TRIPLE-S MANAGEMENT CORP
Form 10-K
March 09, 2011

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, 2010

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 checkmark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). o 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 definition 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 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

As of February 14, 2011, the registrant had 9,042,809 of its Class A common stock outstanding and 19,736,720 of its Class B common stock outstanding.

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, 2010 was approximately $373,047,753 for the Class B common stock (the only stock of the registrant that trades in a public market) and $9,042,809 for the Class A common stock (valued at its par value of $1.00 since it is not publicly traded).

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 on April 29, 2011 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, 2010
Table of Contents

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 one leading managed care companies in Puerto Rico, serving approximately 789,000 members across all regions, and holds a leading market position covering approximately 21.2% of the population. We have the exclusive right to use the Blue Cross and Blue Shield (BCBS) names and marks throughout Puerto Rico and the U.S. Virgin Islands and over 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial and Medicare markets. Until September 30, 2010 we provided managed care services to the Puerto Rico Health Insurance Plan (similar to Medicaid) (HIP or Medicaid). Our HIP contracts expired by their own terms on September 30, 2010; thus, since October 1st, 2010 we no longer provide services to Medicaid enrollees.

We serve a wide range of customer segments from corporate accounts, federal and local government employees and individuals to Medicare recipients with a wide range of managed care products. We market our managed care products through 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 the leading provider of life insurance policies in Puerto Rico.

Substantially all 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 deferred policy acquisition costs and value of business acquired and the deferred tax assets, are located within Puerto Rico.

On February 7, 2011, TSM announced that Triple-S Salud, Inc. (TSS), our managed care subsidiary, completed the acquisition of 100% of the outstanding capital stock of Socios Mayores en Salud Holdings, Inc. (SMSH), the ultimate parent company of American Health, Inc. (AHI), a provider of Medicare Advantage services to over 40,000 dual and non-dual eligible members in Puerto Rico. The cost of this acquisition was approximately $83 million, funded with unrestricted cash. For the twelve months ended December 31, 2010 AHI reported unaudited premium revenue of approximately $380 million. The results of operations and financial condition of the Corporation included in this Annual Report on Form 10-K do not reflect the acquisition or operations of SMSH. The Company is in the process of obtaining third-party valuations of certain intangible assets; thus, as of this date it is not possible to determine the allocation of the purchase price to the net assets acquired.

On September 29, 2010, we announced the immediate commencement of a $30.0 million share repurchase program, as authorized by our Board of Directors. This program is being conducted in accordance with Rules 10b5-1 and 10b-18 under the Securities Exchange Act of 1934.

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.

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 has 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

Table of Contents

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 generally pay co-payments, coinsurance and deductibles when they 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 government of the United States of America (the U.S. government or federal government) provides hospital and medical insurance benefits to eligible people aged 65 and over as well as 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 or PDP). 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.

Recently we have noticed that economic factors and greater consumer awareness have resulted in (a) 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 and (b) products with lower benefits and a narrower network in exchange 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.

We are licensed by Blue Cross and Blue Shield Association (BCBSA) to use the Blue Cross Blue Shield name and mark in Puerto Rico and the U.S. Virgin Islands. The BCBSA had 39 independent licensees as of December 31, 2010. BCBS membership stood at 97.6 million members at September 30, 2010, which represents 31.4% 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 such state or territory. The BlueCard program is a source of revenue for TSS from services provided in Puerto Rico to individuals who are customers of other BCBS plans and also provides us a significant network in the U.S, creating a significant competitive advantage for us because Puerto Ricans frequently travel to the continental United States.

Life Insurance

Total annual premiums in Puerto Rico for the nine months ended September 30, 2010 for the life insurance market approximated $1.1 billion. The main products in this market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are independent agents. In recent years banks have established general agencies to cross sell many life insurance 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 as of September 30, 2010 was approximately $1.4 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 69% of the market is written by the top six companies in terms of market share, and approximately 88% of the market is written by companies incorporated under the laws of, and which operate principally in Puerto Rico.

The Puerto Rican property and casualty insurance market is highly dependent on reinsurance and some local carriers have diversified their operations outside Puerto Rico.

Puerto Rico s Economy

Puerto Rico s economy experienced a considerable transformation during the past sixty-five years, passing from an agriculture economy to an industrial one. Virtually every sector in the economy participated in this expansion.

Table of Contents

Factors contributing to this expansion include government-sponsored economic developments programs, increases in the level of federal transfer payments, and the relatively low cost of borrowing. In some years, these factors were aided by a significant rise in the construction investment driven by infrastructure projects, private investment, primarily in housing, and relatively low oil prices. Nevertheless, the significant oil price increases during the past five years, the continuous contraction of the manufacturing sector, and budgetary pressures on government finances have triggered a general contraction in the economy. Puerto Rico s economy is currently in a recession that began in the fourth quarter of fiscal year 2006, during which the real gross national product grew by only 0.5%. For fiscal years 2007 and 2008, the real gross national product contracted by 1.2% and 2.8%, respectively. For fiscal year 2009, the real gross national product also contracted by 3.7%. In March 2010, the Puerto Rico Planning Board (the Planning Board) announced that it was projecting a contraction of 3.6% in real gross national product for fiscal year 2010 and an increase of 0.4% in real gross national product for fiscal year 2011. The forecast for fiscal year 2011 took into account the estimated effect of the projected growth of the U.S. economy, tourism activity, personal consumption expenditures, U.S. federal government stimulus package, and the acceleration of investment in construction due to the government of Puerto Rico s local stimulus package and the establishment of public-private partnerships.

Personal income, both aggregate and per capita, has increased consistently each fiscal year from 1947 to 2009. In fiscal year 2009, aggregate personal income was $59.0 billion and personal income per capita was $14,905. During the first ten months of fiscal year 2010, total employment averaged 1,106,600, a decline of 5.9% with respect to the same period of the prior year; and the unemployment rate averaged 15.9%.

The economy of Puerto Rico is closely linked to that of the continental 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 U.S. 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. 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, which includes finance, insurance, real estate, wholesale and retail trade, transportation, communications and public utilities, and other services, 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.

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 that limits deductions for expenses incurred outside Puerto Rico and a 5% surcharge on corporations, including insurance companies. The government of Puerto Rico has developed a comprehensive long-term economic development plan aimed at improving overall competitiveness and business environment and increasing private-sector participation in the economy. As part of this plan, the permitting and licensing process was modernize to provide for a leaner and more efficient process that fosters economic development. Furthermore, the government proposes to (i) strengthen the labor market and encourage greater labor-force participation by bringing out-of-date labor laws and regulations in line with U.S. and international standards, (ii) adopt a new energy policy that seeks to lower energy costs and reduce energy-price volatility by reducing Puerto Rico s dependence on fuel oil and the promotion of diverse, renewable-energy technologies, and (iii) adopt a comprehensive tax reform in two phases. The first phase of the tax reform was enacted in the last quarter of 2010 and was mostly related to reducing the income tax burden to individuals. For 2010 only, corporations received an income tax credit amounting to 7% of the tax determined, defined as the tax liability less certain credits. The second phase of the reform, which was approved on January 31, 2011, provides for the reduction of the maximum corporate income tax rate from 40.95% to approximately 30% including the elimination of the above mentioned 5% surcharge on corporations, as well as adding several tax credits and deductions, among other tax reliefs and changes.

In addition, to further stimulate economic development the government of Puerto Rico enacted an act establishing a clear public policy and legal framework for public-private partnerships to finance and develop infrastructure projects and operate and manage certain public assets. See Item 1A. Risk Factors Risks Related to Our Business The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region.

Table of Contents

Products and Services

Managed Care

Through our subsidiary TSS, we offer a broad range of managed care products, including HMOs, PPOs, Medicare Supplement, Medicare Advantage and Medicare Part D. Managed care products represented approximately 89% of our consolidated premiums earned, net for the years ended December 31, 2010, 2009 and 2008. 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 they self-fund 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, including governmental entities, 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 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 members and their dependent family members with health care coverage in exchange for a fixed monthly premium. 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 selected members under ASO arrangements, 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 do not cover, such as deductibles, coinsurance and specified losses that exceed this 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. The Drug Discount Card program is not insurance, but rather provides access to discounts from contracted pharmacies. As of December 31, 2010, we had enrolled approximately 26,000 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2011.

Table of Contents

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, thus we are only subject to credit risk in this business. 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, disability and health and annuity products in Puerto Rico through our subsidiary Triple-S Vida, Inc. (TSV). Life insurance premiums represented approximately 6% of our consolidated premiums earned, net for the years ended December 31, 2010, 2009 and 2008. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases (Cancer line of business), and pre-need life products are marketed through independent agents. TSV is the leading distributor of life products in Puerto Rico. We are the principal home service company in Puerto Rico and offer guaranteed issue, funeral and cancer policies to the lower and middle income market segments directly to people in their homes. We also market our group life and disability coverages 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 Triple-S Propiedad, Inc. (TSP). Property and casualty insurance premiums represented approximately 5% of our consolidated premiums earned, net for the years ended December 31, 2010, 2009 and 2008. Our predominant lines of business are commercial multi-peril, commercial property mono-line, auto physical damage, auto liability and dwelling policies. This 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.

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 ourselves, 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.

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. Practically all 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, 2010, 40.0% 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 Cross 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

Table of Contents

direct-to-consumer marketing efforts which are 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 Cross Blue Shield mark for all managed care products and services in Puerto Rico and the U.S. Virgin Islands, except for Medicare Advantage products and services offered through our recently acquired subsidiary, AHI, which will continue using its own name and will not carry the BCBS mark.

Sales and Marketing

We employ a wide variety of sales and marketing activities. Such activities are closely regulated by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) and other government of Puerto Rico agencies. 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.

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 65 person internal sales force as well as our approximately 168 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.

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 both company-employed and independent agents, as well as group life and disability insurance coverage through our managed care network of agents. We place a majority of our premiums (56% and 57% during the years ended December 31, 2010 and 2009, respectively) through direct selling to customers in their homes. TSV employs approximately 600 full-time active agents and managers and utilizes approximately 800 independent agents and brokers. For individual policies, we advance first year commissions upon issuance and for group policies, we pay commissions on a monthly basis based on premiums received. In addition, TSV has over 400 agents that are licensed to sell certain of our managed care products.

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is exclusively subscribed through approximately 17 general agencies, including our insurance agency, Triple-S Insurance Agency, Inc. (TSIA), where business is placed by independent insurance agents and brokers. During the years ended December 31, 2010, 2009 and 2008 TSIA placed approximately 49%, 47% and 45% of TSP s total premium volume, respectively. The general agencies contracted by TSP remit premiums net of their respective commission.

Customers

Managed Care

We offer our products in the managed care segment to two distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2010:

Market Sector	Enrollment at December 31, 2010	Percentage of Total Enrollment
Commercial	725,328	91.9%
Medicare	63,553	8.1
Total	788,881	100.0%

Table of Contents

Commercial Sector

The commercial accounts sector includes corporate accounts, 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 they maintain stop loss coverage.

Federal Government Employees. For more than 40 years, we have maintained our leadership in providing managed care services to federal government employees in Puerto Rico. We provide our services to these employees 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.

Local Government Employees. We provide managed care services to the local government employees of Puerto Rico through a government-sponsored program whereby TSS 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.

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 do not cover, such as deductibles, coinsurance and specified losses that exceed the federal program s maximum benefits.

