mix of business of the managed care segment corresponding to the Reform business decreased as a result of the termination of the contract for the Metro-North area. The Reform business has a higher loss ratio than other businesses within this segment. On the other hand, the Medicare Advantage business, which at the time had a lower loss ratio than other businesses within the managed care segment, has a higher weight in the mix of business in the 2007 period.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2007 increased by $1.4 million, or 0.6%, to $237.5 million as compared to operating expenses during the 2006 period. This increase is primarily attributed to increases in professional services expense (mainly legal expenses), normal increases in payroll and payroll related expense, as well as higher technology related costs due to the new systems initiative of our managed care subsidiary. This increase is offset in part by the decrease in the operating expenses for the Reform business resulting from the reduction in volume of this business. The consolidated operating expense ratio increased by 0.4 percentage points during the 2007 period mainly due to fixed expenses not affected by a reduction in volume.

Income tax expense

The consolidated effective tax rate remained flat, with a slight increase of 0.1 percentage points, from 19.3% in 2006 to 19.4% in 2007.

Managed Care Operating Results

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico: Commercial, Reform and Medicare (including Medicare Advantage and PDP). For the year ended December 31, 2008, the Commercial sector represented 43.3% and 37.7% of our consolidated premiums earned, net and operating income, respectively. During the same period the Reform sector represented 20.1% and 12.5%, of our consolidated premiums earned, net and our operating income, respectively. Premiums earned, net and operating income generated from our Medicare contracts (including PDP) during the year ended December 31, 2008 represented 25.9% and 12.4%, respectively, of our consolidated earned premiums, net and operating income, respectively.

Table of Contents

(Dollar amounts in millions)	2008	2007	2006
Operating revenues:			
Medical premiums earned, net:			
Commercial	$ 734.2	718.7	713.2
Reform	340.1	327.5	455.8
Medicare	438.7	255.6	170.8
Medical premiums earned, net	1,513.0	1,301.8	1,339.8
Administrative service fees	22.5	17.2	16.9
Net investment income	23.1	19.7	18.8
Total operating revenues	1,558.6	1,338.7	1,375.5
Medical operating costs:			
Medical claims incurred	1,345.4	1,133.2	1,173.6
Medical operating expenses	160.6	148.1	156.4
Total medical operating costs	1,506.0	1,281.3	1,330.0
Medical operating income	$ 52.6	57.4	45.5
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	4,947,854	4,983,980	5,272,987
Self-funded	2,049,140	1,930,850	1,861,833
Total Commercial member months	6,996,994	6,914,830	7,134,820
Reform:			
Fully-insured	4,101,905	4,262,248	6,484,270
Self-funded	376,975		
Total Reform member months	4,478,880	4,262,248	6,484,270
Medicare:			
Medicare Advantange	727,274	416,512	281,274
Stand-alone PDP	127,658	137,528	180,444
Total Medicare member months	854,932	554,040	461,718
Total member months	12,330,806	11,731,118	14,080,808
Medical loss ratio	88.9%	87.0%	87.6%
Operating expense ratio	10.5%	11.2%	11.5%

Year ended December 31, 2008 compared with the year ended December 31, 2007

Medical Operating Revenues

Medical premiums earned during 2008 increased by $211.2 million, or 16.2%, to $1.5 billion when compared to earned premiums during 2007. This increase is principally the result of the following:

Medical premiums generated by the Medicare business increased by $183.1 million, or 71.6%, to $438.7 million, primarily due to an increase in member months enrollment of 300,892, or 54.3%, and a change in the mix of products. The increase in member months is the net result of an increase of 310,762, or 74.6%, in the membership of our Medicare Advantage products, mainly in dual eligible members, and a decrease of 9,870, or 7.2%, in the membership of our PDP product.

Medical premiums generated by the Commercial business increased by $15.5 million, or 2.2%, to $734.2 million during 2008. This fluctuation is primarily the net result of an increase in the average premium rates of approximately 4.4% offset in part by a decrease in fully-insured member months enrollment of 36,126 or 0.7%.

Medical premiums earned of the Reform business increased by $12.6 million, or 3.8%, to $340.1 million during 2008. This fluctuation is primarily due to the increases in premium rates of approximately 10% effective on July 1, 2008 and during 2007 of 8.6%, partially offset by a decrease in member months enrollment of 160,343, or 3.8%.

Table of Contents

Administrative service fees increased by $5.3 million, or 30.8%, to $22.5 million during the 2008 period. This fluctuation is primarily due to an increase in member months enrollment of self-funded arrangements of 495,265, or 25.7%. The higher member months enrollment is mainly the result of the contract for the Reform s Metro-North region, which began on November 1, 2008. This contract is on an ASO basis and represented an increase in member months of 376,975.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2008 increased by $212.2 million, or 18.7%, to $1.3 billion when compared to the year ended December 31, 2007. The medical loss ratio (MLR) of the segment increased 1.9 percentage points during 2008, to 88.9%. These fluctuations are primarily attributed to the effect of the following:

The medical claims incurred of the Medicare business increased by $190.0 million during the 2008 period mainly as the result of the increase in member months and a higher MLR by 10.0 percentage points. The higher MLR is in part due to the effect of prior period reserve developments and to higher utilization trends. Excluding the effect of prior period reserve developments in the 2007 and 2008 periods, the MLR increased by 7.1 percentage points. The increase in utilization trends is primarily the result of higher utilization in outpatient visits and drug benefits for the dual eligible product. The higher MLR is also the result of a change in enrollment mix between dual and non-dual eligible members within the business. Member months during the year ended December 31, 2008 have a higher concentration of dual eligible members than the prior year. Dual eligible members have higher utilization and MLR than non-dual eligible members.

The medical claims incurred of the Reform business increased by $16.9 million during the 2008 period and its MLR increased by 1.6 percentage points during the year ended December 31, 2008. The higher MLR is primarily the effect of prior period reserve developments and the retroactive premium rate increase received by this business during June 2007 amounting to $2.8 million corresponding to 2006. Excluding the effect of prior period reserve developments in the 2007 and 2008 periods and considering the effect of this retroactive premium rate increase, the MLR actually decreased by 1.5 percentage points during the 2008 period.

The medical claims incurred of the Commercial business increased by $5.3 million during the 2008 period and its MLR decreased by 1.2 percentage points during the year ended December 31, 2008. The lower MLR is primarily the result of the re-pricing or termination of less profitable groups, cost containment initiatives and lower utilization trends in drug and medical services.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2008 increased by $12.5 million, or 8.4%, to $160.6 million when compared to 2007. This increase is primarily attributed to the higher volume of the segment, particularly in the Medicare business. The segment s operating expense ratio decreased by 0.7 percentage points during the 2008 period, to 10.5%.

Year ended December 31, 2007 compared with the year ended December 31, 2006

Medical Operating Revenues

Medical premiums earned during 2007 decreased by $38.0 million, or 2.8%, to $1.3 billion when compared to earned premiums during 2006, principally as a result of the following:

Medical premiums earned in the Reform business decreased by $128.3 million, or 28.1%, to $327.5 million during the 2007 period. This fluctuation is due to a decrease in member months enrollment in the Reform business by 2,222,022, or 34.3%, mainly as the result of the termination of the contract for the Metro-North region, the tightening of membership restrictions by the Puerto Rico government, and the shift in membership of dual eligibles to Medicare Advantage policies offered by us and our competitors. The member months enrollment of the Metro-North region was 2,040,714 during the year ended December 31, 2006. The effect of this decrease in membership was mitigated by an increase in premium rates, effective July 1, 2007, of approximately 8.7% and a retroactive increase in rates of approximately 6.7% effective November 1, 2006.

Table of Contents

Medical premiums generated by the Medicare business increased during 2007 by $84.8 million, or 49.6%, to $255.6 million, primarily due to an increase in member months enrollment of 92,322, or 20.0%. The increase in member months is the net result of an increase of 135,238, or 48.1%, in the membership of our Medicare Advantage products and a decrease of 42,916, or 23.8%, in the membership of our PDP product. We expect that Medicare Advantage enrollment will continue to experience growth, but at a slower pace than in prior periods. In addition, the segment recognized an additional premium adjustment of $3.2 million related to the 2006 risk scores review performed by CMS.

Medical premiums generated by the Commercial business increased by $5.5 million, or 0.8%, to $718.7 million during the 2007 period. This increase is primarily the result of an increase in average premium rates of 6.5%, partially offset by a decrease in member months enrollment of 289,007, or 5.5%.

Administrative service fees increased by $0.3 million, or 1.8%, to $17.2 million during the 2007 period due to an increase in member months enrollment of self-funded arrangements of 69,017, or 3.7%, and to a shift of several self-funded groups to arrangements where the administrative service fee is based on contracts instead of claims paid.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2007 decreased by $40.4 million, or 3.4%, to $1.1 billion when compared to the year ended December 31, 2006. The decrease in medical claims incurred is mostly related to the medical claims incurred of the Reform business, which decreased by $119.9 million due its decreased enrollment, partially offset by a combined increase of $85.7 million in the medical claims incurred of the Medicare Advantage and PDP businesses due to an increase in members. The medical loss ratio decreased by 0.6 percentage points during the 2007 period, to 87.0%, primarily due to an overall increase in premium rates, lower utilization trends and a change in the mix of business of the segment. During the year ended December 31, 2007 the weight in the mix of business corresponding to the Reform business decreased as a result of the termination of the contract for the Metro-North area. The Reform business has a higher medical loss ratio than other businesses within the segment. On the other hand, the Medicare Advantage business, which at this time had a lower medical loss ratio than other businesses, had a higher weight in the mix of business in the 2007 period.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2007 decreased by $8.3 million, or 5.3%, to $148.1 million when compared to 2006. This decrease is primarily attributed to the decrease in direct costs of the Reform business due to its reduction in volume. The segment s operating expense ratio decreased by 0.3 percentage points during the 2007 period, to 11.2%.

Table of Contents

Life Insurance Operating Results

(Dollar amounts in millions)	**2008**	**2007**	**2006**
Years ended December 31,			
Operating revenues:			
Premiums earned, net			
Premiums earned, net	$100.1	97.4	91.9
Premiums earned ceded	(7.6)	(8.8)	(9.7)
Assumed premiums earned			4.4
Net premiums earned	92.5	88.6	86.6
Commission income on reinsurance	0.3	0.3	0.3
Premiums earned, net	92.8	88.9	86.9
Net investment income	16.5	15.0	13.7
Total operating revenues	109.3	103.9	100.6
Operating costs:			
Policy benefits and claims incurred	47.4	45.7	43.6
Underwriting and other expenses	49.4	47.5	45.8
Total operating costs	96.8	93.2	89.4
Operating income	$ 12.5	10.7	11.2
Additional data:			
Loss ratio	51.1%	51.4%	50.2%
Expense ratio	53.2%	53.4%	52.7%

Year ended December 31, 2008 compared with the year ended December 31, 2007

Operating Revenues

Premiums earned, net for the segment increased by $3.9 million, or 4.4%, to $92.8 million during the year ended December 31, 2008 as compared to the year ended December 31, 2007, primarily as the result of higher sales in the Cancer and Home Service lines of business during 2008.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred during the year ended December 31, 2008 increased by $1.7 million, or 3.7%, to $47.4 million in 2008. This increase is primarily the result of an increased in claims incurred in the Disability and Cancer lines of business. Despite the higher claim experience, as a result of the increased volume of premiums, the segment experienced a lower loss ratio by 0.3 percentage points, to 51.1%.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $1.9 million, or 4.0%, to $49.4 million during the year ended December 31, 2008 primarily as a result of higher net commissions attributable to new business. The segment s operating expense ratio decreased by 0.2 percentage points during 2008, from 53.4% in 2007 to 53.2% in 2008.