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 organizations (MCO) sponsored Medicare product that offers benefits similar to 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 risk adjusted for health status. Depending on the total benefits offered, for certain of our Medicare Advantage products the member will also be required to pay a premium.

Our *Medicare Selecto* and *Medicare Platino* policies target the sector of the population eligible for both Medicare and Medicaid, or dual-eligible beneficiaries. The government of Puerto Rico has implemented a plan to allow dual-eligibles enrolled in Medicaid to move 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 the Medicare Advantage programs, such as deductibles and co-payments of prescription drug benefits.

Medicare also provides a prescription drug program (Medicare Part D). Medicare beneficiaries are given the opportunity to select a Medicare Part D prescription drug plan provided by MCOs or other Part D sponsors. Our Medicare Advantage policies offer Medicare Part D coverage to our members throughout our service area. We also offer a stand-alone Medicare Part D prescription drug benefits product known as *FarmaMed*.

Table of Contents

Life Insurance

Our life and health insurance customers consist primarily of individuals, who hold approximately 465,000 policies, and we insure approximately 1,400 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 trying to provide all of our managed care members with the best health care coverage at reasonable cost. We believe that disciplined underwriting and appropriate pricing are core strengths of our business and important competitive advantages. We continually review our underwriting and pricing guidelines on a product-by-product and customer group-by-group basis 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 each particular segment.

Our claims database enables us to establish rates based on each renewing group claims experience, which 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, which is the percentage of existing business retained in the renewal process, in the corporate accounts sector of our managed care business and since 2003 have maintained our market share in that sector. The retention rate in our corporate accounts has been 95% or above in each of the last five years.

Our managed care 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 claims data. We consider the actual claims trend of each group when determining the premium rates for the following contract year. Rates in the Medicare sector and for federal and local government employees are generally 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 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 is experiencing a soft market in Puerto Rico, principally as a result of economic conditions. Lower reinsurance costs 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 been able to maintain a stable volume of business as the result of attentive risk assessment and strict adherence to underwriting guidelines,

Table of Contents

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 underwriters.

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 that target asthma, congestive heart failure, hypertension, diabetes, and a prenatal program that focuses on preventing prenatal complications and promoting adequate nutrition. We developed a medication therapy management program aimed at plan members who are identified as having high drug utilization and unrelated diagnostics. We commenced this program in 2010 and expect to fully deploy the program to all our groups during 2011. In addition, we have a contract with McKesson Health Solutions (McKesson) pursuant to which they provide to our members a 24-hour telephone-based triage program and health information services. McKesson also provides utilization management services for our Medicare sector. We intend to maximize utilization of population and case management programs among our insured populations and expand the medication therapy management program to the Commercial 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 reviewed our hospital concurrent review program, the goal of which is to monitor the appropriateness of high admission rate diagnoses and unnecessary stays. To expand the scope of the revision, we established a phone based review for low admissions hospitals, which freed resources to cover the biggest hospitals and allowed the onsite nurses to participate in the patient discharge planning, referral to programs, the quality of the services, including the occurrence of never events. As part of the cost containment measures we have preauthorization services for certain procedures and the mandatory validation of member eligibility prior to accessing services. In addition, we provide a variety of services and programs for the acute, chronic and complex populations. These services and programs seek to enhance quality at physicians premises, thus reducing emergency care and hospitalizations. We promote the use of a formulary for accessing medications, encouraging the use of generic drugs in the three-tier formulary, which offers three co-payment levels.

We have also established an exclusive pharmacy network with higher discounted rates than our broader network. In addition, through arrangements with our pharmacy benefits 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 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 in chronic care improvement programs and the achievement of specific clinical outcomes. The HQIP encourages participating hospitals to achieve the national benchmarks related to the five core measures established by CMS and the Joint Commission.

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.

Table of Contents

In addition, we selected Quality Care Solutions, Inc. (QCSI) to implement a new core business application for our managed care segment. QCSI was subsequently acquired by The Trizetto Company. In the second quarter of 2010, our Managed Care segment began transitioning to the new electronic data processing system. This transition will continue into the third quarter of 2011, when we expect to complete the full migration. Total external costs for the entire project are expected to amount approximately $55.0 million.

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

Provider Arrangements

Approximately 98% of member services are provided through one of our contracted provider networks and the remainder 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, 2010, we had provider contracts with approximately 5,400 primary care physicians, 3,700 specialists and 60 hospitals.

We contract with our managed care providers in different forms, including capitation-based reimbursement. For certain ancillary services, such as behavioral health services and primary care services in our *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 by our providers. Approximately 93% of claims are submitted electronically through our fully automated claims processing system, and our first-pass rate , or rate at which a claim is approved for payment when first processed by our system without human intervention, for provider claims has averaged 86% and 85% in 2010 and 2009, respectively.

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 adding 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 BCBSA, 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 in our PPO products and services referred by the independent practice associations (IPAs) under capitation agreements. 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 Medicare program and other major payers. Payments to physicians under the Medicare Advantage program are based on Medicare fees. For certain of our Medicare products we contract with IPAs in the form of capitation-based reimbursement for certain risks. We have a network of IPAs that provide managed care services to our members in exchange for a capitation fee. The IPAs assume the costs of certain primary care services provided and referred by their primary care physicians (PCPs), including procedures and in-patient services not related to risks assumed by us.

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.

Table of Contents

Subcontracting. We subcontract our triage call center, certain utilization management, mental and substance abuse health services, 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 national entities. The approval of the Gramm-Leach-Bliley Act of 1999, which applies to financial institutions in the United States, including those 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, brokers and reinsurers.

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 Cross 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. At December 31, 2010 we have approximately 789,000 members enrolled in our managed care segment, representing approximately 21.2% of the population of Puerto Rico. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 19% for the nine-month period ended September 30, 2010. 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 Medical Card Systems Inc., Aveta Inc. (or MMM Healthcare), and Humana Inc.

Life Insurance

We are one of the leading providers of life insurance products in Puerto Rico. In the nine-month period ended September 30, 2010, we were the largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 8%. 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 19%, and our main competitors are Cooperativa de Seguros de Vida de Puerto Rico, AXA Equitable Life and National Life Insurance Co.. In the cancer sector, we were the second largest company with a market share of approximately 18%, and our main competitors are AFLAC (sector leader) and Trans-Oceanic 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 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 price, policy terms and quality of services. We compete by reasonably pricing our products and providing efficient services to producers, agents and clients.

In the nine-month period ended September 30, 2010, 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 competitor in the property and casualty insurance market in Puerto Rico was Chartis Insurance Company of Puerto Rico (formerly American International Insurance Company of Puerto Rico). The market leaders in the property and

Table of Contents

casualty insurance market in Puerto Rico were Universal Insurance Group, MAPFRE Corporation, and Cooperativa de Seguros Múltiples de Puerto Rico.

Blue Cross and Blue Shield License

We have the exclusive right to use the BCBS name and mark for the sale, marketing and administration of managed care plans and related services in Puerto Rico and the U.S. Virgin Islands. We believe that the BCBS 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 BCBS 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 BCBS name and mark in Puerto Rico and the U.S. Virgin Islands. 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 BCBS name and marks in Puerto Rico and the U.S. Virgin Islands to another entity, which could have a material adverse affect on our business, financial condition and results of operations. See "Item 1A. Risk Factors Risks Related to Our Business The termination or modification of our license agreements to use the BCBS name and mark could have a material 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:

failure to maintain our total adjusted capital at or above 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 BCBSA, 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 Cross 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 Cross Blue Shield name and mark is already present. Currently, the Blue Cross and Blue Shield name and mark is licensed to other entities in all markets in the continental United States, Hawaii, and Alaska.

As required by our BCBS license agreements, our articles of incorporation 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.

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.

Table of Contents

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 BCBS name and mark. The annual BCBSA fee for the year 2011 is $1,764,143. During the years ended December 31, 2010 and 2009, we paid fees to the BCBSA in the amount of $1,717,677 and $1,345,489, 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 BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the BCBS names and marks outside our BCBS licensed territory.

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 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 significant 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 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 of the Board of Directors (the Investment and Financing Committee). Our internal investment group is comprised of the Chief Financial Officer, a Vice President and Treasurer, an investment analyst, and a treasury operations analyst. The internal investment group uses an external investment consultant and manages our short-term investments, fixed income portfolio and equity securities.

The Investment and Financing Committee monitors and approves investment policies and procedures. The investment portfolio is managed following those policies and procedures, and any exception must be reported to the Investment and Financing Committee.

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

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

Table of Contents

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 Cross and Blue Shield name and mark in Puerto Rico and the U.S. Virgin Islands. See Blue Cross and 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 Division of Banking and Insurance of the Office of the Lieutenant Governor of the U.S. Virgin Islands, the Health Department of the Commonwealth of Puerto Rico and the Administration for Health Insurance of the government of Puerto Rico (ASES , for its Spanish acronym), which administers the government of Puerto Rico Health Insurance Plan including the dual-eligible beneficiaries program. 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, the U.S. Department of Labor, and 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
- 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 insurance laws and regulations.

Our operations and accounts are subject to examination and audits at regular intervals by a number of 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 could 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 without adequate funding to health plans or to be funded through taxes or other negative financial levy on health plans;
- payments to health plans that are tied to achievement of certain quality performance measures;
- other efforts or specific legislative changes to the Medicare program, including changes in the bidding process or other means of materially reducing premiums;
- local government regulatory changes;
- increased government enforcement, or changes in interpretation or application of fraud and abuse laws; and
- regulations that increase the operational burden on health plans or laws that increase a health plan s exposure to liabilities, including efforts to expand the tort liability of health care plans;

On March 23, 2010, President Obama signed into law federal health reform legislation, known as the Patient Protection and Affordable Care Act. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, signed into law on March 30, 2010 (collectively, Pub. L. No. 111-148, and referred to herein as PPACA), includes certain mandates that took effect in 2010, as well as other requirements that are to be implemented over the next several years. Many aspects of the PPACA will be further articulated and clarified through regulation and guidance. The PPACA effects all aspects of the health care delivery and reimbursement system in the United States, including health insurers, managed care organizations, health care providers, employers, and U.S. states and territories.

The implementation of PPACA could have a material adverse effect on the profitability or marketability of our business, financial condition and results of operations. Various federal agencies, including, but not limited to, HHS, the U.S. Department of Labor, and the U.S. Department of the Treasury are issuing regulations in several phases implementing specific PPACA provisions. While CMS recently issued a Final Rule that implements certain PPACA provisions that effect provider and supplier participation and enrollment in federal and state health payor programs, this Final Rule is not expected to have a material impact on our business. Additionally, federal agencies have issued Requests for Information and Interim Final Regulations implementing certain other PPACA provisions

Table of Contents

that could affect our business. Final regulations and guidance are anticipated in the near future and we will continue to assess PPACA s impact on us as final regulations and guidance are issued.

Some of the more significant PPACA issues that may affect our managed care business (including our Commercial and Medicare sectors) include:

- Provisions requiring greater access to coverage for certain uninsured and under-insured populations and the elimination of certain underwriting practices without adequate funding to health plans or with negative financial levies on health plans such as restrictions in the ability to charge additional premium for additional risk. These include, among others, (i) extending dependent coverage for unmarried individuals until age 26 under their parents health coverage, (ii) limiting a health plan s ability to rescind coverage and restrict the plan s ability to establish annual and lifetime financial caps, and (iii) limiting a health plan s ability to deny or limit coverage on grounds of a person s pre-existing medical condition;
- Provisions restricting medical loss ratios and imposing significant penalties for non-compliance beginning in 2011;
- Provisions requiring health plans to report to their members and HHS certain quality performance measures and their wellness promotion activities;
- Provisions that freeze premium payments to Medicare Advantage health plans beginning in 2011 and that tie such premium to the local Medicare fee for service costs. The adjustment will be phased in over between 3 and 7 years depending on the amount of the eventual adjustment;
- Provisions that tie Medicare Advantage premiums to achievement of certain quality performance measures;
- Provisions requiring non-exempt individuals to maintain minimum essential coverage (i.e. the individual mandate), whether through a government-sponsored program, an employer-sponsored program, or an individual market health plan, or pay a penalty. In connection with the individual mandate provisions, insurers and employers will have reporting obligations to various federal agencies.
- Other efforts or specific legislative changes to the Medicare and Medicaid programs, including changes in the bidding process, authority of CMS to deny bids, or other means of materially reducing premiums such as through further adjustments to the risk adjustment methodology;
- Increased federal funding to the Puerto Rico Medicaid program available for years 2014 2019;
- Funding provided to the government of Puerto Rico to either establish health insurance exchanges or fund the Puerto Rico Medicaid program at the discretion of the Governor;
- Increased government funding to enforcement agencies and/or changes in interpretation or application of fraud and abuse laws;
- Expanded scope of authority and/or funding to audit Medicare Advantage health plans and recoup premiums or other funds by the government or its representatives; and
- The increase in persons eligible for coverage under the Medicaid program in Puerto Rico, which may result in some persons currently insured by us in our Commercial programs becoming eligible for, and thus moving to, the Medicaid program.

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;
- 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;

Table of Contents

- security of electronically transmitted individually identifiable health information;
- geographic service areas;
- market conduct;
- 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;
- rates of payment to providers of care;
- surcharges on payments to providers;
- provider contract forms;
- delegation of financial risk and other financial 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) that 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.

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, and consistent with the law, and that 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 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 security-holders.

Table of Contents

In addition, Puerto Rico insurance laws 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 (defined below). 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

Participating managed care providers of the dual-eligible sector of the population, ministered by the Puerto Rico Health Insurance Administration (PRHIA), are required to 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 Medicaid is authorized to review and supervise the operations of entities contracted by the government of Puerto Rico to provide services to the dual-eligible sector of the population. The Solicitor may investigate and adjudicate claims filed by Medicaid beneficiaries against the various service providers contracted by the government of Puerto Rico. See Business Customers-Medicare Supplement and Medicare Advantage Sector sections included in this Item for more information.

Capital and Reserve Requirements

Since 2009, local insurers and health organizations are required by the Insurance Code to submit to the Puerto Rico Commissioner of Insurance RBC reports following the NAIC s RBC Model Act and accordingly are subject to certain regulatory actions if their capital levels do not meet minimum specific risk based capital requirements. In February 2010, Insurance Regulation No. 92, which establishes the guidelines to implement RBC requirements went into effect. Rule 92 provides for gradual compliance over a period of five years.

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 various risks, including 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 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

Table of Contents

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, TSP 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 catastrophic 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 2010, 2009 and 2008), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2010 and 2009, we had $35.9 million and $33.7 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 19 of the audited consolidated financial statements.

Dividend Restrictions

We 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.

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. 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 Restrictions on Certain Payments by the Corporation s Subsidiaries .

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 Associations for additional information.

Federal Regulation

Our business is subject to extensive federal law and regulation. New laws, regulations or guidance or changes to existing laws, regulations or guidance or their enforcement, may materially impact our business financial condition and results of operations.

Table of Contents

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, known as Medicare fee-for-service, 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 an annual $162 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often purchase Medicare supplement products, commonly known as Medigap , which is regulated but not funded by CMS, 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 meets 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, since the 1980 s, Medicare has also offered Medicare managed care benefits provided though contracted private health plans. Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans members. Beginning in 1997, CMS gradually phased in a risk adjustment payment methodology that based the CMS monthly premium payments to plans on various clinical and demographic factors. Beginning in 2003, Congress introduced a new Medicare managed care approach.

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). The MMA transformed Medicare s managed care program known as Medicare Part C or Medicare Advantage and also introduced a prescription drug program known as Medicare Part D.

Under Medicare Part C, Medicare Advantage plans contract with CMS and in exchange for a monthly payment per member from CMS, agree to provide a minimum benefits package that is equivalent to the benefits provided by Medicare under the traditional fee-for-service Medicare program and to provide additional benefits to the extent a Medicare Advantage plan is able to do so.

As of January 1, 2006, such contracts are awarded and premiums are set based upon a prescribed bidding. Local Medicare Advantage plans annually submit bids based upon their expected costs to provide the minimum Medicare Part A and Part B benefits in their applicable service areas. The bids are then compared to a county level benchmark amount that is based upon the historic cost of providing Medicare fee for service benefits adjusted by CMS over time.

If the bid is less than the benchmark, CMS 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 supplemental benefits, reductions in cost sharing, or reductions in premiums for Part D benefits or other supplemental benefits. It is common for Medicare Advantage plans to provide additional benefits to enrollees such as lower deductibles and co-payments than those required by traditional fee-for-service Medicare, and plan members do not need to purchase supplemental Medigap policies because those types of benefits are covered under the Medicare Advantage benefits package. Because Medicare Advantage plans frequently employ a managed care

Table of Contents

model, members are often required to use only the service and provider network contracted by the Medicare Advantage plan for non-emergency care. In some geographic areas, however, and for plans employing an open access model, members may be required to pay a monthly premium. For our products such additional benefits include increased preventive services, and dental and vision benefits.

If a Medicare Advantage plan s bid is greater than the benchmark, the plan receives the benchmark as payment from Medicare and is required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark. Currently some of the bids that TSS has submitted each year for its products have been below the CMS benchmark, meaning TSS has not been required to charge its members a premium in those particular products.

The Medicare Advantage premium amount is risk adjusted by enrollee depending on the documented health characteristics of each enrollee. The monthly payment amounts from CMS to each Medicare Advantage plan are based on a fixed premium amount per member per month that is set each year by CMS. That fixed amount is then risk adjusted by member based upon each member s documented health characteristics. In order to facilitate the risk adjustment system, CMS requires all Medicare Advantage plans to collect and submit diagnosis code information to CMS twice a year for reconciliation with CMS s internal database. Between 2003 and 2010, payments were further adjusted by a budget neutrality factor, which has now been phased out.

Under Medicare Part D, every Medicare beneficiary is able to select a Medicare prescription drug plan provided through private Medicare Part D plans 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 has replaced state level Medicaid prescription drug coverage for dual-eligibles (e.g., beneficiaries eligible for participation under both the Medicare and Medicaid programs). The Medicare Part D prescription drug benefit payments to plans are determined through a competitive bidding process, and enrollee premiums also are based upon plan bids. The bids are based upon a 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 funded by the federal government with some 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 2011, Medicare beneficiaries enrolled in a stand-alone PDP will pay a $310 deductible, co-insurance payments equal to 25% of the drug costs between $310 and the initial annual coverage limit of $2,840 and all drug costs between the annual coverage limit and $4,550 in out-of-pocket drug expenses, which is commonly referred to as the Part D doughnut hole or coverage gap . However, in 2011 Medicare beneficiaries are entitled to a fifty percent (50%) discount on brand name formulary drugs and a seven percent (7%) discount on generics purchased during the doughnut hole period. After the Medicare beneficiary has incurred $4,550 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 three MA-PD plans, which have generic coverage with a $5 co-payment during the doughnut

Table of Contents

hole period. On the PDP side, we currently offer two plans, one of which has 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 and Medicaid, because of age or other qualifying status, and Medicaid, because of economic status. The government of Puerto Rico established a model that wraps-around benefits included in Medicaid that were not included in MA benefits. Dual-eligible beneficiaries in Puerto Rico have the option to participate in this model called *Platino*. Health plans that offer *Platino* products receive premiums from CMS and the government of Puerto Rico. In this plan 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. 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, dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid 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. Our sales and marketing activities are closely regulated by CMS, ASES and the Office of the Solicitor for the Beneficiaries of Medicaid. CMS Regulations in this area preempt local law.

Fraud and Abuse Laws. Entities, such as TSS, that receive federal funds from government health care programs, such as Medicare and Medicaid, are subject to a wide variety of federal fraud and abuse laws and enforcement activities. Such laws include the federal anti-kickback laws and the False Claims Act.

Anti-kickback Laws. The federal anti-kickback laws 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. In 2010, recoveries from civil health care matters brought under the False Claims Act exceeded $2.5 million.

HIPAA and Gramm-Leach-Bliley Act

Health care entities, such as TSS, are subject to laws, including HIPAA and the Gramm-Leach-Bliley Act, that require the protection of certain health and other information. 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 promulgated pursuant to the Stimulus (as defined below) also require that business associates acting for or on behalf of HIPAA-covered entities comply with many of the HIPAA standards regarding the privacy and security of individually identifiable health

Table of Contents

information. The regulations of the Administrative Simplification section of HIPAA establish significant criminal penalties and civil sanctions for noncompliance.

HHS has released rules mandating the use of 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 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 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.

We have recently learned of a breach and other unauthorized access to a specific internet database managed by TCI. We have completed our investigation and determined that the intrusions were the result of the unauthorized use of one of more active user IDs and passwords and not the result of a breach to our security system. See Item 3. Legal Proceedings Intrusions into Triple-C, Inc. Internet IPA Database .

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. Many of those Stimulus provisions that affect and expand HIPAA became effective on February 17, 2010. The Secretary of HHS has promulgated regulations clarifying certain aspects of the Stimulus pertaining to HIPAA and it is expected that the Secretary of HHS will issue additional regulations pertaining to HIPAA in the near future. We have updated our internal policies and operations to comply with the Stimulus pertaining to HIPAA. We will monitor the further implementation of the Stimulus and the regulations promulgated thereunder, and we will modify our policies and operations as necessary to comply with these future amendments. In the fall of 2010 CMS notified all Medicare Advantage plans, including TSS, that it intends to devote greater attention to HIPAA enforcement under its legal mandate to protect Medicare beneficiaries and ensure that CMS contractors comply with the law. See Item 1. Business Regulation Legislative and Regulatory Initiatives for additional information.

HHS has released rules mandating the use of standard formats in electronic health care transactions (for example, health care claims submission and payment, plan eligibility, precertification, 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 unique identifiers for employers and providers. By 2013, the federal government will require that healthcare organizations, including health insurers, upgrade to updated and expanded standardized code sets used for describing health conditions. The Regulation requires a conversion from the ICD-9 diagnosis and procedure code set to the ICD-10 diagnosis and procedure code set. Our managed care subsidiary has initiated a project to comply with the ICD-10 capabilities by the October 1, 2013 (effective date), that will require a substantial investment.