Year ended December 31, 2007 compared with the year ended December 31, 2006

Operating Revenues

Premiums earned, net for the segment increased by $2.0 million, or 2.3%, to $88.9 million during the year ended December 31, 2007 as compared to the year ended December 31, 2006, principally reflecting the acquisition of GA Life effective January 31, 2006. This increase is principally the result of the following:

Table of Contents

The premiums earned generated by the segment increased by $5.5 million, or 6.0%, to $97.4 million during the 2007 period. Premiums earned by GA Life during the month of January 2006 were $6.6 million, which are not reflected in our consolidated financial statements. Eliminating the effect of GA Life s premiums for the month of January 2006, the premiums earned in the segment decreased by $1.1 million primarily the result of lower sales in the Group Disability and Group Life businesses offset in part by an increase in the premiums of the Individual Life and Cancer businesses.

On December 22, 2005, we entered into a coinsurance funds withheld agreement with GA Life pursuant to which our former subsidiary SVTS assumed 69% of all the business written by GA Life (prior to its acquisition by us) as of and after the effective date of the agreement. Our results reflect premiums assumed under this agreement of $4.4 million, which represents our share of premiums for the month of January 2006 under the coinsurance agreement. The effects of the reinsurance transactions corresponding to this agreement were eliminated for consolidated financial statement purposes for the period following January 31, 2006.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred during the year ended December 31, 2007 increased by $2.1 million, or 4.8%, to $45.7 million in the 2007 period when compared to the 2006 period, principally reflecting the acquisition of GA Life effective January 31, 2006. Policy benefits and claims incurred by GA Life during the month of January 31, 2006, net of the effect of the coinsurance agreement, were $1.0 million. Eliminating the effect of GA Life s policy benefits and claims incurred for the month of January 2006, this segment presented an increase of $1.1 million. This increase is primarily driven by increases in the benefits of the Cancer and Group Life businesses, as well as to an increase in policy surrenders. These increases were partially offset by decreases in the benefits of the Group Disability and Individual Life businesses. The segment s loss ratio increased by 1.2 percentage points, from 50.2% in 2006 to 51.4% in the 2007 period, principally as a result of the inclusion of twelve months of GA Life benefits and claims incurred in the 2007 period (as compared to eleven months in 2006) and a higher loss ratio in the cancer business.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $1.7 million, or 3.7%, to $47.5 million during the year ended December 31, 2007. Considering the effect of underwriting and other expenses of $1.7 million incurred by GA Life during the month of January 2006, net of the effect of the coinsurance agreement, the underwriting and other expenses of the segment remained flat during the 2007 period. The segment s operating expense ratio increased by 0.7 percentage points during the year 2007, from 52.7% in 2006 to 53.4% in 2007.

Table of Contents

Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	**2008**	**2007**	**2006**
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$168.0	170.9	158.9
Premiums ceded	(72.1)	(69.1)	(65.7)
Change in unearned premiums	(2.1)	(4.9)	(4.7)
Premiums earned, net	93.8	96.9	88.5
Net investment income	12.5	11.8	9.6
Total operating revenues	106.3	108.7	98.1
Operating costs:			
Claims incurred	42.1	44.9	41.7
Underwriting and other operating expenses	51.1	53.1	45.2
Total operating costs	93.2	98.0	86.9
Operating income	$ 13.1	10.7	11.2
Additional data:			
Loss ratio	44.9%	46.3%	47.1%
Expense ratio	54.5%	54.8%	51.1%
Combined ratio	99.4%	101.1%	98.2%

Table of Contents

Year ended December 31, 2008 compared with the year ended December 31, 2007

Operating Revenues

Total premiums written during the year ended December 31, 2008 decreased by $2.9 million, or 1.7%, to $168.0 million. This fluctuation is mostly due to the decrease in the premiums written for the Commercial Auto and inland marine insurance policies amounting to $7.3 million. These decreases were partially offset by increases in the Commercial Multi-Peril and Dwelling insurance policies of $4.4 million. The Commercial products are under soft market conditions reducing premiums and increasing competition for renewals and new business. The Auto insurance products have been affected by lower economic activity in sales and auto loan originations.

Premiums ceded to reinsurers increased by $3.0 million, or 4.3%, to $72.1 million during the year ended December 31, 2008. The ratio of premiums ceded to premiums written increased by 2.5 percentage points, from 40.4% in 2007 to 42.9% in 2008, primarily due to the effect of non-proportional reinsurance treaties in relation to the level of premiums written as well as to the mix of business. The cost of non-proportional treaties is negotiated for the whole year based on expected premium volume; however, since volume for the year was lower than expected, the cost of reinsurance as a percentage of premiums was higher.

The change in unearned premiums presented a decrease of $2.8 million when compared to the prior year as the result of the lower volume of business written during the period.

Claims Incurred

Claims incurred during the year ended December 31, 2008 decreased by $2.8 million, or 6.2%, to $42.1 million. The loss ratio decreased by 1.4 percentage points during this period, to 44.9% in 2008, primarily as the result of the segment s underwriting guidelines focus on good selection, disciplined pricing, well diversified business, and with a low risk profile. In addition, we have made enhancements to the claims handling process to speed up claims processing. These efforts have resulted in improved loss ratios in the Commercial Multi-Peril and Liability coverages.

Underwriting and Other Operating Expenses

Underwriting and other operating expenses for the year ended December 31, 2008 decreased by $2.0 million, or 3.8%, to $51.1 million. The operating expense ratio decreased by 0.3 percentage points during the same period, to 54.5% in 2008. This decrease is primarily due to a lower net commission expense resulting from the segment s lower volume of business.

Year ended December 31, 2007 compared with the year ended December 31, 2006

Operating Revenues

Total premiums written during the year ended December 31, 2007 increased by $12.0 million, or 7.6%, to $170.9 million, principally as a result of increases in the commercial multi-peril, auto and dwelling lines of business of $11.2 million.

Premiums ceded to reinsurers increased by $3.4 million, or 5.2%, to $69.1 million during 2007. The ratio of premiums ceded to premiums written decreased by 0.9 percentage points, from 41.3% in 2006 to 40.4% in 2007 primarily as a result of lower costs of facultative reinsurance and the effects of the mix of business.

Claims Incurred

Claims incurred during the year ended December 31, 2007 increased by $3.2 million, or 7.7%, to $44.9 million. The loss ratio decreased by 0.8 percentage points during this period, to 46.3% in 2007, primarily as the result of the segment s adherence to underwriting guidelines and enhancements to the claims handling process, which included hiring additional in-house claim adjusters. These efforts have resulted in improved loss ratios in the commercial multi-peril, general liability, auto liability and commercial auto physical damage lines of business.

Table of Contents

Underwriting and Other Operating Expenses

Underwriting and other operating expenses for the year ended December 31, 2007 increased by $7.9 million, or 17.5%, to $53.1 million. The operating expense ratio increased by 3.7 percentage points during the same period, to 54.8% in 2007. This increase is primarily due to increases in net commission expense, payroll and payroll related expenses, corporate costs allocations and a provision for a possible loss contingency. The segment has also experienced an increase in its depreciation expense, including the depreciation and amortization expense related to the segment s investment in a new IT system.

Liquidity and Capital Resources

Cash Flows

A summary of our major sources and uses of cash for the periods indicated is presented in the following table:

(dollar amounts in millions)	**2008**	**2007**	**2006**
Years ended December 31,			
Sources of cash:			
Cash provided by operating activities	$	115.9	75.6
Net proceeds from investments sold		1.0	
Proceeds from long-term borrowings			35.0
Proceeds from annuity contracts	8.0	6.1	6.0
Net proceeds from initial public offering		70.3	
Other	18.3		
Total sources of cash	26.3	193.3	116.6
Uses of cash:			
Cash used in operating activities	(3.0)		
Net purchases of investment securities	(178.6)		(9.3)
Acquisition of GA Life, net of cash acquired			(27.8)
Capital expenditures	(22.4)	(9.4)	(11.9)
Dividends		(2.4)	(6.2)
Payments of long-term borrowings	(1.6)	(12.1)	(2.5)
Payments of short-term borrowings			(1.7)
Surrenders of annuity contracts	(7.1)	(7.4)	(16.0)
Repurchase and retirement of common stock	(7.6)		
Other		(3.4)	(8.7)
Total uses of cash	(220.3)	(34.7)	(84.1)
Net increase (decrease) in cash and cash equivalents	$(194.0)	158.6	32.5

Year ended December 31, 2008 compared to year ended December 31, 2007

Cash flows from operating activities decreased by $118.9 million for the year ended December 31, 2008, principally due to the effect of an increase in the amount of claims paid of $246.3 million; offset in part by an increase in premiums collected of $128.2 million. These fluctuations are primarily the result of the higher volume and increased utilization trends in our managed care segment, particularly in the Medicare business. The increase in premiums collected would have been higher when considering the $22.8 million of managed care premiums collected in December 2007 but corresponding to January 2008. In addition, as of December 31, 2008 the managed care segment experienced a significant increase in its premiums receivable amounting to $41.1 million, mostly from the government

of Puerto Rico and its instrumentalities. A significant amount of these balances has been collected by the managed care segment subsequent to December 31, 2008.

The increase in the other sources of cash of $18.3 million is attributed to a higher balance in outstanding checks over bank balances in 2008.

Table of Contents

Net acquisitions of investment securities increased by $179.6 million during the year ended December 31, 2008, principally as the result of acquisitions of available for sale securities mainly in our managed care segment and the effect of purchases of investments with trade date in December 2007 and a settlement date in January 2008, amounting to $117.5 million.

Capital expenditures increased by $13.0 million as a result of the capitalization of costs related to the new systems initiative in our managed care segment.

On December 8, 2008 we announced the immediate commencement of our $40.0 million share repurchase program. As of December 31, 2008, we have paid approximately $7.6 million under our stock repurchase program.

We repaid upon its maturity on August 1, 2007 the outstanding balance of $10.5 million of one of our secured term loans.

In March 2007, we declared and paid dividends to our stockholders of $2.4 million.