The Gramm-Leach-Bliley Act applies to financial institutions in the United States, including those 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

Table of Contents

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 participated in the Health Insurance Plan provided by the government of Puerto Rico (similar to Medicaid) (Medicaid) to provide health coverage to medically indigent citizens in Puerto Rico. See Item 1. Business Customers Medicaid Sector . On August 31, 2010, the Puerto Rico Health Insurance Administration notified our managed care subsidiary, TSS, that the proposal submitted by TSS to continue to provide services to the Medicaid population was not selected. Thus, its contracts expired by their own terms on September 30, 2010. Medicaid enrollment as of September 30, 2010 was 544,448 members. Medicaid premiums earned, net during 2010, 2009 and 2008 amounted to $287.5 million, $348.1 million and $340.1 million, respectively. The operating income for the Medicaid business during 2010, 2009 and 2008 amounted to $19.0 million, $12.4 million and $10.5 million, respectively.

Legislative and Regulatory Initiatives

Puerto Rico Initiatives

The Commissioner of Insurance adopted on December 2010 Rule No. 83, titled Rules and Procedures to Regulate the Systems of the Holding Companies of Insurers and Organizations of Health Services and Criteria for Evaluating Change of Control . Rule No. 83 requires insurance companies and health services organizations domiciled in the Commonwealth of Puerto Rico and that are within an insurance holding company system to register with the Commissioner of Insurance 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 requires prior notice, reporting and regulatory approval of mergers and acquisitions of an insurer or health services organization, distributions of extraordinary dividends and other distributions to stockholders.

The Commissioner of Insurance, along with the Puerto Rico Legislature, is currently evaluating the adoption of a Health Insurance Code through the Puerto Rico Senate Bill Number 1856. This new Code will replace the current Insurance Code for the topics related to health insurance. The Commissioner has publicly expressed his intention to implement this Code in phases during 2011. The main objective of the proposed Code will be to update the regulatory framework for this activity and harmonize local provisions with recently approved federal legislation. The most recent draft of this Code contains the general dispositions, handling of prescription medicines, availability of health insurance for small and medium companies, prohibition of discretionary clauses, complaint procedures of health organizations, among others.

Also, the Puerto Rico Senate is working on Bill S. 746, which would allow healthcare service providers to form cooperatives in order to collectively negotiate the terms and conditions of their contracts with insurers, health maintenance organizations and pharmacy benefit managers. The Bill would exempt these cooperatives from the provisions of antimonopoly statutes and empower the Corporación Pública para la Supervisión y Seguro de Cooperativas de Puerto Rico to authorize and monitor the negotiation process. This new Bill would not repeal Law number 203 of August 8, 2008, which also granted providers collective bargaining rights; instead the new bill would provide alternate means to attain the same objective.

Federal Initiatives

The constitutionality of the PPACA is being challenged by at least 26 states, including Florida, Michigan and Virginia. Currently there is a division in the federal courts as it relates to the constitutionality of PPACA. On October 7, 2010, Judge George C. Steech, of the United States District Court for the Eastern District of Michigan upheld the United States Congress power under the United States Constitution s interstate commerce clause to impose the penalty under PPACA for violation of the individual mandate provision in the law. On November 30, 2010, Judge Norman K. Moon of the United States District Court for the Western District of Virginia found that the United States Congress was within its authority in passing PPACA and dismissed claims challenging the law. On December13, 2010, Judge Henry E. Hudson of the United States Disctrict Court for the Eastern District of Virginia granted the state attorney general s motion for summary judgment in the case filed against the legality of the individual mandate

provision of PPACA, stating that the United States Congress exceeded its authority to regulate economic activity under the United States Constitution s interstate commerce clause by including the individual mandate provision in PPACA. On January 31, 2011, Judge Roger Vinson of the United States Disctrict Court for the Northern District of Florida declared PPACA is unconstitutional and inseverable from the remainder of PPACA. In February 2011, Judge Gladys Kessler of the United States District court in Washington, D.C. ruled that Congress was authorized under the Commerce clause to enact PPACA s individual mandate and that the individual mandate

Table of Contents

was necessary to making PPACA work. We will continue to assess the impact of these state challenges on PPACA as they develop.

In addition to the constitutional challenges to PPACA, members of the United States Congress continue to introduce legislation in an attempt to repeal or defund PPACA. To date, none of these measures have passed both chambers of the United States Congress.

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 29 to the audited consolidated financial statements for the years ended December 31, 2010, 2009 and 2008.

Employees

As of December 31, 2010, we had approximately 2,200 full-time employees and 330 temporary employees. Our managed care subsidiary has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 41% of our managed care subsidiary s 878 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 our 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 Code of Business Conduct and Ethics 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 Code of Business Conduct and Ethics 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; 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 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 may , will , shall , should and similar expressions, whether in the positive or negative, are 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

Table of Contents

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 and government agencies 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 in 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.

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 TSS 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

Table of Contents

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 TSS 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 TSS 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. See Item 3. Legal Proceedings Hau et al Litigation (formerly known as Jordan et al) . 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 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, we are defending five judicial claims by non-medical heirs of former shareholders whose shares were repurchased upon their death seeking the return of or compensation for a total of 71 shares (prior to giving effect to the 3,000-for-one stock split). See Item 3. Legal Proceedings Claims by Heirs of Former Shareholders . 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

Table of Contents

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, TSS, 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 were 19,772,614 shares of Class B common stock and 9,042,809 shares of Class A common stock outstanding as of December 31, 2010. 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 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 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 or 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 in the case of the Medicare Advantage products, 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 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,

Table of Contents

changes in the regulatory environment including the implementation of HIPAA amendments under the Stimulus, as well as others, such as implementation of PPACA, 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 premium rate levels may be affected by continuing government efforts to contain medical expense or other budgetary constraints. Changes in the Medicare Advantage program, 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. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

The property and casualty insurance industry is under soft market conditions for commercial lines and consequently is highly competitive, and we believe that it will remain highly competitive for the foreseeable future. Competitors may offer products at prices and on terms that are not consistent with economic standards in an effort to maintain or increase their business. The property and casualty insurance industry has historically been cyclical, with periods characterized by intense price competition and less restrictive underwriting standards followed by periods of higher premium rates and more selective underwriting standards. The competitive environment in which we operate is also impacted by current general economic conditions, which could reduce the volume of business available to us, as well as to our competitors.

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. Currently certain providers are pressing for legislation that would allow them to collectively negotiate service fees through cooperatives. 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 Cross 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:

Medicare: We provide services through our Medicare Advantage products 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 the process for bidding materially changes or if any of these contracts are terminated, our business could be materially impaired. During each of the years ended December 31, 2010, 2009 and 2008, contracts with CMS represented 24.6%, 27.4% and 25.9% of our consolidated premiums earned, net, respectively, and 45.2%, 33.9% and 12.4% of our consolidated operating income, respectively.

Table of Contents

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, 2010, 2009 and 2008 premiums generated under this contract represented 6.9%, 6.7% and 7.3% of our consolidated premiums earned, net, respectively. The operating income generated under this contract represented 1.0%, 1.2% and 1.1% of our consolidated operating income during the years ended December 31, 2010, 2009 and 2008, respectively.

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 consolidated premiums earned would be materially adversely affected.

We participated in the government of Puerto Rico Health Insurance Plan (similar to Medicaid) to provide health coverage to medically indigent citizens in Puerto Rico until September 30, 2010, when our contracts with the government of Puerto Rico expired by their own terms. Thus since October 1, 2010 we no longer provide services to these members. Our results of operations have depended to a significant extent on our participation in this sector. During each of the years ended December 31, 2010, 2009 and 2008, Medicaid premiums have accounted for 15.0%, 18.6% and 20.1%, respectively, of our consolidated premiums earned, net.

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. As of December 31, 2010, 69.4% of our managed care customers had fully insured arrangements and 30.6% had ASO arrangements, as compared to approximately 66.1% and 33.9%, respectively, as of December 31, 2009. 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-estimate 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 Operations Critical Accounting Estimates . 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 BCBS name and mark could have a material adverse effect on our business, financial condition and results of operations.

We are a party to license agreements with the BCBSA that entitle us to the exclusive use of the BCBS name and mark in Puerto Rico and the U.S. Virgin Islands. We believe that the Blue Cross and Blue Shield name and mark are valuable identifiers of our products and services in the marketplace. The termination of these license agreements or changes in their terms and conditions could adversely affect our business, financial condition and results of operations.

Table of Contents

Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS name and mark. Failure to comply with any of these requirements and restrictions could result in the 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 a license agreement are adopted 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 BCBS name and mark in Puerto Rico and the U.S. Virgin Islands. Furthermore, the BCBSA would be free to issue a license to use the BCBS name and mark in Puerto Rico and the U.S. Virgin Islands 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 licenses.

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 Cross Blue Shield presence in the vacated service area with another managed care company. The fee is currently $98.33 per licensed enrollee. If the re-establishment fee were applied to our total Blue Cross Blue Shield enrollees as of December 31, 2010, we would be assessed approximately $77.6 million by the BCBSA.

See Item 1. Business Blue Cross and 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, 2010, 40.0%, or $63.7 million, of the premiums written in the property and casualty insurance segment and 5.0%, or $5.6 million, of the premiums written in the life insurance segment were ceded to reinsurers. In the year ended December 31, 2009, 41.3%, or $67.5 million, of the premiums written in the property and casualty insurance segment and 5.7%, or $6.1 million, of the premiums written in the life insurance segment were ceded to reinsurers. The premiums ceded and 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 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 Risks Related to Our Business Large-scale natural disasters may have a material adverse effect on our business, financial condition and results of operations. 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

Table of Contents

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 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 2010, 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) with a stable outlook. 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 our managed care company. In addition, the managed care market in Puerto Rico is mature. According to the U.S. Census Bureau, Puerto Rico s population decreased by 6.1% between April 1, 2010 and July 2009, however the national population rate grew 0.5% during the same period. According to the US Census Bureau, between 2010 and 2050, the United States is projected to experience rapid growth in its population over 65 years. This population is projected to more than double from 2010 to 2050. A similar trend is expected for the Puerto Rico population. As a result, in order to increase our profitability we must increase our membership in the 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. These other plans entered that market in 2006 and 2007. We anticipate that they can 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.

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 Puerto Rico s stagnant economy, there are few new sources of business in this segment. As a result, property and casualty insurance companies compete for the same accounts through pricing, policy terms and quality of services. We also face heavy competition in the life and disability insurance market.

Table of Contents

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.

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 Risks Related to Our Business Our insurance subsidiaries are subject to minimum capital requirements. Our failure to meet these standards could subject us to regulatory actions. 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, and other business and 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 Risks Related to Our Business The termination or modification of our license agreements to use the BCBS 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.

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 as well as credit 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. The outlook of our investment portfolio depends on the future direction of interest rates, fluctuations in the equity securities market and the amount of cash flows available for investment. For additional information, see Item 7A. 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, and real estate and equity investments, amongst others, which could generate higher returns on our investments. If we fail to comply with these laws and

Table of Contents

regulations, any investments exceeding regulatory limitations would be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital.

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, other investments, our profitability and our financial position, and we do not expect these conditions to improve in the near future.

The global capital markets, including credit markets, have been experiencing extreme volatility. 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 reduce our operating results and/or net unrealized capital losses that reduce our shareholders equity.

Lowering 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 other-than-temporary impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. It also requires us to make certain assessments about the potential recovery of the assets we hold. For the purpose of determining gross realized gains and losses, the cost of investment securities is based upon specific identification. During the years ended December 31, 2010 and 2009, we realized losses associated with other-than-temporary impairments of $3.0 million and $7.1 million, respectively. The gross unrealized losses of our available-for-sale and held-to-maturity securities were $5.4 million and $14.9 million at December 31, 2010 and 2009, respectively. The gross unrealized gains of our available-for-sale and held-to-maturity securities were $47.8 million and $26.4 million at December 31, 2010 and 2009, respectively. 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.

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. The major factors affecting the economy are, among others, high oil prices, the slowdown of economic activity in the United States, and the continuing economic uncertainty generated by the budgetary deficiency affecting the government of Puerto Rico.

The Puerto Rico government is currently facing a structural deficit between recurring government revenues and expenses. On March 9, 2009, the Governor signed the multi-year Fiscal Stabilization and Economic Reconstruction Plan, 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 in Puerto Rico, these

measures could have the effect of intensifying the current recessionary cycle.

Table of Contents

If economic conditions in Puerto Rico continue to 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 successfully operate and expand a business such as ours. We do not currently maintain key-man life insurance on any of our executive officers nor do we have a non-competition agreement in place with any executive officer, other than our Chief Executive Officer.

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 member 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 selected Quality Care Solutions, Inc., a wholly owned subsidiary of The TriZetto Group, Inc, to implement new core business applications for our managed care segment. We completed an initial assessment during 2007 and commenced the implementation of the new application in 2008. Our Managed Care segment began transitioning to the new application in 2010. The transitioning process is expected to continue into 2011, when we expect to complete the full migration. 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 events 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 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 security breaches are not prevented or appropriately remediated.

Table of Contents

In September 2010, we have recently learned of a breach and other unauthorized access to a specific internet database managed by TCI. We have completed our investigation and determined that the intrusions were the result of the unauthorized use of one of more active user IDs and passwords and not the result of a breach to our security system. See Item 3. Legal Proceedings Intrusions into Triple-C, Inc. Internet IPA Database .

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 and health information privacy (including HIPAA).

We are a defendant in various lawsuits, 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 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 managed care, property and casualty and life insurance segments 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.

Non-financial 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 $21.0 million as of December 31, 2010. Also, we have an aggregate principal amount of $120.0 million of senior unsecured notes outstanding, consisting of a $50.0 million aggregate principal amount of 6.30% notes due 2019, a $35.0 million aggregate principal amount of 6.60% notes due 2020 and a $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 non-financial covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These non-financial 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 comply with any of the non-financial 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 re-finance the amounts due and our business may be materially adversely affected.

Table of Contents

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 may pursue acquisitions in the future.

We may acquire additional companies or assets if consistent with our strategic plan for growth. The following are some of the potential 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 an acquired entity and unanticipated expenses related to such integration;
- difficulty in the integration of an acquired entity 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.

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.

Table of Contents

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 substantial federal and local regulation and frequent changes to the applicable legislative and regulatory schemes, including general business regulations and laws relating to taxation, privacy, data protection, pricing, insurance, Medicare and health care fraud and abuse laws. Please refer to Item 1. Business Regulation . Changes in these laws, enactment of new laws or regulations, changes in interpretation of these laws or changes in enforcement of these laws and regulations may materially impact our business. Such changes include without limitation:

initiatives to provide greater access to coverage for uninsured and under-insured populations without adequate funding to health plan or to be funded through taxes or other negative financial levy on health plans;

payments to health plans that are tied to achievement of certain quality performance measures;

other efforts or specific legislative changes to the Medicare or Medicaid programs, including changes in the bidding process or other means of materially reducing premiums;

local government regulatory changes;

increased government enforcement, or changes in interpretation or application, of fraud and abuse laws; and

regulations that increase the operational burden on health plans that increase a health plan s exposure to liabilities, including efforts to expand the tort liability of health plans.

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, including federal regulations, could have a material adverse effect on the profitability or marketability of our business, financial

condition and results of operations.

Table of Contents

We may be subject to government audits, regulatory proceedings or investigative actions, which may find that our policies, procedures, practices or contracts are not compliant with, or are in violation of, applicable healthcare regulations.

Federal and Puerto Rico government authorities, including but not limited to the Commissioner of Insurance, ASES, CMS, the OIG, the Office of the Civil Rights of HHS, the U.S. Department of Justice, the U.S. Department of Labor, and the OPM, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations. We may also become the subject of non-routine regulatory or other investigations or proceedings brought by these or other 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, diversion of resources, and a possible material adverse effect on our business.

An adverse action 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 or other federal or local programs; damage to our reputation;

increased difficulty in marketing our products and services;

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 or our operations may be required to change in a manner that has a material impact on our business.

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.

A number of legislative proposals, as well as PPACA, includes efforts to save federal funds by implementing significant rate reductions to Medicare Advantage plans through changes in the competitive bidding process, tying the country benchmarks to Medicare fee for service expenditures, or other means.

Table of Contents

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 affected 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 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.

Between 2003 and 2010, payments to Medicare Advantage plans are also adjusted by a budget neutrality factor that was implemented 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 has been phased out. Furthermore, even with the enactment of PPACA, MedPac and other constituencies continue to recommend that Congress enact legislation that would reduce Medicare Advantage payment to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program. We cannot provide assurance if, when or to what degree Congress may enact legislation including any such recommendation, 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

Table of Contents

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 the holding company s or its 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 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 Risks Related to Our Business The termination or modification of our license agreements to use the BCBS name and mark could have a material 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

Table of Contents

HIPAA amendments under the Stimulus are implemented. In addition, last fall CMS advised all Medicare Advantage plans, including TSS, of CMS intention to increase its enforcement activities of the privacy regulations under HIPAA with respect to Medicare beneficiaries. 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 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 Risks Relating to the Regulation of Our Industry If we are deemed to have violated the insurance company change of control statutes in Puerto Rico, 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 Risks Relating to the Regulation of Our Industry If we are deemed to have violated the insurance company change of control statutes in Puerto Rico, 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.

Table of Contents

Item 2. Properties

We own a seven story 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 .

We also own land in the municipality of Mayagüez, Puerto Rico, in which we have begun to build a multi-segment customer service center. 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.

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, 2010, 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, the Corporation s subsidiary TSS and others in the Court of First Instance for San Juan, Superior Section (the Court of First Instance), 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. After extensive discovery, plaintiffs amended their complaint for the third time and dropped all claims predicated on violations of the antitrust and RICO laws and the Puerto Rico Insurance Code. In addition, the plaintiffs voluntarily dismissed with prejudice any and all claims against officers of the Corporation and TSS. Two of the original plaintiffs were also eliminated from the Third Amended Complaint (TAC). The TAC only alleges breach of seven share acquisition agreements (see Item 1A Risk Factors Risks Relating to our Capital Stock), breach of the provider contract by way of discriminatory audits and improper payment of services rendered. Against a former President of TSM, Plaintiffs allege a claim for libel and slander. Discovery is ongoing. The Corporation intends to vigorously defend this claim.

Table of Contents

Dentists Association Litigation

On February 11, 2009, the Puerto Rico Dentists Association (Colegio de Cirujanos Dentistas de Puerto Rico) filed a complaint in the Court of First Instance against 24 health plans operating in Puerto Rico that offer dental health coverage. The Corporation and two of its subsidiaries, TSS and Triple-C, Inc. (TCI), 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 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 Corporation intends to vigorously defend this claim.

Two codefendant plans, whose main operations are outside Puerto Rico, removed the case to federal court in Florida, which the plaintiffs and the other codefendants, including the Corporation, opposed. The federal district court in Florida decided that it lacked jurisdiction under the Class Action Fairness Act (CAFA) and remanded the case to state court. The removing defendants petitioned to appeal to the First Circuit Court of Appeals. Having accepted the appeal, the First Circuit Court of Appeals issued an order in late October 2009 which found the lower court s decision premature. The Court of Appeals remanded the case to the federal district court in Puerto Rico (the DC) and allowed limited discovery to determine whether the case should be heard in federal court pursuant to CAFA. The parties completed the limited discovery in August 2010 and supplemented their previous filings.

On February 8, 2011 the DC issued its Opinion and Order, denying plaintiff s motion to remand the case to state court because the injuries alleged in the complaint could be suffered outside Puerto Rico. It also decided to retain jurisdiction.

We plan to petition the DC to reconsider its ruling, pointing to clear evidence that the removing defendants are not primary defendants for purposes of CAFA and therefore, the case should be heard in state court.

Colón Litigation

On October 15, 2007, José L. Colón-Dueño, a former holder of one share of TSS predecessor stock, filed suit against TSS and the Puerto Rico Commissioner of Insurance (the Commissioner) in the Court of First Instance. 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 TSS shareholders was voided. TSS, however, appealed the Commissioner s order before the Puerto Rico Court of Appeals, which upheld the order on March 31, 2000. Plaintiff requests that the court direct TSS to return his share of stock and compensate him for alleged damages in excess of $500,000 plus attorney s fees. On January 13, 2011 case was dismissed with prejudice and plaintiff filed an appeal on the Puerto Rico Court of Appeals. The Corporation is vigorously contesting this lawsuit because, among other reasons, the Commissioner s order is final and cannot be collaterally attacked in this litigation.

Claims by Heirs of Former Shareholders

The Corporation and TSS are defending five individual lawsuits, all filed in state court, from persons who claim to have inherited a total of 71 shares of the Corporation or one of its predecessors or affiliates (before giving effect to the 3,000-for-one stock split) . While each case presents unique facts and allegations, the lawsuits generally allege that the redemption of the shares by the Corporation pursuant to transfer and ownership restrictions contained in the Corporation s (or its predecessors or affiliates) articles of incorporation and bylaws was improper. One of the cases is in its initial stage and one other case was dismissed with prejudice and plaintiff has filed a request for reconsideration. In the other cases, discovery has been completed and the parties are awaiting trial. Management believes all these claims are time barred under one or more statutes of limitations and other grounds and is vigorously defending them. This belief is supported by the outcome of a similar claim brought by non-medical heirs against us in 2009. The Puerto Rico Court of Appeals dismissed that case as time barred under the two year statute

Table of Contents

of limitations contained in the local securities law, and the Puerto Rico Supreme Court denied the plaintiffs petition for certiorari in January 2011.

ACODESE Investigation

During April 2010, each of the Company s wholly-owned insurance subsidiaries received subpoenas for documents from the U.S. Attorney for the Commonwealth of Puerto Rico (the U.S. Attorney) and the Puerto Rico Department of Justice (PRDOJ) requesting information principally related to the Asociación de Compañías de Seguros de Puerto Rico, Inc. (ACODESE by its Spanish acronym). Also in April, the Company s insurance subsidiaries received a request for information from the Office of the Commissioner of Insurance of Puerto Rico (OCI) related principally to ACODESE. The Company s insurance subsidiaries are members of ACODESE, an insurance trade association established in Puerto Rico since 1975, and their current presidents have participated over the years on ACODESE s board of directors.

The Company believes similar subpoenas and information requests were issued to other member companies of ACODESE in connection with the investigation of alleged payments by the former Executive Vice President of ACODESE to members of the Puerto Rico Legislative Assembly beginning in 2005. The Company, however, has not been informed of the specific subject matter of the investigations being conducted by the U.S. Attorney, the PRDOJ or the OCI. The Company is fully complying with the subpoenas and the request for information and intends to cooperate with any related government investigation. The Company at this time cannot reasonably assess the outcome of these investigations or their impact on the Company.