Year ended December 31, 2007 compared to year ended December 31, 2006

Cash provided by operating activities increased by $40.3 million, or 53.3%, to $115.9 million for the year ended December 31, 2007, principally due to the net effect of an increase of $14.2 million in net proceeds received from the sale of trading securities, a reduction in claims paid of $54.4 million, a reduction in cash paid to suppliers and employees of $8.6 million, partially offset by a reduction in premiums collected of $16.2 million. These fluctuations were impacted by the termination of the contract for the Metro-North region of our managed care segment. In addition, in 2007 there was an increase of $23.1 million in the amount of income taxes paid that is the result of the higher taxable income in 2007 of our managed care subsidiary, which has a higher effective tax rate than the other segments.

Proceeds from long-term borrowings amounted to $35.0 million during 2006 as a result of the issuance and sale of our 6.7% senior unsecured notes during the first quarter of 2006, which were used for the acquisition of GA Life.

On December 2007, the Corporation received net proceeds amounting to $70.3 million upon our initial public offering.

On January 31, 2006, we acquired GA Life at a cost of $27.8 million, net of $10.4 million of cash acquired.

Capital expenditures decreased by $2.5 million as the result of the completion of the renovation of a building adjacent to our corporate headquarters which was completed during the last quarter of 2006. In addition, our property and casualty insurance segment acquired new hardware and software as part of its new insurance application during 2006.

In March 2007, we declared and paid dividends to our stockholders amounting to $2.4 million.

On August 1, 2007, we repaid the outstanding balance of $10.5 million of one of our secured term loans upon its maturity.

Financing and Financing Capacity

We have several short-term facilities available to address timing differences between cash receipts and disbursements. These short-term facilities are mostly in the form of arrangements to sell securities under repurchase agreements. As of December 31, 2008, we had $131.0 million of available credit under these facilities. There were no outstanding short-term borrowings under these facilities as of December 31, 2008.

As of December 31, 2008, we had the following senior unsecured notes payable:

On January 31, 2006, we issued and sold $35.0 million of our 6.7% senior unsecured notes payable due January 2021 (the 6.7% notes). The 6.7% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at par, in whole or in part, as determined by us. The proceeds obtained from this issuance were used to finance the acquisition of 100% of the common stock of GA Life effective January 31, 2006.

Table of Contents

On December 21, 2005, we issued and sold $60.0 million of our 6.6% senior unsecured notes due December 2020 (the 6.6% notes). The 6.6% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at par, in whole or in part, as determined by us. The proceeds obtained from this issuance were used to pay the ceding commission to GA Life on the effective date of the coinsurance funds withheld reinsurance agreement.

On September 30, 2004, our managed care subsidiary issued and sold $50.0 million of its 6.3% senior unsecured notes due September 2019 (the 6.3% notes). The 6.3% notes are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us. The notes were privately placed to various institutional accredited investors. The notes pay interest semiannually until the principal becomes due and payable. These notes can be prepaid after five years at par, in whole or in part, as determined by our managed care subsidiary. Most of the proceeds obtained from this issuance were used to repay $37.0 million of short-term borrowings. The remaining proceeds were used for general business purposes.

The 6.3% notes, the 6.6% notes and the 6.7% notes contain certain covenants. At December 31, 2008, we and our managed care subsidiary, as applicable, are in compliance with these covenants.

In addition, as of December 31, 2008 we are a party to a secured term loan with a commercial bank, FirstBank Puerto Rico. This secured loan bears interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus 100 basis points and requires monthly principal repayment of $0.1 million. As of December 31, 2008, this secured loan had an outstanding balance of $24.3 million and an average annual interest rate of 2.4%.

This secured loan is guaranteed by a first lien on our land, buildings and substantially all leasehold improvements, as collateral for the term of the agreements under a continuing general security agreement. This secured loan contains certain covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2008, we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the secured loan s outstanding balances. Principal repayments on this loan are expected to be paid out from our operating and investing cash flows.

We were also a party to another secured loan whose outstanding balance of $10.5 million was repaid upon its maturity on August 1, 2007.

We anticipate that we will have sufficient liquidity to support our currently expected needs.

Planned Capital Expenditures

During 2005, our managed care business began a project to change a significant part of its operations computer system. This project is expected to be carried out in phases until 2012 at a cost of approximately $64.0 million. Our managed care business expects to incur costs of approximately $26 million during 2008. We estimate that $17 million of the costs expected to be incurred in 2009 will be capitalized over the system s useful life and the remaining amount will be expensed. This amount is expected to be paid out of the operating cash flows of our managed care business.

Contractual Obligations

Our contractual obligations impact our short and long-term liquidity and capital resource needs. However, our future cash flow prospects cannot be reasonably assessed based solely on such obligations. Future cash outflows, whether contractual or not, will vary based on our future needs. While some cash outflows are completely fixed (such as commitments to repay principal and interest on borrowings), most are dependent on future events (such as the payout pattern of claim liabilities which have been incurred but not reported).

The table below describes the payments due under our contractual obligations, aggregated by type of contractual obligation, including the maturity profile of our debt, operating leases and other long-term liabilities, and excludes an estimate of the future cash outflows related to the following liabilities:

Table of Contents

Unearned premiums This amount accounts for the premiums collected prior to the end of coverage period and does not represent a future cash outflow. As of December 31, 2008, we had $110.1 million in unearned premiums.

Policyholder deposits The cash outflows related to these instruments are not included because they do not have defined maturities, such that the timing of payments and withdrawals is uncertain. There are currently no significant policyholder deposits in paying status. As of December 31, 2008, our policyholder deposits had a carrying amount of $48.7 million.

Other long-term liabilities Due to the indeterminate nature of their cash outflows, $64.5 million of other long-term liabilities are not reflected in the following table, including $44.1 million of liability for the pension benefits and $11.2 million in liabilities to the Federal Employees Health Benefits Plan Program.

		Contractual obligations by year					
(Dollar amounts in millions)	**Total**	**2009**	**2010**	**2011**	**2012**	**2013**	**Thereafter**
Long-term borrowings (1)	$ 283.4	11.7	11.6	11.6	11.5	11.5	225.5
Operating leases	16.9	6.0	4.4	2.7	1.2	0.5	2.1
Purchase obligations (2)	151.6	148.5	1.3	1.1	0.5	0.2	
Claim liabilities (3)	293.3	206.2	52.3	11.3	10.5	5.5	7.5
Estimated obligation for future policy benefits (4)	994.9	70.2	61.3	57.8	55.0	52.6	698.0
	$1,740.1	442.6	130.9	84.5	78.7	70.3	933.1

(1) As of December 31, 2008, our long-term borrowings consist of our managed care subsidiary s 6.3% senior unsecured notes payable (which are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us), our 6.6% senior unsecured notes payable, our 6.7% senior

unsecured notes payable, and a loan payable to a commercial bank. Total contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.3%, 6.6% and 6.7% senior unsecured notes, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity dates of the notes in 2019, 2020, and 2021, respectively. We may redeem the notes starting five years after issuance; however no redemption is considered in this schedule. The interest payments related to our loan payable were estimated using the interest rate applicable as of December 31, 2008. The actual amount of interest

payments of the loans payable will differ from the amount included in this schedule due to the loans variable interest rate structure. See the Financing and Financing Capacity section for additional information regarding our long-term borrowings.

(2) Purchase obligations represent payments required by us under material agreements to purchase goods or services that are enforceable and legally binding and where all significant terms are specified, including: quantities to be purchased, price provisions and the timing of the transaction. Other purchase orders made in the ordinary course of business for which we are not liable are excluded from the table above. Estimated pension plan

contributions amounting to $7 million were included within the total purchase obligations. However, this amount is an estimate which may be subject to change in view of the fact that contribution decisions are affected by various factors such as market performance, regulatory and legal requirements and plan funding policy.

(3) Claim liabilities represent the amount of our claims processed and incomplete as well as an estimate of the amount of incurred but not reported claims and loss-adjustment expenses. This amount does not include an estimate of claims to be incurred subsequent to December 31, 2008. The expected claims payments are an estimate and may differ

materially from the actual claims payments made by us in the future. Also, claim liabilities are presented gross, and thus do not reflect the effects of reinsurance under which $30.4 million of reserves had been ceded at December 31, 2008.

(4) Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or

Table of Contents

becomes disabled or upon the occurrence of other covered events. A significant portion of the estimated obligation for future policy benefits to be paid included in this table considers contracts under which we are currently not making payments and will not make payments until the occurrence of an insurable event not under our control, such as death, illness, or the surrender of a policy. We have estimated the timing of the cash flows related to these contracts based on historical experience as well as expectations of future payment patterns. The amounts presented in the table above represent the estimated cash payments for benefits under such contracts based on assumptions related to the receipt of future premiums and assumptions related to mortality, morbidity, policy lapses, renewals, retirements, disability incidence and other contingent events as appropriate for the respective product type. All estimated cash payments included in this table are not discounted to present value nor do they take into account estimated future premiums on policies in-force as of December 31, 2008, and are gross of any reinsurance recoverable. The $994.9 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $207.5 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual experience and the assumptions used in the estimation of these payments.

Off-Balance Sheet Arrangements

We have no off-balance sheet arrangements that have or are reasonably likely to have a current or future material effect on our financial condition, revenues, expenses, results of operations, liquidity, capital expenditures or capital resources.

Restriction on Certain Payments by the Corporation s Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico. These regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by the insurance subsidiaries to TSM. Our managed care subsidiary is required to have minimum capital of $1.0 million, our life insurance subsidiary is required to have minimum capital of $2.5 million and our property and casualty insurance subsidiary is required to have minimum capital of $3.0 million. As of December 31, 2008, our insurance subsidiaries were in compliance with such minimum capital requirements.

During 2008, the Commissioner of Insurance approved the requirement to use the National Association of Insurance Commissioners (NAIC) RBC Model Act by all local insurers in determining minimum capital level. This requirement goes into effect in 2009, and will be phased in over a five-year period.

These regulations are not directly applicable to us, as a holding company, since we are not an insurance company.

Our secured term loan restricts the amount of dividends that we and our subsidiaries can declare or pay to shareholders. Under the secured term loan, dividend payments cannot be made in excess of the accumulated retained earnings of the paying entity.

We do not expect that any of the previously described dividend restrictions will have a significant effect on our ability to meet our cash obligations.

Solvency Regulation

To monitor the solvency of the operations, the BCBSA requires us and our managed care subsidiary to comply with certain specified levels of risk-based capital (RBC). RBC is designed to identify weakly capitalized companies by comparing each company s adjusted surplus to its required surplus (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2008, both we and our managed care subsidiary s estimated RBC ratio were above the 200% of our RBC required by the BCBSA and the 375% of our RBC level required by the BCBSA to avoid monitoring.

Table of Contents

Other Contingencies

Legal Proceedings

Various litigation claims and assessments against us have arisen in the course of our business, including but not limited to, our activities as an insurer and employer. Furthermore, the Commissioner of Insurance, as well as other Federal and Puerto Rico government authorities, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations.

Based on the information currently known by our management, in its opinion, the outcomes of such pending investigations and legal proceedings are not likely to have a material adverse effect on our financial position, results of operations and cash flows. However, given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could, from time to time, have an adverse effect on our operating results and/or cash flows. See Item 3 Legal Proceedings .

Guarantee Associations

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared to be insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. During the years ended December 31, 2008 and 2007, no assessment or payment was made in connection with insurance companies declared insolvent. During 2006, we paid assessments in connection with insurance companies declared insolvent in the amount of $1.0 million. It is the opinion of management that any possible future guarantee association assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

Pursuant to the Puerto Rico Insurance Code, our property and casualty insurance subsidiary is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED) and of the Sindicato de Aseguradores de Responsabilidad Profesional para Médicos. Both syndicates were organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the previously mentioned syndicates cannot meet their obligations. During 2008, 2007 and 2006, no assessment or payment was made for this contingency. It is the opinion of management that any possible future syndicate assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

In addition, pursuant to Article 12 of Rule LXIX of the Insurance Code, our property and casualty insurance subsidiary is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the Association). The Association was organized in 1997 to underwrite insurance coverage of motor vehicle property damage liability risks effective January 1, 1998. As a participant, the segment shares the risk proportionally with other members based on a formula established by the Insurance Code. During the years 2008, 2007 and 2006, the Association distributed a dividend based on the good experience of the business amounting to $1.1 million, $1.0 million and $0.8 million, respectively.

Critical Accounting Estimates

Our consolidated financial statements and accompanying notes included in this Annual Report on Form 10-K have been prepared in accordance with GAAP applied on a consistent basis. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. We continually evaluate the accounting policies and estimates we use to prepare our consolidated financial statements. In general, management s estimates are based on historical experience and various other assumptions it believes to be reasonable under the circumstances. The following is an explanation of our accounting policies considered most significant by management. These accounting policies require us to make estimates and assumptions that affect the amounts reported in the financial statements and

Table of Contents

accompanying notes. Such estimates and assumptions could change in the future as more information is known. Actual results could differ materially from those estimates.

The policies discussed below are considered by management to be critical to an understanding of our financial statements because their application places the most significant demands on management s judgment, with financial reporting results relying on estimation about the effect of matters that are inherently uncertain. For all these policies, management cautions that future events may not necessarily develop as forecasted, and that the best estimates routinely require adjustment. Management believes that the amounts provided for these critical accounting estimates are adequate.

Claim Liabilities

Claim liabilities as of December 31, 2008 by segment were as follows:

(Dollar amounts in millions)	**Managed Care**	**Life Insurance**	**Property and Casualty Insurance**	**Consolidated**
Claims processed and incomplete [1]	$ 78.2	31.3	46.6	156.1
Unreported losses [2]	119.3	8.3	22.5	150.1
Unpaid loss-adjustment expenses [3]	4.4	0.3	12.8	17.5
	$ 201.9	39.9	81.9	323.7

(1) The liability for claims processed and incomplete represents those claims that have been incurred and reported to us that remain unpaid as of the balance sheet date. This amount includes claims that have been investigated and adjusted but have not been paid as well as those reported claims that have not gone through the investigation and adjustment

process.

(2) The liability for estimated unreported losses is the amount needed to provide for the estimated ultimate cost of settling those claims related to insured events that have occurred but have not been reported to us.

(3) The liability for unpaid loss-adjustment expenses is the amount needed to provide for the estimated ultimate cost required to investigate and adjust claims related to insured events that have occurred as of the balance sheet date, whether or not the claims have been reported to us at that date.

Management continually evaluates the potential for changes in its claim liabilities estimates, both positive and negative, and uses the results of these evaluations to adjust recorded claim liabilities and underwriting criteria. Our profitability depends in large part on our ability to accurately predict and effectively manage the amount of claims incurred, particularly those of the managed care segment and the losses arising from the property and casualty and life insurance segment. Management regularly reviews its premiums and benefits structure to reflect our underlying claims experience and revised actuarial data; however, several factors could adversely affect our underwriting results. Some of these factors are beyond management s control and could adversely affect its ability to accurately predict and effectively control claims incurred. Examples of such factors include changes in health practices, economic conditions, change in utilization trends, healthcare costs, the advent of natural disasters, and malpractice litigation. Costs in excess of those anticipated could have a material adverse effect on our results of operations.

We recognize claim liabilities as follows:

Managed Care Segment

At December 31, 2008, claim liabilities for the managed care segment amounted to $201.9 million and represented 62.4% of our total consolidated claim liabilities and 19.0% of our total consolidated liabilities.

Liabilities for reported but incomplete claims are recorded at the contractual rate. Liabilities for unreported losses are determined employing actuarial methods that are commonly used by managed care actuaries and meet Actuarial Standards of Practice, which require that the claim liabilities be adequate under moderately adverse circumstances. The segment determines the amount of the liability for unreported losses by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project a best estimate of claim liabilities. Under this process, historical claims incurred dates are compared to actual dates of claims payment. This information is analyzed to

Table of Contents

create completion or development factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of claim liabilities are then determined by subtracting the actual paid claims from the estimate of the total expected claims incurred. The majority of unpaid claims, both reported and unreported, for any period, are those claims which are incurred in the final months of the period. Since the percentage of claims paid during the period with respect to claims incurred in those months is generally very low, the above-described completion factor methodology is less reliable for such months. In order to complement the analysis to determine the unpaid claims, historical completion factors and payment patterns are applied to incurred and paid claims for the most recent twelve months and compared to the prior twelve month period. Incurred claims for the most recent twelve months also take into account recent claims expense levels and health care trend levels (trend factors). Using all of the above methodologies, our actuaries determine based on the different circumstances the unpaid claims as of the end of period.

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed.

Circumstances to be considered in developing our best estimate of reserves include changes in enrollment, utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns, and claim submission patterns. A comparison or prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 77% of the claims are paid within three months after the last day of the month in whish they were incurred and about 13% are within the next three months, for a total of 90% paid within six months after the last day of the month in which they were incurred.

Management regularly reviews its assumptions regarding claim liabilities and makes adjustments to claims incurred when necessary. If management s assumptions regarding cost trends and utilization are significantly different than actual results, our statement of earning and financial position could be impacted in future periods. Changes to prior year estimates may result in an increase in claims incurred or a reduction of claims incurred in the period the change is made. Further, due to the considerable variability of health care costs, adjustments to claims liabilities are made in each period and are sometimes significant as compared to the net income recorded in that period. Prior year development of claim liabilities is recognized immediately upon the actuary s judgment that a portion of the prior year liability is no longer needed or that an additional liability should have been accrued. Health care trends are monitored in conjunction with the claim reserve analysis. Based on these analyses, rating trends are adjusted to anticipate future changes in health care cost or utilization. Thus, the managed care segment incorporated those trends as part of the development of premium rates in an effort to keep premium rating trends in line with claims trends.

As described above, completion factors and claims trend factors can have a significant impact on determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2008 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

Table of Contents

(Dollar amounts in millions)

Completion Factor[1] (Decrease) Increase		Claims Trend Factor[2] (Decrease) Increase	
In completion factor	**In unpaid claim liabilities**	**In claims trend factor**	**In unpaid claim liabilities**
(0.6)%	$11.2	(0.6)%	$6.0
(0.4)%	7.5	(0.4)%	4.0
(0.2)%	3.7	(0.2)%	2.0
0.2%	(3.7)	0.2%	(2.0)
0.4%	(7.4)	0.4%	(4.0)
0.6%	(11.0)	0.6%	(6.0)

1 Assumes (decrease) increase in the completion factors for the most recent twelve months.

2 Assumes (decrease) increase in the claims trend factors for the most recent twelve months.

The segments reserving practice is to consistently recognize the actuarial best estimate as the ultimate liability for claims within a level of confidence required by actuarial standards. Management believes that the methodology for determining the best estimate for claim liabilities at each reporting date has been consistently applied.

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments, or run-out becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred claims related to prior years result from claims being settled for amounts less than originally estimate. The reverse is true of reserve shortfalls. Medical claim liabilities are usually described as having a short tail: which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 95%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 5% related to claims incurred prior to the previous calendar year-end. In 2005, the managed care segment began offering Medicare Advantage products for the first time. There has been a rapid growth in this line of business-from minimal enrollment in 2005 to approximately 75,000 members by the end of 2008. There have been some increases in both completion and trend factors because of the growth of this business. The effect should lessen with the maturity of this business. Management has not noted any significant emerging trends in claim frequency and severity, other than as described above, and the normal fluctuations in utilization trends from year to year.

The following table shows the variance between the segment s incurred claims for current period insured events and the incurred claims for such years had they been determined retrospectively (the Incurred claims related to current period insured events for the year shown plus or minus the Incurred claims related to prior period insured events for the following year as included in note 8 to the audited consolidated financial statements). This table shows that the

segments estimates of this liability have approximated the actual development.

(Dollar amounts in millions	**2007**	**2006**	**2005**
Years ended December 31,			
Total incurred claims:			
As reported [(1)]	$ 1,156.8	1,184.3	1,148.2
On a retrospective basis	1,149.2	1,160.7	1,137.5
Variance	$ 7.6	23.6	10.7
Variance to total incurred claims as reported	0.7%	2.0%	0.9%

(1) Includes total claims incurred less adjustments for prior year reserve development.

Table of Contents

Management expects that substantially all of the development of the 2008 estimate of medical claims payable will be known during 2009 and that the variance of the total incurred claims on a retrospective basis when compared to reported incurred claims will be similar to the prior years.

In the event this segment experiences an unexpected increase in health care cost or utilization trends, we have the following options to cover claim payments:

Through the management of our cash flows and investment portfolio.

We have the ability to increase the premium rates throughout the year in the monthly renewal process, when renegotiating the premiums for the following contract year of each group as they become due. We consider the actual claims trend of each group when determining the premium rates for the following contract year.

We have available short-term borrowing facilities that from time to time address differences between cash receipts and disbursements.

For additional information on our credit facilities, see section Financing and Financing Capacity of this Item.

Life Insurance Segment

At December 31, 2008, claim liabilities for the life insurance segment amounted to $39.9 million and represented 12.3% of total consolidated claim liabilities and 3.7% of our total consolidated liabilities.

The claim liabilities related to the life insurance segment are based on methods and underlying assumptions in accordance with GAAP and applicable actuarial standards. The estimate of claim liabilities for this segment is based on the amount of benefits contractually determined and on actuarial estimates of the amount of loss inherent in that period s claims, including losses for which claims have not been reported. This estimate relies on actuarial observations of ultimate loss experience for similar historical events. Principal assumptions used in the establishment of claim liabilities for this segment are mortality, morbidity and claim submission patterns, among others.

Claim reserve reviews are generally conducted on a quarterly basis, in light of continually updated information, and include participation of the segment s external actuaries. Our actuaries review reserves using the current inventory of policies and claims data. These reviews incorporate a variety of actuarial methods, judgments and analysis.

The key assumption with regard to claim liabilities for our life insurance segment is related to claims included prior to the end of the year, but not yet reported to our subsidiary. A liability for these claims is estimated based upon experience with regards to amounts reported subsequent to the close of business in prior years. There are uncertainties attendant to these estimates; however, in recent years our estimates have proved to be slightly conservative.