Intrusions into Triple-C, Inc. Internet IPA Database

On September 21, 2010, we learned from a competitor that a specific internet database managed by our subsidiary TCI containing information pertaining to individuals previously insured by TSS under the Government of Puerto Rico s Health Insurance Plan (HIP) and to independent practice associations (IPAs) that provided services to those individuals, had been accessed without authorization by certain of our competitor s employees from September 9 to September 15, 2010. TCI served as a third-party administrator for TSS in the administration of its HIP contracts until September 30, 2010. We conducted a thorough investigation with the assistance of external resources and identified the information that was accessed and downloaded into the competitor s system. The September 2010 intrusions may have potentially compromised protected health information of approximately 398,000 beneficiaries in the North and Metro-North regions of the HIP. Our investigation also revealed that protected health information of approximately 5,500 HIP beneficiaries, 2,500 Medicare beneficiaries and IPA data from all three HIP regions previously serviced by TSS was accessed through multiple, separate intrusions into the TCI IPA database from October 2008 to August 2010. We have no evidence indicating that the stolen information included Social Security numbers. We attempted to notify by mail all such beneficiaries whose information may have been compromised by these intrusions. We also established a toll-free call center to address inquiries and complaints from the individuals to whom notice was provided. We received a total of approximately 1,530 inquiries and no complaints from these individuals.

Our investigation has revealed that the security breaches were the result of unauthorized use of one or more active user IDs and passwords specific to the TCI IPA database, and not the result of breaches of TCI s, TSS s or the Corporation s system security features. Nonetheless, we took measures to strengthen TCI s server security and credentials management procedures and conducted an assessment of our system-wide data and facility security to prevent the occurrence of a similar incident in the future.

We were unable to determine the purpose of these breaches and do not know the extent of any fraudulent use of the information or its impact on the potentially affected individuals and IPAs. According to representations made by our competitor, however, the target was financial information related to IPAs rather than the beneficiaries information.

We notified the appropriate Puerto Rico and federal government agencies of these events, including public notice of the breaches as required under Puerto Rico and federal law. We received a number of inquiries and requests for information related to these events from these government agencies and are cooperating with them. The Puerto Rico government agency that oversees the HIP levied a fine of $100,000 on TSS in connection with these incidents, but following our request for reconsideration, the agency withdrew the fine until the pertinent federal authorities conclude their investigations of this matter. We do not have sufficient information at this time to predict

Table of Contents

whether any future action by government entities or others as a result of the data breaches would adversely affect our business, financial condition and results of operations.

Item 4. Removed and Reserved

Part II

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

Market Information

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. There is no established public trading market for our Class A common stock.

The following table presents high and low sales prices of our Class B common stock for the each quarter of the years ended December 31, 2009 and 2010:

	High	Low
2009		
First quarter	$ 15.00	$ 10.67
Second quarter	16.23	12.06
Third quarter	17.84	14.50
Fourth quarter	18.88	15.52
2010		
First quarter	$ 18.67	$ 15.85
Second quarter	20.12	17.30
Third quarter	21.34	14.65
Fourth quarter	21.23	16.15

On February x, 2011 the closing price of our Class B common stock on the NYSE was $xx.xx.

Holders

As of February x, 2011, there were 9,042,809 and 19,772,614 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A common stock as of February x, 2011 was x,xxx. The number of our holders of Class B common stock as of January 15, 2011 was x,xxx.

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. 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 ..

We did not declare any dividends during the two most recent fiscal years and 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,

Table of Contents

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 herein by reference from our definitive Proxy Statement for our 2011 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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 (*in millions*)**
October 1, 2010 to October 31, 2010	176,300	$ 17.02	176,300	$ 26.6
November 1, 2010 to November 30, 2010	60,419	$ 18.21	60,419	$ 25.5
December 1, 2010 to December 31, 2010	91,672	18.87	91,672	23.8

[1] In September 29, 2010, the Board of Directors authorized a $30.0 million share repurchase program of Class B shares only, which commenced on September 29, 2010.

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, 2010, 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

	Period Ending							
Index	**12/07/07**	**12/31/07**	**06/30/08**	**12/31/08**	**06/30/09**	**12/31/09**	**06/30/10**	**12/31/10**
||||||||								
Triple-S Management Corporation	100.00	133.40	107.92	75.91	102.90	116.17	122.44	125.94
S&P 500	100.00	97.59	85.07	60.03	61.10	74.11	68.50	83.58
Morgan Stanley Healthcare Payor Index	100.00	100.38	58.66	45.37	52.42	69.59	66.12	79.94

Table of Contents

Item 6. Selected Financial Data

Statement of Earnings Data

	2010	2009	2008	2007	2006
(Dollar amounts in millions, except per share data)					
Years ended December 31,					
Premiums earned, net	$ 1,901.1	$ 1,869.1	$ 1,692.4	$ 1,483.6	$ 1,511.6
Administrative service fees	39.6	48.6	19.2	14.0	14.1
Net investment income	49.1	52.1	56.2	47.2	42.7
Total operating revenues	1,989.8	1,969.8	1,767.8	1,544.8	1,568.4
Net realized investments gains (losses)	2.5	0.6	(13.9)	5.9	0.8
Net unrealized investment gain (loss) on trading securities	5.4	10.5	(21.1)	(4.1)	7.7
Other income (expense), net	0.9	1.3	(2.5)	3.2	2.3
Total revenues	1,998.6	1,982.2	1,730.3	1,549.8	1,579.2
Benefits and expenses:					
Claims incurred	1,596.8	1,605.8	1,431.8	1,223.8	1,259.0
Operating expenses	305.0	279.4	251.9	237.5	236.1
Total operating costs	1,901.8	1,885.2	1,683.7	1,461.3	1,495.1
Interest expense	12.6	13.3	14.7	15.9	16.6
Total benefits and expenses	1,914.4	1,898.5	1,698.4	1,477.2	1,511.7
Income before taxes	84.2	83.7	31.9	72.6	67.5
Income tax expense	17.4	14.9	7.1	14.1	13.0
Net income	$ 66.8	$ 68.8	$ 24.8	$ 58.5	$ 54.5
Basic net income per share (1):	$ 2.30	$ 2.33	$ 0.77	$ 2.15	$ 2.04
Diluted net income per share:	$ 2.28	$ 2.33	$ 0.77	$ 2.15	$ 2.04
Dividend declared per common share (2):	$	$	$	$ 0.82	$ 0.23

Balance Sheet Data

	2010	2009	2008	2007	2006
December 31,					

Cash and cash equivalents	$ 45.0	$ 40.4	$ 46.1	$ 240.2	$ 81.6
Total assets	$ 1,759.7	$ 1,648.7	$ 1,559.2	$ 1,659.5	$ 1,345.5
Long-term borrowings	$ 166.0	$ 167.7	$ 169.3	$ 170.9	$ 183.1
Total stockholders equity	$ 617.3	$ 537.8	$ 485.9	$ 482.5	$ 342.6

Table of Contents

Additional Managed Care Data (3)

	2010	2009	2008	2007	2006
Years ended December 31,					
Medical loss ratio	88.1%	89.9%	88.9%	87.0%	87.6%
Operating expense ratio	11.6%	10.7%	10.5%	11.2%	11.5%
Medical membership (period end)	788,881	1,347,033	1,195,450	977,190	979,506

(1) Further details of the calculation of basic earnings per share are set forth in notes 2 and 23 of the audited consolidated financial statements for the years ended December 31, 2010, 2009 and 2008.

(2) Shareowners holding qualifying shares were excluded from dividend payment. See note 20 of the audited consolidated financial statements for the years ended December 31, 2010, 2009 and 2008.

(3) 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, 2010 and 2009, and consolidated results of operations for 2010, 2009 and 2008. 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 one of the leading companies in the managed care industry in Puerto Rico and have over 50 years of experience in this industry. We offer a broad portfolio of managed care and related products in the Commercial and the Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plans (PDP)) markets. We also participated in the government of Puerto Rico Health Care Plan (similar to Medicaid) (Medicaid) up to September 30, 2010.

We have the exclusive right to use the Blue Cross and Blue Shield name and mark throughout Puerto Rico and U.S. Virgin Islands, and serve approximately 789,000 members across all regions of Puerto Rico and hold a leading market position covering approximately 21.2% of the population. For the years ended December 31, 2010 and 2009 respectively, our managed care segment represented approximately 89.4% and 89.8% of our total consolidated premiums earned, net, and approximately 72.4% and 67.6% 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 8% (in terms of premiums written) for the nine-month period ended September 30, 2010. Our property and casualty segment had a market share of approximately 8% (in terms of direct premiums) during the nine-month period ended September 30, 2010.

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

We participate in the life insurance market through our subsidiary, TSV, and in the property and casualty insurance market through our subsidiary, TSP. TSV and TSP represented approximately 5.6% and 5.2%, respectively, of our consolidated premiums earned, net for the year ended December 31, 2010 and 19.7% and 4.1%, respectively, of our

operating income for that period.

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

Table of Contents

accepted accounting principles (GAAP) in making such determinations. See note 26 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)	**2010**	**2009**	**2008**
Premiums earned, net:			
Managed care	$ 1,700.3	$ 1,677.1	$ 1,509.9
Life insurance	105.8	100.1	92.8
Property and casualty insurance	99.2	96.2	93.8
Intersegment premiums earned	(4.2)	(4.3)	(4.1)
Consolidated premiums earned, net	$ 1,901.1	$ 1,869.1	$ 1,692.4
Administrative service fees:			
Managed care	$ 43.2	$ 51.3	$ 22.5
Intersegment administrative service fees	(3.6)	(2.7)	(3.3)
Consolidated administrative service fees	$ 39.6	$ 48.6	$ 19.2
Operating income:			
Managed care	$ 63.8	$ 57.2	$ 52.6
Life insurance	17.3	14.6	12.5
Property and casualty insurance	3.6	8.8	13.1
Intersegment and other	3.3	4.0	5.9
Consolidated operating income	$ 88.0	$ 84.6	$ 84.1

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.

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, federal government employees, local government employees, individual accounts and Medicare Supplement, as well as to the Medicare Advantage (including PDP) and, up to September 30, 2010, the Medicaid sectors. We receive a monthly payment from or on behalf of each member enrolled in our 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 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 as their existing annual contracts become due. 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 competitive bidding process under the MMA. Retroactive rate adjustments

Table of Contents

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 contracts. 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 and dividend income from investment securities and other income primarily consists of net unrealized gains (losses) of derivative instruments. See note 2 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) capitation 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 PMPM payment and share the risk of certain 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 and losses. 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 impact on our profitability. The MLR 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 MLR 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 MLRs 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.

Table of Contents

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 July 1, 2009, our subsidiary TSS completed the acquisition of certain managed care assets of La Cruz Azul de Puerto Rico, including members. As of December 31, 2009, the membership attributable to this transaction was 108,502.

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

	As of December 31,		
	2010	**2009**	**2008**
Commercial [(1)]	725,328	737,286	592,723
Medicare [(2)]	63,553	69,605	75,280
Medicaid [(3)]		540,142	527,447
Total	788,881	1,347,033	1,195,450

(1) Commercial membership includes corporate accounts, self-funded employers, individual accounts, Medicare Supplement, Federal government employees and local government employees.

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

(3) Medicaid membership includes rated and self-funded members. We participated in this sector up to September 30, 2010.

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2010, 2009 and 2008.