Property and Casualty Insurance Segment

At December 31, 2008, claim liabilities for the property and casualty insurance segment amounted to $81.9 million and represented 25.3% of the total consolidated claim liabilities and 7.7% of our total consolidated liabilities.

Estimates of the ultimate cost of claims and loss-adjustment expenses of this segment are based largely on the assumption that past developments, with appropriate adjustments due to known or unexpected changes, are a reasonable basis on which to predict future events and trends, and involve a variety of actuarial techniques that analyze current experience, trends and other relevant factors. Property and casualty insurance claim liabilities are categorized and tracked by line of business. Medical malpractice policies are written on a claims-made basis. Policies written on a claims-made basis require that claims be reported during the policy period. Other lines of business are written on an occurrence basis.

Individual case estimates for reported claims are established by a claims adjuster and are changed as new information becomes available during the course of handling the claim. Our property and casualty business, other than medical malpractice, is primarily short-tailed business, where losses (e.g. paid losses and case reserves) are generally reported quickly.

Table of Contents

Claim reserve reviews are generally conducted on a quarterly basis, in light of continually updated information. Our actuaries certify reserves for both current and prior accident years using current claims data. These reviews incorporate a variety of actuarial methods, judgments, and analysis. For each line of business, a variety of actuarial methods are used, with the final selections of ultimate losses that are appropriate for each line of business selected based on the current circumstances affecting that line of business. These selections incorporate input from management, particularly from the claims, underwriting and operations divisions, about reported loss cost trends and other factors that could affect the reserve estimates.

Key assumptions are based on the consideration that past emergence of paid losses and case reserves is credible and likely indicative of future emergence and ultimate losses. A key assumption is the expected loss ratio for the current accident year. This expected loss ratio is generally determined through a review of the loss ratios of prior accident years and expected changes to earned pricing, loss costs, mix of business, and other factors that are expected to impact the loss ratio for the current accident year. Another key assumption is the development patterns for paid and reported losses (also referred to as the loss emergence and settlement patterns). The reserves for unreported claims for each year are determined after reviewing the indications produced by each actuarial projection method, which, in turn, rely on the expected paid and reported development patterns and the expected loss ratio for that year.

At December 31, 2008, the actuarial reserve range determined by the actuaries was from $79.2 million to $89.7 million. Management reviews the results of the reserve estimates in order to determine any appropriate adjustments in the recording of reserves. Adjustments to reserve estimates are made after management s consideration of numerous factors, including but not limited to the magnitude of the difference between the actuarial indication and the recorded reserves, improvement or deterioration of actuarial indications in the period, the maturity of the accident year, trends observed over the recent past and the level of volatility within a particular line of business. In general, changes are made more quickly to more mature accident years and less volatile lines of business. Varying the net expected loss ratio by +/-1% in all lines of business for the six most recent accident years would increase/decrease the claims incurred by approximately $5.3 million.

Liability for Future Policy Benefits

Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. We compute the amounts for actuarial liabilities in conformity with GAAP. Liabilities for future policy benefits for whole life and term insurance products are computed by the net level premium method, using interest assumptions ranging from 5.0% to 5.4% and withdrawal, mortality and morbidity assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.

The liabilities for all products, except for universal life and deferred annuities, are based upon a variety of actuarial assumptions that are uncertain. The most significant of these assumptions is the level of anticipated death and health claims. Other assumptions that are less significant to the appropriate level of the liability for future policy benefits are anticipated policy persistency rates, investment yields, and operating expense levels. These are reviewed frequently by our subsidiary s external actuaries, to assure that the current level of liabilities for future policy benefits is sufficient, in combination with anticipated future cash flows, to provide for all contractual obligations. For all products except for universal life and deferred annuities, according to Statement of Financial Accounting Standards (SFAS) No. 60, *Accounting and Reporting by Insurance Enterprises*, the basis for the liability for future policy benefits is established at the time of issuance of each contract and would only change if our experience deteriorates to the point that the level of the liability is not adequate to provide for future policy benefits. We do not currently expect that level of deterioration to occur.

Table of Contents

Deferred Policy Acquisition Costs and Value of Business Acquired

Certain costs for acquiring life and property and casualty insurance business are deferred. Acquisition costs related to the managed care business are expensed as incurred.

The costs of acquiring new life business, principally commissions, and certain variable underwriting, agency and policy issue expenses of our life insurance segment, have been deferred. These costs, including value of business acquired (VOBA) recorded upon our acquisition of GA Life (now TSV), are amortized to income over the premium-paying period of the related whole life and term insurance policies in proportion to the ratio of the expected annual premium revenue to the expected total premium revenue, and over the anticipated lives of universal life policies in proportion to the ratio of the expected annual gross profits to the expected total gross profits. The expected premiums revenue and gross profits are based upon the same mortality and withdrawal assumptions used in determining the liability for future policy benefits. For universal life policies, changes in the amount or timing of expected gross profits result in adjustments to the cumulative amortization of these costs. The effect on the amortization of deferred policy acquisition costs of revisions to estimated gross profits is reported in earnings in the period such estimated gross profits are revised.

The schedules of amortization of life insurance deferred policy acquisition costs (DPAC) and VOBA are based upon actuarial assumptions regarding future events that are uncertain. For all products, other than universal life and deferred annuities, the most significant of these assumptions is the level of contract persistency and investment yield rates. For these products according to FASB No. 60 the basis for the amortization of DPAC and VOBA is established at the issue of each contract and would only change if our segment s experience deteriorates to the point that the level of the liability is not adequate. We do not currently expect that level of deterioration to occur. For the universal life and deferred annuity products, amortization schedules are based upon the level of historic and anticipated gross profit margins, from the date of each contract s issued (or purchase, in the case of VOBA). These schedules are based upon several actuarial assumptions that are uncertain, are reviewed annually and are modified if necessary. The most significant of these assumptions are anticipated universal life claims, investment yield rates and contract persistency. Based upon the most recent actuarial reviews of all of the assumptions, we do not currently anticipate material changes to the level of these amortization schedules.

The managed care and property and casualty business acquisition costs consist of commissions incurred during the production of business and are deferred and amortized ratably over the terms of the policies.

Impairment of Investments

Impairment of an investment exists if a decline in the estimated fair value is below the amortized cost of the security. When this happens, an evaluation of whether that impairment is other than temporary is necessary. This evaluation is subjective and requires a high degree of judgment. Management regularly reviews each investment security for impairment based on criteria that include the extent to which cost exceeds estimated fair value, general market conditions (like changes in interest rates), our ability and intent to hold the security until recovery in estimated fair value, the duration of the estimated fair value decline and the financial condition and specific prospects for the issuer. Management regularly performs market research and monitors market conditions to evaluate impairment risk. A decline in the estimated fair value of any available-for-sale or held-to-maturity security below cost, which is deemed to be other than temporary, results in a reduction of the carrying amount to its fair value. The impairment is charged to operations when that determination is made and a new cost basis for the security is established.

During the years ended December 31, 2008, 2007 and 2006 we recognized other-than-temporary impairments amounting to $16.5 million, $1.1 million and $2.1 million, respectively, on equity securities and perpetual preferred stocks classified as available for sale. As of December 31, 2008, of the total amount of investments in securities of $1,010.3 million, $32.2 million, or 3.2%, are classified as trading securities, and thus are recorded at fair value with changes in estimated fair value recognized in the statement of operations. The remaining $978.1 million is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $805.0 million, or 82.3%, are securities in obligations of U.S. government-sponsored enterprises, U.S. Treasury securities, obligations of the Commonwealth of Puerto Rico, municipal securities, obligations of U.S. states and its political subdivisions, mortgage backed and collateralized mortgage obligations that are U.S. agency-backed. The

Table of Contents

remaining $173.1 million, or 17.7%, are from corporate fixed, equity securities and mutual funds. Gross unrealized losses as of December 31, 2008 of the available-for-sale and held-to-maturity portfolios amounted to $7.9 million. The impairment analysis as of December 31, 2008 and 2007 indicated that, other than the equity security for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was other-than-temporarily impaired as of that date; however, several factors are beyond management s control, such as the following: financial condition of the issuer, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management s judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income.

Our fixed maturity securities are sensitive to interest rate fluctuations, which impact the fair value of individual securities. Our equity securities are sensitive to equity price risks, for which potential losses could arise from adverse changes in the value of equity securities. For additional information on the sensitivity of our investments, see Item 7A Quantitative and Qualitative Disclosures About Market Risk in this Annual Report on Form 10-K.

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2008 and 2007 is included in note 3 to the audited consolidated financial statements.

Allowance for Doubtful Receivables

We estimate the amount of uncollectible receivables in each period and establish an allowance for doubtful receivables. The allowance for doubtful receivables amounted to $14.7 million and $15.9 million as of December 31, 2008 and 2007, respectively. The amount of the allowance is based on the age of unpaid accounts, information about the customer s creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

In addition to premium-related receivables, we evaluate the risk in the realization of other accounts receivable, including balances due from third parties related to overpayment of medical claims and rebates, among others. These amounts are individually analyzed and the allowance determined based on the specific collectivity assessment and circumstances of each individual case.

We consider this allowance adequate to cover potential losses that may result from our inability to subsequently collect the amounts reported as accounts receivable. However, such estimates may change significantly in the event that unforeseen economic conditions adversely impact the ability of third parties to repay the amounts due to us.

Other Significant Accounting Policies

We have other accounting policies that are important to an understanding of the financial statements. See note 2 to the audited consolidated financial statements.

Recently Issued Accounting Standards

In September 2006, the Financial Accounting Standards Board (FASB) issued Financial Accounting Standard (FAS) No. 157, *Fair Value Measurements*. FAS 157 defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements. FAS 157 does not require any new fair value measurements. We adopted FAS 157 on January 1, 2008. This adoption did not have an impact on our financial position or results of operations. See Note 8 to the audited consolidated financial statements for disclosure related to FAS 157.

Table of Contents

In February 2007, the FASB issued FAS 159, *The Fair Value Option for Financial Assets and Financial Liabilities Including an Amendment of FASB Statement No. 115*. FAS 159 allows entities to measure many financial instruments and certain other assets and liabilities at fair value on an instrument-by-instrument basis under the fair value option. We adopted FAS 159 on January 1, 2008. We have chosen not to elect the fair value option for any items that are not already required to be measured at fair value in accordance with GAAP. Accordingly, the adoption of FAS 159 did not have an impact on our financial position or operating results.

In March 2008, the FASB issued FAS 161, *Disclosures about Derivative Instruments and Hedging Activities*. FAS 161 requires companies with derivative instruments to disclose information about how and why a company uses derivative instruments, how derivative instruments and related hedged items are accounted for under FAS 133, *Accounting for Derivative Instruments and Hedging Activities*, and how derivative instruments and related hedged items affect a company s financial position, financial performance, and cash flows. This statement expands the current disclosure framework in FAS 133. FAS 161 is effective prospectively for periods beginning on or after November 15, 2008. We do not expect the adoption of FAS 161 to have a material impact on our consolidated financial statements.

In May 2008, the FASB issued FAS 163, *Accounting for Financial Guarantee Insurance Contracts an Interpretation of FASB Statement No. 60*. FAS 163 prescribes the accounting for premium revenue and claims liabilities by insurers of financial obligations, and requires expanded disclosures about financial guarantee insurance contracts. FAS 163 applies to financial guarantee insurance and reinsurance contracts issued by insurers subject to FAS 60, *Accounting and Reporting by Insurance Enterprises*. The Statement does not apply to insurance contracts that are similar to financial guarantee insurance contracts such as mortgage guaranty or trade-receivable insurance, financial guarantee contracts issued by noninsurance entities, or financial guarantee contracts that are derivative instruments within the scope of FAS 133. Statement 163 is effective for financial statements issued for fiscal years beginning after December 15, 2008, and interim periods within those years, except for certain disclosure requirements about the risk-management activities of the insurance enterprise that are effective for the first quarter beginning after the Statement was issued (May 23, 2008). Except for those disclosures, early application is prohibited. This standard has no impact on our consolidated financial statements.

In December 2008, the FASB issued a FASB Staff Position (FSP) amending FASB 132 (revised 2003), *Employers Disclosures about Pensions and Other Postretirement Benefits,* to provide guidance on an employer s disclosures about plan assets of a defined benefit pension or other postretirement plan. This FSP requires employers to disclose information about fair value measurements of plan assets that would be similar to the disclosures about fair value measurements required by FAS 157, *Fair Value Measurements.* The disclosures about plan assets required by this FSP are required for fiscal years ending after December 15, 2009. Upon initial application, the provisions of this FSP are not required for earlier periods that are presented for comparative purposes. Earlier application of the provisions of this FSP is permitted.

There were no other new accounting pronouncements issued during the year ended December 31, 2008 that had a material impact on our financial position, operating results or disclosures.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

We are exposed to certain market risks that are inherent in our financial instruments, which arise from transactions entered into in the normal course of business. We are also subject to additional market risk with respect to certain of our financial instruments. We must effectively manage, measure, and monitor the market risk associated with our invested assets and interest rate sensitive liabilities. We have established and implemented comprehensive policies and procedures to minimize the effects of potential market volatility.

Market Risk Exposure

We have exposure to market risk mostly in our investment activities. For purposes of this disclosure, market risk is defined as the risk of loss resulting from changes in interest rates and equity prices. Analytical tools and monitoring systems are in place to assess each one of the elements of market risks.

Table of Contents

As in other insurance companies, investment activities are an integral part of our business. Insurance statutes regulate the type of investments that the insurance segments are permitted to make and limit the amount of funds that may be invested in some types of securities. We have a diversified investment portfolio with a large portion invested in investment-grade, fixed income securities.

Our investment philosophy is to maintain a largely investment-grade fixed income portfolio, provide adequate liquidity for expected liability durations and other requirements, and maximize total return through active investment management.

We evaluate the interest rate risk of our assets and liabilities regularly, as well as the appropriateness of investments relative to our internal investment guidelines. We operate within these guidelines by maintaining a diversified portfolio, both across and within asset classes.

The board of directors monitors and approves investment policies and procedures. Investment decisions are centrally managed by investment professionals based on the guidelines established in our investment policies and procedures. The investment portfolio is managed following those policies and procedures.

Our investment portfolio is predominantly comprised of obligations of U.S. government-sponsored enterprises, U.S. Treasury securities, obligations of state and political subdivisions, obligations of the Commonwealth of Puerto Rico, municipal securities and obligations of U.S. states and its political subdivisions and obligations from U.S. and Puerto Rican government instrumentalities. These investments comprised approximately 82.3% of the total portfolio value as of December 31, 2008, of which 15.0% consisted of U. S. agency-backed mortgage backed securities and collateralized mortgage obligations. The remaining balance of the investment portfolio consists of an equity securities portfolio that seeks to replicate the S&P 500 Index, a large-cap growth index, a large-cap value index, mutual funds, investments in local stocks from well-known financial institutions and investments in corporate bonds.

We use a sensitivity analysis to measure the market risk related to our holdings of invested assets and other financial instruments. This analysis estimates the potential changes in fair value of the instruments subject to market risk. The sensitivity analysis was performed separately for each of our market risk exposures related to our trading and other than trading portfolios. This sensitivity analysis is an estimate and should not be viewed as predictive of our future financial performance. Our actual losses in any particular year could exceed the amounts indicated in the following paragraphs. Limitations related to this sensitivity analysis include:

- the market risk information is limited by the assumptions and parameters established in creating the related sensitivity analysis, including the impact of prepayment rates on mortgages; and

- the model assumes that the composition of assets and liabilities remains unchanged throughout the year.

Accordingly, we use such models as tools and not as a substitute for the experience and judgment of our management.

Interest Rate Risk

Our exposure to interest rate changes results from our significant holdings of fixed maturity securities. Investments subject to interest rate risk are held in our other-than-trading portfolios. We are also exposed to interest rate risk from our variable interest secured term loan and from our policyholder deposits.

Equity Price Risk

Our investments in equity securities expose us to equity price risks, for which potential losses could arise from adverse changes in the value of equity securities. Financial instruments subject to equity prices risk are held in our trading and other-than-trading portfolios.

Table of Contents

Risk Measurement

Trading Portfolio

Our trading securities are a source of market risk. As of December 31, 2008, our trading portfolio was comprised of investments in publicly-traded common stocks. The securities in the trading portfolio are believed by management to be high quality and are diversified across industries and readily marketable. Trading securities are recorded at fair value, and changes in fair value are included in operations. The fair value of the investments in trading securities is exposed to equity price risk. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2008 and 2007, the hypothetical loss in the fair value of these investments would have been approximately $3.2 million and $6.7 million, respectively.

Other than Trading Portfolio

Our available-for-sale and held-to-maturity securities are also a source of market risk. As of December 31, 2008 approximately 96.8% and 100.0% of our investments in available-for-sale and held-to-maturity securities, respectively, consisted of fixed income securities. The remaining balance of the available-for-sale portfolio is comprised of equity securities. Available-for-sale securities are recorded at fair value and changes in the fair value of these securities, net of the related tax effect, are excluded from operations and are reported as a separate component of other comprehensive income (loss) until realized. Held-to-maturity securities are recorded at amortized cost and adjusted for the amortization or accretion of premiums or discounts. The fair value of the investments in the other-than-trading portfolio is exposed to both interest rate risk and equity price risk.

Interest Rate Risk

We have evaluated the net impact to the fair value of our fixed income investments of a significant one-time change in interest rate risk using a combination of both statistical and fundamental methodologies. From these shocked values a resultant market price appreciation/depreciation can be determined after portfolio cash flows are modeled and evaluated over instantaneous 100, 200 and 300 basis point rate shifts. Techniques used in the evaluation of cash flows include Monte Carlo simulation through a series of probability distributions over 200 interest rate paths. Necessary prepayment speeds are compiled using Salomon Brothers Yield Book, which sources numerous factors in deriving speeds, including but not limited to: historical speeds, economic indicators, street consensus speeds, etc. Securities evaluated by us under these scenarios include mortgage pass-through certificates and collateralized mortgage obligations of U.S. agencies, and private label structures, provided that cash flows information is available. The following table sets forth the result of this analysis for the years ended December 31, 2008 and 2007.

Table of Contents

(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2008:			
Base Scenario	$910.7		
+100 bp	891.0	(19.7)	(2.2)%
+200 bp	844.9	(65.8)	(7.2)%
+300 bp	787.7	(123.0)	(13.5)%
December 31, 2007:			
Base Scenario	$867.5		
+100 bp	819.3	(48.2)	(5.6)%
+200 bp	777.3	(90.2)	(10.4)%
+300 bp	732.6	(134.9)	(15.6)%

We believe that an interest rate shift in a 12-month period of 100 basis points represents a moderately adverse outcome, while a 200 basis point shift is significantly adverse and a 300 basis point shift is unlikely given historical precedents. Although we classify 97.5% of our fixed income securities as available-for-sale, our cash flows and the intermediate duration of our investment portfolio should allow us to hold securities until maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Equity Price Risk

Our equity securities in the available-for-sale portfolio are comprised primarily of stock of several Puerto Rican financial institutions and mutual funds. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2008 and 2007, the hypothetical loss in the fair value of these investments would have been approximately $6.9 million and $7.1 million, respectively.

Other Risk Measurement

We are subject to interest rate risk on our variable interest secured term loan and our policyholder deposits. Shifting interest rates do not have a material effect on the fair value of these instruments. The secured term loan has a variable interest rate structure, which reduces the potential exposure to interest rate risk. The policyholder deposits have short-term interest rate guarantees, which also reduce the accounts exposure to interest rate risk.

We have invested in derivative instruments with a market value of approximately $11.1 million and $14.6 million as of December 31, 2008 and 2007 in order to diversify our investment in securities and participate in foreign stock markets.

In 2005, we invested in $5.0 million in each of two structured note agreements, under which the interest income received is linked to the performance of the Dow Jones Euro STOXX 50 and Nikkei 225 Equity Indices (the Indices). Under these agreements the principal invested by us is protected, the only amount that varies according to the performance of the Indices is the interest to be received upon the maturity of the instruments. Should the Indices experience a negative performance during the holding period of the structured notes, no interest will be received and no amount will be paid to the issuer of the structured notes. The contingent interest payment component within the structured note agreements meets the definition of an embedded derivative. In accordance with the provisions of SFAS No. 133, *Accounting for Derivative Instruments and Certain Hedging Activities*, as amended, the embedded derivative component of the structured note is separated from the structured notes and accounted for separately as a derivative instrument. The derivative component of the structured notes exposes us to credit risk and market risk. We minimize credit risk by entering into transactions with counterparties that we believe to be high-quality based on their credit ratings. The market risk is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. As of December 31, 2008 and 2007, the fair value of the derivative component of the structured notes amounted to $1.7 million and $6.3 million,

Table of Contents

respectively, and is included within other assets in the consolidated balance sheets. Assuming an immediate decrease of 10% in the period-end Indices as of December 31, 2008 and 2007, the hypothetical loss in the estimated fair value of the derivative component of the structured notes would have been approximately $0.2 million and $0.6, respectively. The investment component of the structured notes, which had a fair value of $9.4 million and $8.3 million as of December 31, 2008 and 2007, respectively, is accounted for as a held-to-maturity debt security and is included within investment in securities in the consolidated balance sheet and its risk measurement is evaluated along the other investments in Other Than Trading Portfolio above.

Item 8. Financial Statements and Supplementary Data.

Financial Statements

For our audited consolidated financial statements as of December 31, 2008 and 2007 and for the three years ended December 31, 2008 see Index to financial statements in Item 15 Exhibits and Financial Statement Schedules to this Annual Report on Form 10-K.

Selected Quarterly Financial Data

For the selected unaudited quarterly financial data corresponding to the years 2008 and 2007, see note 28 of the audited consolidated financial statements as of December 31, 2008 and 2007 and for the three years ended December 31, 2008.

Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosures.

None.

Table of Contents

Item 9A. Controls and Procedures.

(a) Evaluation of Disclosure Controls and Procedures

In connection with the preparation of this Annual Report on Form 10-K, we conducted an evaluation of the effectiveness of our disclosure controls and procedures (as such term is defined under Exchange Act Rule 13a-15(e)), under the supervision and with the participation of our management, including our chief executive officer and our chief financial officer. Disclosure controls and procedures are designed to ensure that information required to be disclosed in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms and that such information is accumulated and communicated to management, including the chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility that judgments in decision-making can be faulty, and breakdowns as a result of simple errors or mistake. Accordingly, even effective disclosure controls and procedures can only provide reasonable assurance of achieving their control objectives. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions.

Based on this evaluation, our chief executive officer and our chief financial officer have concluded that as of December 31, 2008, which is the end of the period covered by this Annual Report on Form 10-K, our disclosure controls and procedures were not effective due to the material weakness described in Management s Report on Internal Control Over Financial Reporting, below.

(b) Management s Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting and for the assessment of the effectiveness of internal control over financial reporting, as defined under Exchange Act Rule 13a-15(f). The Company s internal control over financial reporting is a process designed by, or under the supervision of, the Company s chief executive officer and chief financial officer, and effected by the Company s board of directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company s consolidated financial statements for external purposes in accordance with GAAP, and includes those policies and procedures that:

(i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company;

(ii) 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

(iii) 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 consolidated financial statements.

A material weakness is a deficiency, or 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. 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.

Management assessed the effectiveness of the Company s internal control over financial reporting as of December 31, 2008 based on criteria described in the Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Based on that assessment and those criteria, management has concluded that the Company s internal control over financial reporting was not effective as of December 31, 2008 due

to the material weakness described below.

Our processes, procedures, and controls are not designed or operating effectively to ensure that other-than-temporary impairment (OTTI) on available for sale investment securities were recorded in accordance with generally accepted accounting principles. Specifically, our policies and procedures were not designed effectively to identify a complete population of available for sale investments that should be analyzed for OTTI. Also, our monitoring controls are not designed to consider factors that may indicate a decline in the value of available for sale investments is other than temporary in accordance with generally accepted accounting principles. These control deficiencies constitute a material weakness that resulted in material errors in net realized investment losses in our preliminary 2008 annual consolidated financial statements which were corrected prior to issuance of the Company s consolidated financial statements.

KPMG LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Annual Report on Form 10-K, has also issued an attestation report on the effectiveness of the Company s internal control over financial reporting as of December 31, 2008.

(c) Changes in Internal Control Over Financial Reporting

No changes in our internal control over financial reporting (as such term is defined in the Exchange Act Rule 13a-15(f)) occurred during the fiscal quarter ended December 31, 2008 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

(d) Remediation of Material Weakness

We are currently taking steps to enhance our OTTI evaluation and remediate this material weakness in our internal control over financial reporting, including in particular:

1. Improving the governance process over the Company s investment activities, by including OTTI analysis as a quarterly agenda at the meetings of our Investment Committee and report at least quarterly at the meetings of our Audit Committee.

2. Amending and expanding our OTTI evaluation selection criteria for impaired investments to require an individual OTTI analysis for all impaired investments if such investments are impaired for more than one month over a materiality level to be determined.

3. Preparing more robust supporting documentation and related reports used for the OTTI analysis by including additional information for those impaired investments described in the previous paragraph, addressing the reasons for the decline in value, period for which the decline has been observed, an estimate of the anticipated recovery period and its related probability of recoverability, credit ratings for the issue and issuer (where available) and any changes thereto.

4. Implementing a procedure designed to effectively disseminate the most recent authoritative accounting pronouncements related to OTTI to ensure that our employees involved in the evaluation receive the information on a timely basis.

Management believes that these steps will remediate the material weakness by improving our systems of disclosure controls and procedures and internal control over financial reporting; however, during execution their effectiveness will be subject to testing by us, and there can be no assurance at this time that the plan will effectively remediate the material weakness described above.

Table of Contents

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Triple-S Management Corporation and Subsidiaries:

We have audited Triple-S Management Corporation and Subsidiaries internal control over financial reporting as of December 31, 2008, based on criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Triple-S Management Corporation and Subsidiaries 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 (Item 9A(b)). Our responsibility is to express an opinion on the Company s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). 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, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

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.

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 company s annual or interim financial statements will not be prevented or detected on a timely basis. A material weakness related to the other-than-temporary impairment of investment securities has been identified and included in management s assessment. We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Triple-S Management Corporation and Subsidiaries as of December 31, 2008 and 2007, and the related consolidated statements of earnings, stockholders equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2008. This material weakness was considered in determining the nature, timing, and extent of audit tests applied in our audit of the 2008 consolidated financial statements, and this report does not affect our report dated March 18, 2009, which expressed an unqualified opinion on those consolidated financial statements.

In our opinion, because of the effect of the aforementioned material weakness on the achievement of the objectives of the control criteria, Triple-S Management Corporation and Subsidiaries has not maintained effective internal control over financial reporting as of December 31, 2008, based on the criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

/s/ KPMG LLP
San Juan, Puerto Rico
March 18, 2009

Stamp No. 2376408 of the Puerto Rico
Society of Certified Public Accountants
was affixed to the record copy of this report.

Item 9B. Other Information.

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance.

The Board has established a code of business conduct and ethics that applies to our employees, agents, independent contractors, consultants, officers and directors. The complete text of the Code of Business Conduct and Ethics is available at the Corporation s website at www.triplesmanagement.com.

The remaining information required by this item is incorporated by reference to the sections Nominees for Election , Executive Officers , Section 16(a) Beneficial Ownership Reporting Compliance , Standing

Table of Contents

Committees Corporate Governance and Nominations Committee , Standing Committees Audit Committee , and Standing Committees Audit Committee Financial Experts included in the Corporation s definitive Proxy Statement.

Item 11. Executive Compensation.

The information required by this item is incorporated by reference to the sections Compensation Discussion and Analysis and Standing Committees Compensation Committee Interlocks and Insider Participation included in the Corporation s definitive Proxy Statement.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.

The information required by this item is incorporated by reference to the sections Principal Shareholders , Stock Ownership of Directors and Executive Officers and Compensation Discussion and Analysis included in the Corporation s definitive Proxy Statement.

Item 13. Certain Relationships and Related Transactions, and Director Independence.

The information required by this item is incorporated by reference to the section Other Relationships, Transactions and Events and Board of Directors Independence included in the Corporation s definitive Proxy Statement.

Item 14. Principal Accountant Fees and Services

The information required by this item is incorporated by reference to the section Disclosure of Auditor s Fees included in the Corporation s definitive Proxy Statement.

Item 15. Exhibits and Financial Statements Schedules.

Financial Statements and Schedules

Financial Statements	*Description*
F-1	Report of Independent Registered Public Accounting Firm
F-2	Consolidated Balance Sheets as of December 31, 2008 and 2007
F-3	Consolidated Statements of Earnings for the years ended December 31, 2008, 2007 and 2006
F-4	Consolidated Statements of Stockholders Equity and Comprehensive Income for the years ended December 31, 2008, 2007 and 2006
F-5	Consolidated Statements of Cash Flows for the years ended December 31, 2008, 2007 and 2006
F-7	Notes to Consolidated Financial Statements December 31, 2008, 2007 and 2006

Financial Statements Schedules	*Description*
S-1	Schedule II Condensed Financial Information of the Registrant
S-2	Schedule III Supplementary Insurance Information

Table of Contents

Financial Statements Schedules	*Description*
S-3	Schedule IV Reinsurance
S-4	Schedule V Valuation and Qualifying Accounts

Schedule I Summary of Investments was omitted because the information is disclosed in the notes to the audited consolidated financial statements. Schedule VI Supplemental Information Concerning Property Casualty Insurance Operations was omitted because the schedule is not applicable to the Corporation.

Exhibits

Exhibits	*Description*
3(i)(a)	Amended and Restated Articles of Incorporation (incorporated herein by reference to Exhibit 3(i)(d) to TSM s Annual Report on Form 10-K for the Year Ended December 31, 2007 (File No. 001-33865).
3(i)(b)	Amendment to Article Tenth of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation, incorporated by reference to Exhibit 3(i)(b) to TSM s Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865).
3(i)(c)	Articles of Incorporation of Triple-S Management Corporation, as currently in effect, incorporated by reference to Exhibit 3(i)(c) to TSM s Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865).
3(ii)	Amended and Restated Bylaws (incorporated herein by reference to Exhibit 3.1 to TSM s Current Report on Form 8-K filed on October 23, 2007 (File No. 001-33865)).
10.1	Agreement between the Puerto Rico Health Insurance Administration and Triple-S, Inc. for the provision of health insurance coverage to eligible population in the North and South-West Regions (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the Quarter Ended September 30, 2008 (File No. 001-33865)).
10.2	Extension to the agreement between the Puerto Rico Health Insurance Administration and Triple-S, Inc. for the provision of health insurance coverage to eligible population in the North and South-West regions (incorporated herein by reference to Exhibit 10.1 of TSM s Quarterly Report on Form 10-Q for the Quarter Ended June 30, 2008 (File No. 001-33865)).
10.3	Federal Employees Health Benefits Contract (incorporated herein by reference to Exhibit 10.5 to TSM s General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.4	Credit Agreement with FirstBank Puerto Rico in the amount of $41,000,000 (incorporated herein by reference to Exhibit 10.6 to TSM s General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.5	Credit Agreement with FirstBank Puerto Rico in the amount of $20,000,000 (incorporated herein by reference to Exhibit 10.7 to TSM s General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.6	

Non-Contributory Retirement Program (incorporated herein by reference to Exhibit 10.8 to TSM s General Form of Registration of

Table of Contents

Exhibits	*Description*
	Securities on Form 10 (File No. 001-33865)).
10.7	BCBSA Licensure Documents (incorporated herein by reference to Exhibit 10.10 to TSM s General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.8*	Blue Shield License and other Agreements with Blue Cross Blue Shield Association.
10.9	Stock Purchase Agreement by and between Triple-S Management Corporation and Great American Financial Resources, Inc. dated December 15, 2005 (incorporated herein by reference to Exhibit 10.9 to TSM s Registration Statement on Form S-1 filed on November 16, 2007 (File No. 001-33865)).
10.10	Reinsurance Agreement between Great American Life Assurance Company of Puerto Rico and Seguros de Vida Triple-S, Inc. dated December 15, 2005 (incorporated herein by reference to Exhibit 10.14 to TSM s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).
10.11	6.30% Senior Unsecured Notes Due September 2019 Note Purchase Agreement, dated September 30, 2004, between Triple-S Management Corporation, Triple-S, Inc. and various institutional accredited investors (incorporated herein by reference to Exhibit 10.15 to TSM s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).
10.12	6.60% Senior Unsecured Notes Due December 2020 Note Purchase Agreement, dated December 15, 2005, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.16 to TSM s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).
10.13	6.70% Senior Unsecured Notes Due December 2021 Note Purchase Agreement, dated January 23, 2006, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2006 (File No. 001-33865)).
10.14	Triple-S Management Corporation 2007 Incentive Plan, dated October 16, 2007 (incorporated herein by reference to Exhibit C to TSM s 2007 Proxy Statement (File No. 001-33865)).
10.15	Software License and Maintenance Agreement between Quality Care Solutions, Inc, and Triple-S, Inc. dated August 16, 2007 (incorporated herein by reference to Exhibit 10.15 to TSM s Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.15(a)	Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and Triple-S, Inc. (incorporated herein by reference to Exhibit 10.15(a) to TSM s Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.15(b)	Addendum Number Two to the Software License and Maintenance