(Dollar amounts in millions)	**2010**	**2009**	**2008**
Years ended December 31,			
Revenues:			
Premiums earned, net	$ 1,901.1	$ 1,869.1	$ 1,692.4
Administrative service fees	39.6	48.6	19.2
Net investment income	49.1	52.1	56.2
Total operating revenues	1,989.8	1,969.8	1,767.8
Net realized investment gains (losses)	2.5	0.6	(13.9)
Net unrealized investment gain (loss) on trading securities	5.4	10.5	(21.1)
Other income (expense), net	0.9	1.3	(2.5)
Total revenues	1,998.6	1,982.2	1,730.3
Benefits and expenses:			
Claims incurred	1,596.8	1,605.8	1,431.8
Operating expenses	305.0	279.4	251.9

Total operating costs	1,901.8	1,885.2	1,683.7
Interest expense	12.6	13.3	14.7
Total benefits and expenses	1,914.4	1,898.5	1,698.4
Income before taxes	84.2	83.7	31.9
Income tax expense	17.4	14.9	7.1
Net income	$ 66.8	$ 68.8	$ 24.8

Table of Contents

Year ended December 31, 2010 compared with the year ended December 31, 2009

Operating Revenues

Consolidated premiums earned, net increased by $32.0 million, or 1.7%, to $1.9 billion during the year ended December 31, 2010 compared to the year ended December 31, 2009. The increase was primarily due to the net effect of an increase in the premiums earned in our managed care segment, primarily from growth in Commercial member months enrollment, as well as higher premium rates across all businesses, offset in part by the termination of the Medicaid contracts effective September 30, 2010.

The decrease in the administrative service fees of the managed care segment of $9.0 million in the 2010 period is attributed to a lower self-funded member months enrollment after the termination of the Medicaid contract for Metro-North region, which we served on an ASO basis until September 30, 2010.

Consolidated net investment income decreased by $3.0 million, or 5.8%, to $49.1 million during the year ended December 31, 2010 mostly as the result of lower yields in fixed income investments acquired during the period.

Net Realized Investment Gains

Consolidated net realized investment gains of $2.5 million during the year ended December 31, 2010 are the result of net realized gains from the sale of fixed income and equity securities amounting to $5.5 million. The net realized gains were partially offset by $3.0 million of other-than-temporary impairments related to fixed income and equity securities.

Net Unrealized Gains on Trading Securities and Other Income, Net

The combined balance of our consolidated net unrealized gain on trading securities and other income, net decreased by $5.5 million, to $6.3 million during the year ended December 31, 2010. This decrease is attributable to a lower increase in the fair value of our trading securities portfolio as compared to last year s increase. The unrealized gain experienced on our trading portfolio represents a combined increase of 12.4% in the market value of the portfolio, which is slightly lower than the changes experienced by the comparable indexes; the Standard and Poor s 500 Index increased by 12.8% and the Russell 1000 Growth increased by 14.9%.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2010 decreased by $9.0 million, or 0.6%, to $1.6 billion when compared to the claims incurred during the year ended December 31, 2009. This decrease is principally due to the termination of the Medicaid contracts effective September 30, 2010 offset in part by increased claims in the managed care segment s Commercial business as a result of higher volume. The consolidated loss ratio decreased by 1.9 percentage points to 84.0%, mostly as the result of lower MLRs in the managed care segment s Commercial and Medicare businesses.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2010 increased by $25.6 million, or 9.2%, to $305.0 million as compared to the operating expenses during the year ended December 31, 2009. The consolidated operating expense ratio increased by 1.1 percentage points, to 15.7%, primarily attributed to higher costs associated to the implementation of a new information system in the managed care segment, intangible asset amortization, and the effect of the lower volume of business in the managed care segment after the termination of the Medicaid contracts.

Income tax expense

Consolidated income tax expense during the year ended December 31, 2010 increased by $2.5 million to $17.4 million as compared to the income tax expense during the year ended December 31, 2009. The effective tax rate increased by 2.9 percentage points to 20.7% primarily due to the use of tax credits during the 2009 period and a higher taxable income in the managed care segment, which operates at a higher effective tax rate.

Table of Contents

Year ended December 31, 2009 compared with the year ended December 31, 2008

Operating Revenues

Consolidated premiums earned, net increased by $176.7 million, or 10.4%, to $1.87 billion during the year ended December 31, 2009 compared to the year ended December 31, 2008. The increase was primarily due to an increase in the premiums earned, net in our managed care segment, primarily from growth in Commercial member months enrollment, reflecting, in large part, the La Cruz Azul de Puerto Rico, Inc. (LCA) transaction, as well as higher premium rates across all businesses.

The increase in the administrative service fees of the managed care segment of $29.4 million in the 2009 period is attributed to a higher self-insured member months enrollment. Increase is mostly due to the fact that TSS was granted the contract for the Reform s Metro-North region, which began on November 2008 on an ASO basis and added approximately 190,000 members to our enrollment, as well as new members enrolled in our Commercial business principally as the result of the aforementioned LCA transaction.

Consolidated net investment income decreased by $4.1 million, or 7.3%, to $52.1 million during the year ended December 31, 2009. This decrease is attributed to a lower yield in investments acquired during the period.

Net Realized Investment Gains

Consolidated net realized investment gains of $0.6 million during the year ended December 31, 2009 are the result of net realized gains from the sale of fixed income and equity securities amounting to $7.7 million. The net realized gains were offset in part by $7.1 million of other-than-temporary impairments related to fixed income and equity securities.

Net Unrealized Gains on Trading Securities and Other Income, Net

The combined balance of our consolidated net unrealized gain on trading securities and other income, net increased by $35.4 million, to $11.8 million during the year ended December 31, 2009. This increase is attributable to an increase in the fair value of our trading securities portfolio and in the derivative component of our investment in structured notes linked to the Euro Stoxx 50 and Nikkei 225 stock indexes; both fluctuations are due to general market fluctuations. The unrealized gain experienced on our trading portfolio represents a combined increase of 29.0% in the market value of the portfolio, which compares favorably with the changes experienced by the comparable indexes; the Standard and Poor s 500 Index increased by 23.5% and the Russell 1000 Growth increased by 34.8%.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2009 increased by $174.0 million, or 12.2%, to $1.61 billion when compared to the claims incurred during the year ended December 31, 2008. This increase is principally due to increased claims in the managed care segment as a result of higher enrollment and MLR. The consolidated loss ratio increased by 1.3 percentage points to 85.9%, primarily due to higher utilization trends in the managed care segment and the effect of reserve developments, offset by the risk score premium adjustment in the Medicare business.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2009 increased by $27.5 million, or 10.9%, to $279.4 million as compared to the operating expenses during the year ended December 31, 2008. This increase is primarily attributed to a higher volume of business, particularly in our managed care segment as a result of the Metro-North region which began in November 2008, the LCA transaction and the increased volume in the Medicare and Commercial businesses. In addition, an accrual for litigation expense of approximately $7.5 million was recorded during the 2009 period, partially offset by the effect in this period of $3.6 million related to the settlement of an insurance recovery of legal expenses. The consolidated operating expense ratio decreased by 0.1 percentage points to 14.5%.

Table of Contents

Income tax expense

Consolidated income tax expense during the year ended December 31, 2009 increased by $7.8 million to $14.9 million as compared to the income tax expense during the year ended December 31, 2008. The effective tax rate decreased by 4.5 percentage points to 17.8% primarily due to the use of tax credits during the 2009 period, the increase in the weight of exempt income as compared to the taxable income and a higher taxable income in the Life segment, which is taxed at a lower rate.

Managed Care Operating Results

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico: Commercial, Medicare (including Medicare Advantage and PDP) and Medicaid up to September 30, 2010. For the year ended December 31, 2010, the Commercial sector represented 49.8% and 5.6% of our consolidated premiums earned, net and operating income, respectively. Premiums earned, net and operating income generated from our Medicare contracts (including PDP) during the year ended December 31, 2010 represented 24.6% and 45.2%, respectively, of our consolidated earned premiums, net and operating income, respectively. During the same period the Medicaid sector represented 15.0% and 21.6%, of our consolidated premiums earned, net and our operating income, respectively.

(Dollar amounts in millions)	**2010**	**2009**	**2008**
Operating revenues:			
Medical premiums earned, net:			
Commercial	$ 947.1	$ 822.1	$ 734.2
Medicare	468.4	506.9	435.6
Medicaid	284.8	348.1	340.1
Medical premiums earned, net	1,700.3	1,677.1	1,509.9
Administrative service fees	43.2	51.3	22.5
Net investment income	19.8	21.6	23.1
Total operating revenues	1,763.3	1,750.0	1,555.5
Medical operating costs:			
Medical claims incurred	1,497.8	1,508.2	1,342.3
Medical operating expenses	201.7	184.6	160.6
Total medical operating costs	1,699.5	1,692.8	1,502.9
Medical operating income	$ 63.8	$ 57.2	$ 52.6
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	5,982,094	5,421,586	4,947,854
Self-funded	2,966,291	2,726,036	2,049,140
Total Commercial member months	8,948,385	8,147,622	6,996,994
Medicaid:			
Fully-insured	3,078,288	4,016,332	4,101,905
Self-funded	1,782,426	2,321,144	376,975

Total Medicaid member months	4,860,714	6,337,476	4,478,880
Medicare:			
Medicare Advantange	670,250	742,666	727,274
Stand-alone PDP	112,297	117,700	127,658
Total Medicare member months	782,547	860,366	854,932
Total member months	14,591,646	15,345,464	12,330,806
Medical loss ratio	88.1%	89.9%	88.9%
Operating expense ratio	11.6%	10.7%	10.5%

Table of Contents

Year ended December 31, 2010 compared with the year ended December 31, 2009

Medical Operating Revenues

Medical premiums earned for the year ended December 31, 2010 increased by $23.1 million, or 1.4%, to $1.7 billion when compared to the medical premiums earned during the year ended December 31, 2009. This increase is principally the result of the following:

Medical premiums generated by the Commercial business increased by $125.0 million, or 15.2%, to $947.1 million. This fluctuation is primarily the result of an increase in member months enrollment of 560,508, or 10.3%, and higher average premium rates per member of approximately 4.4%. Increase in member months was mainly attributed to the La Cruz Azul acquisition and organic growth, mostly in large accounts. Premium rate increases were consistent with claims trends.

Medicare premiums decreased by $38.5 million, or 7.6%, to $468.4 million, primarily due to a lower member months enrollment of approximately 77,800 or 9.0%, mostly in our dual eligible product, particularly during the first half of the year and resulting from changes in our product offering. In addition, the premiums for the year ended December 31, 2010 reflect a lower final risk score adjustment as compared to 2009. The 2010 and 2009 periods include the net effect of approximately $3.0 million and $8.7 million in adjustments related to CMS final risk score adjustment corresponding to prior periods. These fluctuations were partially offset by higher average premium rates, mostly due to higher risk scores in our dual-eligible product.

Medical premiums earned in the Medicaid business decreased by $63.3 million, or 18.2%, to $284.8 million during the year ended December 31, 2010. This fluctuation results from the termination of the Medicaid contracts effective September 30, 2010. Total Medicaid enrollment as of September 30, 2010 was 544,448 members. This decrease is offset in part by an increase in premiums of $11.7 million as the result of a clean up of accounts receivable and the reversal of allowances for unresolved reconciling items with the government of Puerto Rico.