Table of Contents

Exhibits	*Description*
	Agreement between Quality Care Solutions, Inc, and Triple-S, Inc. (incorporated herein by reference to Exhibit 10.15(b) to TSM s Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.15(c)	Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and Triple-S, Inc. (incorporated herein by reference to Exhibit 10.15(c) to TSM s Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.16	Work Order Agreement between Quality Care Solutions, Inc. and Triple-S, Inc. (incorporated herein by reference to Exhibit 10.16 to TSM s Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.17*	Agreement between the Puerto Rico Health Insurance Administration and Triple-S, Inc. for the provision of act as Third Party Administrator in the Metro-North Region.
11.1	Statement re computation of per share earnings; an exhibit describing the computation of the earnings per share has been omitted as the detail necessary to determine the computation of earnings per share can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K.
12.1	Statement re computation of ratios; an exhibit describing the computation of the loss ratio, expense ratio and combined ratio has been omitted as the detail necessary to determine the computation of the loss ratio, operating expense ratio and combined ratio can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K.
21.1	List of Subsidiaries of Triple-S Management Corporation (incorporated herein by reference to Exhibit 21 to TSM s General Form of Registration of Securities on Form 10 (File No. 001-33865)).
31.1*	Certification of the President and Chief Executive Officer required by Rule 13a-14(a)/15d-14(a).
31.2*	Certification of the Vice President of Finance and Chief Financial Officer required by Rule 13a-14(a)/15d-14(a).
32.1*	Certification of the President and Chief Executive Officer required pursuant to 18 U.S. Section 1350.
32.2*	Certification of the Vice President of Finance and Chief Financial Officer required pursuant to 18 U.S. Section 1350.

All other exhibits for which provision is made in the applicable accounting regulation of the SEC are not required under the related instructions or are inapplicable, and therefore have been omitted.

* Filed herein.

Table of Contents

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

Triple-S Management Corporation
Registrant

By: /s/ Ramón M. Ruiz-Comas Date: March 18, 2009

Ramón M. Ruiz-Comas
President and Chief Executive Officer

By: /s/ Juan J. Román Date: March 18, 2009

Juan J. Román
Vice President of Finance and Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

By: /s/ Luis A. Clavell-Rodríguez Date: March 18, 2009

Luis A. Clavell-Rodríguez, MD
Director and Chairman of the Board

By: /s/ Vicente J. León-Irizarry Date: March 18, 2009

Vicente J. León-Irizarry, CPA
Director and Vice-Chairman of the Board

By: /s/ Jesús R. Sánchez-Colón Date: March 18, 2009

Jesús R. Sánchez-Colón, DMD
Director and Secretary of the Board

By: /s/ Adamina Soto-Martínez Date: March 18, 2009

Adamina Soto-Martínez, CPA
Director

By: /s/ Ms. Carmen Ana Culpeper-Ramírez Date: March 18, 2009

Ms. Carmen Ana Culpeper-Ramírez
Director

Table of Contents

By: /s/ Valeriano Alicea-Cruz Date: March 18, 2009

Valeriano Alicea-Cruz, MD
Director

By: /s/ Mr. José Arturo Álvarez-Gallardo Date: March 18, 2009

Mr. José Arturo Álvarez-Gallardo
Director

By: /s/ Porfirio E. Díaz-Torres Date: March 18, 2009

Porfirio E. Díaz-Torres, MD
Director

By: /s/ Mr. Antonio F. Faría-Soto Date: March 18, 2009

Mr. Antonio F. Faría-Soto
Director

By: /s/ Manuel Figueroa-Collazo Date: March 18, 2009

Manuel Figueroa-Collazo, PE, Ph.D.
Director

By: /s/ José Hawayek-Alemañy Date: March 18, 2009

José Hawayek-Alemañy, MD
Director

By: /s/ Jaime Morgan-Stubbe Date: March 18, 2009

Jaime Morgan-Stubbe, Esq.
Director

By: /s/ Roberto Muñoz-Zayas Date: March 18, 2009

Roberto Muñoz-Zayas, MD
Director

By: /s/ Juan E. Rodríguez-Díaz Date: March 18, 2009

Juan E. Rodríguez-Díaz, Esq.
Director

Table of Contents

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2008, 2007, and 2006

(With Independent Auditors Report Thereon)

Table of Contents

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Table of Contents

Table of Contents

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Triple-S Management Corporation:

We have audited the accompanying consolidated balance sheets of Triple-S Management Corporation and Subsidiaries (the Company) as of December 31, 2008 and 2007, and the related consolidated statements of earnings, stockholders equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2008. These consolidated financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Triple-S Management Corporation and Subsidiaries at December 31, 2008 and 2007, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2008, in conformity with U.S. generally accepted accounting principles.

As discussed in note 16 to the consolidated financial statements, the Company adopted the recognition and disclosure provisions of Statement of Financial Accounting Standards No. 158, *Employers Accounting for Defined Benefit Pension and Other Postretirement Plans*, as of December 31, 2006.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Triple-S Management Corporation and Subsidiaries internal control over financial reporting as of December 31, 2008, based on criteria established in *Internal Control-Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 18, 2009 expressed an adverse opinion on the effectiveness of the Company s internal control over financial reporting.

/s/ KPMG LLP
March 18, 2009
Stamp No. 2376402 of the Puerto Rico
Society of Certified Public Accountants
was affixed to the record copy of this report.

Table of Contents

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Balance Sheets
December 31, 2008 and 2007
(Dollar amounts in thousands, except per share data)

	2008	2007
Assets		
Investments and cash:		
Equity securities held for trading, at fair value (cost of $40,847 in 2008 and $54,757 in 2007)	$ 32,184	67,158
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $879,663 in 2008 and $816,536 in 2007)	887,684	823,629
Equity securities (cost of $70,060 in 2008 and $66,747 in 2007)	68,629	71,050
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $23,063 in 2008 and $43,849 in 2007)	21,753	43,691
Policy loans	5,451	5,481
Cash and cash equivalents	46,095	240,153
Total investments and cash	1,061,796	1,251,162
Premium and other receivables, net	237,158	202,268
Deferred policy acquisition costs and value of business acquired	126,347	117,239
Property and equipment, net	58,448	43,415
Net deferred tax asset	25,195	6,783
Other assets	39,515	38,675
Total assets	$ 1,548,459	1,659,542
Liabilities and Stockholders Equity		
Claim liabilities:		
Claims processed and incomplete	$ 156,137	186,065
Unreported losses	150,079	149,996
Unpaid loss-adjustment expenses	17,494	17,769
Total claim liabilities	323,710	353,830
Liability for future policy benefits	207,545	194,131
Unearned premiums	110,141	132,599
Policyholder deposits	48,684	45,959
Liability to Federal Employees Health Benefits Program	11,157	21,338
Accounts payable and accrued liabilities	148,713	228,980
Borrowings	169,307	170,946
Liability for pension benefits	44,103	29,221
Total liabilities	1,063,360	1,177,004
Stockholders equity:		
	9,043	16,043

Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 9,042,809 and 16,042,809 at December 31, 2008 and 2007, respectively		
Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 22,104,989 and 16,266,554 shares at December 31, 2008 and 2007, respectively	22,105	16,266
Additional paid-in capital	179,504	188,935
Retained earnings	292,112	267,336
Accumulated other comprehensive loss, net	(17,665)	(6,042)
	485,099	482,538
Commitments and contingencies		
Total liabilities and stockholders equity	$ 1,548,459	1,659,542

See accompanying notes to consolidated financial statements.

Table of Contents

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Earnings
Years ended December 31, 2008, 2007, and 2006
(Dollar amounts in thousands, except per share data)

	2008	2007	2006
Revenues:			
Premiums earned, net	$ 1,695,457	1,483,548	1,511,626
Administrative service fees	19,187	14,018	14,089
Net investment income	56,253	47,194	42,657
Total operating revenues	1,770,897	1,544,760	1,568,372
Net realized investment (losses) gains	(13,940)	5,931	837
Net unrealized investment (loss) gain on trading securities	(21,064)	(4,116)	7,699
Other income (loss), net	(2,467)	3,217	2,323
Total revenues	1,733,426	1,549,792	1,579,231
Benefits and expenses:			
Claims incurred	1,434,914	1,223,775	1,258,981
Operating expenses	251,887	237,533	236,065
Total operating costs	1,686,801	1,461,308	1,495,046
Interest expense	14,681	15,839	16,626
Total benefits and expenses	1,701,482	1,477,147	1,511,672
Income before taxes	31,944	72,645	67,559
Income tax expense (benefit):			
Current	11,542	15,906	15,407
Deferred	(4,388)	(1,779)	(2,381)
Total income taxes	7,154	14,127	13,026
Net income	$ 24,790	58,518	54,533
Basic net income per share	$ 0.77	2.15	2.04
Diluted net income per share	0.77	2.15	2.04

See accompanying notes to consolidated financial statements.

Table of Contents

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES

Consolidated Statements of Stockholders Equity
and Comprehensive Income
Years ended December 31, 2008, 2007, and 2006
(Dollar amounts in thousands, except per share data)

	Class A common stock	Class B common stock	Additional paid-in capital	Retained earnings	Accumulated other comprehensive income (loss)	Total stockholders equity
Balance, December 31, 2005	$ 26,712		124,052	162,964	(5,025)	308,703
Dividends declared				(6,231)		(6,231)
Adjustment to initially apply SFAS No. 158, net of tax					(16,081)	(16,081)
Other	21		(21)			
Comprehensive income:						
Net income				54,533		54,533
Net unrealized change in fair value of available for sale securities					(3,212)	(3,212)
Net change in minimum pension liability					4,952	4,952
Net change in fair value of cash flow hedges					(65)	(65)
Total comprehensive income						56,208
Balance, December 31, 2006	26,733		124,031	211,266	(19,431)	342,599
Dividends declared				(2,448)		(2,448)
Sale of stock in public offering	(10,813)	16,100	64,992			70,279
Grant of restricted Class B common stock		166				166
Share-based compensation			34			34
Other	123		(122)			1
Comprehensive income:						
Net income				58,518		58,518
Net unrealized change in fair value of available for sale securities					9,549	9,549
Defined benefit pension plan:						

Prior service cost, net	3,935	3,935
Actuarial loss	155	155
Net change in fair value of cash flow hedges	(250)	(250)
Total comprehensive income		71,907