Administrative service fees decreased by $8.1 million, to $43.2 million during the 2010 period, mainly due to a decrease in self-funded member months enrollment of 298,463 members. Such decrease results from the net effect of the termination of the Medicaid contract effective September 30, 2010 and an increase in the Commercial ASO member months enrollment resulting from the LCA acquisition on July 1, 2009 and organic growth.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2010 decreased by $10.4 million, or 0.7%, to $1.5 billion, when compared to the year ended December 31, 2009. The MLR of the segment decreased by 1.8 percentage points during the 2010 period, to 88.1%. These fluctuations are primarily attributed to the effect of the following:

The medical claims incurred of the Commercial business increased by $106.9 million during the 2010 period and its MLR decreased by 0.7 percentage points. The increase in claims relates primarily to the increase in member month enrollment during this year. The lower MLR is primarily due to lower utilization trends in 2010 and stable pricing environment.

The medical claims incurred of the Medicare business decreased by $52.6 million during the 2010 period primarily due to the lower member months enrollment. The MLR for the year was 83.9%, 4.1 percentage points lower than 2009. Adjusting the MLR for changes in prior period reserve developments and risk score premium adjustments, the 2010 MLR would have decreased by 2.7 percentage points as compared to the adjusted MLR for 2009. The lower adjusted MLR is primarily the result of the new risk sharing agreement with our providers in the dual-eligible product, changes in benefits and higher average premium rates.

The medical claims incurred of the Reform business decreased by $64.7 million and its MLR decreased by 2.3 percentage points during the year ended December 31, 2010. Excluding the effect of prior period reserve developments and premium adjustments, the MLR would have increased 1.3 percentage points, mostly

resulting from a lower premium yield due to the extension of prior year s Medicaid contracts without premium rate increases until September 2010.

Table of Contents

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2010 increased by $17.1 million, or 9.3%, to $201.7 million when compared to the year ended December 31, 2009. The increase in the operating expenses is mainly due to the segment s higher volume in the Commercial business, as well as to the costs related to the implementation of a new information system and a higher amortization of intangibles. The operating expense ratio increased by 0.9 percentage points, from 10.7% in 2009 to 11.6% in 2010. The higher operating expense ratio is primarily the result of expenses related to the implementation of the segment s new IT system, including information systems consultants and depreciation and amortization expense, which increased by approximately $6.2 million. The higher operating expense ratio was also attributed to the effect of the termination of the Medicaid contracts. In addition, the operating expenses were affected by an increase of $1.4 million related to a new product launched during January 2010 and higher charges and amortization expense related to the intangible assets recorded after the LCA acquisition by approximately $2.3 million. In the 2009 period a contingent property tax accrual of approximately $7.5 million was recorded, offset in part by the effect of $3.6 million related to the settlement of an insurance recovery receivable of legal expenses. This contingent property tax accrual was approximately $2.1 million higher than the actual payment made during the 2010 period.

Year ended December 31, 2009 compared with the year ended December 31, 2008

Medical Operating Revenues

Medical premiums earned for the year ended December 31, 2009 increased by $167.2 million, or 11.1%, to $1.68 billion when compared to the medical premiums earned during the year ended December 31, 2008. This increase is principally the result of the following:

Medical premiums generated by the Commercial business increased by $87.9 million, or 12.0%, to $822.1 million during the year ended December 31, 2009. This fluctuation is primarily the result of an increase in member months enrollment of 473,732, or 9.6%, and higher average premium rates per member of approximately 2.9%. Increase in member months was mainly attributed to new members acquired from LCA effective July 1, 2009, which represented 49.1% of the increase in member months enrollment during this period, and to new groups acquired during the period.

Medical premiums generated by the Medicare business increased during the year ended December 31, 2009 by $71.3 million, or 16.4%, to $506.9 million, primarily due to higher average premium rates by approximately 11% and an increase in member months enrollment of 5,434 or 0.6%. The fluctuation in member months is the net result of an increase of 15,392, or 2.1%, in the membership of our Medicare Advantage products and a decrease of 9,958, or 7.8%, in the membership of our PDP product. In addition, the premiums for the year ended December 31, 2009 include the net effect of approximately $8.7 million in adjustments related to CMS final risk score adjustment for 2008. The premiums for the year ended December 31, 2008 include the net effect of approximately $1.4 million related to CMS final risk score adjustments for 2007.

Medical premiums earned in the Medicaid business increased by $8.0 million, or 2.4%, to $348.1 million during the year ended December 31, 2009. This fluctuation is due to an increase in premium rates, effective July 1, 2008, of approximately 10%, offset in part by a lower member months enrollment in the Reform s fully-insured membership by 85,573, or 2.1% and premium adjustments of approximately $8.3 million to provide for unresolved reconciling items with the government of Puerto Rico.

Administrative service fees increased by $28.8 million, to $51.3 million during the 2009 period, mainly due to an increase in self-funded member months enrollment of 2,621,065. Such increase is mainly the result of the contract obtained to administer the Reform s Metro-North region, which began on an ASO basis on November 1, 2008, new ASO Commercial contracts effective January 1, 2009, as well as the ASO members from the contracts acquired from LCA. In addition, as the result of the savings achieved in the Metro-North region, during 2009 we recognized a performance incentive of approximately $6.0 million. Total ASO member months enrollment for the Metro-North region and LCA for the year ended December 31, 2009 totaled 2,321,144 and 469,530, respectively.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2009 increased by $165.9 million, or 12.4%, to $1.51 billion, when compared to the year ended December 31, 2008. The MLR of the segment increased by 1.0

Table of Contents

percentage points during the 2009 period, to 89.9%. These fluctuations are primarily attributed to the effect of the following:

The medical claims incurred of the Commercial business increased by $99.3 million during the 2009 period and its MLR increased by 2.8 percentage points during the year ended December 31, 2009. The increase in claims was partially attributed to the increase in members. The increase in the MLR is primarily due to the effect of prior period reserve developments in the 2009 and 2008 periods and higher utilization trends. Excluding the effect of prior period reserve developments, the MLR increased by 1.6 percentage points. This variance in the MLR is due to a higher than expected claims experience in the local government employees policy, mainly in the utilization of pharmacy and in-patient benefits, and the effect of the AH1N1 flu of approximately $4.4 million, or 0.5 percentage points.

The medical claims incurred of the Medicare business increased by $55.3 million during the 2009 period primarily due to the higher member months enrollment of this business. The MLR for the year ended December 31, 2009 was 88.1%, 1.6 percentage points lower than 2008. The reduction in MLR is attributed to the effect of risk score premium adjustments recorded during this period, as well as premium rate increases and lower utilization trends. Excluding the effect of prior period reserve developments in the 2009 and 2008 periods, as well as premium adjustments, the MLR decreased by 4.7 percentage points, mostly due to the effect of lower medical costs resulting from an improvement in utilization trends and premium rate increases effective January 1, 2009.

The medical claims incurred of the Reform business increased by $11.3 million and its MLR increased by 1.2 percentage points during the year ended December 31, 2009. The increase in MLR is primarily due to reserve development in the 2009 and 2008 periods and the effect of the premium adjustments to provide for unresolved reconciling items with the government of Puerto Rico. Such increase is also a result of the extension during 2009 of the current Reform contracts to all the participating insurance companies without the re-negotiation of premium rates. In addition, during 2008 we recognized a retroactive adjustment due to a reduction in capitation rates. Excluding the effect of these items in the 2009 and 2008 periods the MLR increased by 1.9 percentage points.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2009 increased by $24.0 million, or 14.9%, to $184.6 million when compared to the year ended December 31, 2008. This increase is mainly due to the higher volume of business of the segment, associated to the higher member months enrollment, as well as to the operating costs related to the administration of the Metro-North region and the acquisition and administration of the LCA customers. In addition, an accrual for litigation expense of approximately $7.5 million was recorded during the 2009 period, partially offset by the effect in this period of $3.6 million related to the settlement of an insurance recovery of legal expenses. The segment s operating expenses ratio increased by 0.2 percentage points, from 10.5% in 2008 to 10.7% in 2009.

Table of Contents

Life Insurance Operating Results

(Dollar amounts in millions)	**2010**	**2009**	**2008**
Years ended December 31,			
Operating revenues:			
Premiums earned, net			
Premiums earned, net	$ 111.4	$ 106.2	$ 100.1
Premiums earned ceded	(5.6)	(6.1)	(7.6)
Net premiums earned	105.8	100.1	92.5
Commission income on reinsurance			0.3
Premiums earned, net	105.8	100.1	92.8
Net investment income	17.1	16.8	16.5
Total operating revenues	122.9	116.9	109.3
Operating costs:			
Policy benefits and claims incurred	49.8	50.3	47.4
Underwriting and other expenses	55.8	52.0	49.4
Total operating costs	105.6	102.3	96.8
Operating income	$ 17.3	$ 14.6	$ 12.5
Additional data:			
Loss ratio	47.1%	50.2%	51.1%
Expense ratio	52.7%	51.9%	53.2%

Year ended December 31, 2010 compared with the year ended December 31, 2009

Operating Revenues

Premiums earned, net for the segment increased by $5.7 million, or 5.7%, to $105.8 million during the year ended December 31, 2010 as compared to the year ended December 31, 2009, primarily as the result of higher sales in the Cancer and Individual Life lines of business during the period.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred during the year ended December 31, 2010 decreased by $0.5 million, or 1.0%, to $49.8 million during the year ended December 31, 2010. This fluctuation is primarily the result of a reduction in the change in the liability for future policy benefits when compared to 2009, resulting from a change in the mix of business subscribed by the segment. As a result of the reduction in policy benefits, the loss ratio improved by 3.1 percentage points, to 47.1% during the year ended December 31, 2010.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $3.8 million, or 7.3%, to $55.8 million during the year ended December 31, 2010 primarily the result of a higher amortization of deferred policy acquisition costs and the higher volume of business of this segment. The segment s operating expense ratio increased by 0.8 percentage points, to 52.7% during the 2010 period.

Year ended December 31, 2009 compared with the year ended December 31, 2008

Operating Revenues

Premiums earned, net for the segment increased by $7.3 million, or 7.9%, to $100.1 million during the year ended December 31, 2009 as compared to the year ended December 31, 2008, primarily as the result of higher sales in the Cancer and Home Service lines of business during the period, offset in part by a lower sales in the Group Life and Disability business.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred during the year ended December 31, 2009 increased by $2.9 million, or 6.1%, to $50.3 million during the year ended December 31, 2009. This fluctuation is primarily the result of the

Table of Contents

segments increased volume in the Cancer and Home Service lines of business and a higher amount of claims incurred in the Ordinary Life business, partially offset by a lower volume and claims experience in the Group Life line of business. The segment also experienced an increase in the change of the liability for future policy benefits. The segment s loss ratio decreased by 0.9 percentage points, to 50.2% during the year ended December 31, 2009.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $2.6 million, or 5.3%, to $52.0 million during the year ended December 31, 2009 primarily the result of the higher volume of business of this segment. The segment s operating expense ratio decreased by 1.3 percentage points, to 51.9% during the 2009 period.

Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	**2010**	**2009**	**2008**
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$159.2	$163.3	$168.0
Premiums ceded	(63.7)	(67.5)	(72.1)
Change in unearned premiums	3.7	0.4	(2.1)
Premiums earned, net	99.2	96.2	93.8
Net investment income	10.1	11.7	12.5
Total operating revenues	109.3	107.9	106.3
Operating costs:			
Claims incurred	49.2	47.3	42.1
Underwriting and other operating expenses	56.5	51.8	51.1
Total operating costs	105.7	99.1	93.2
Operating income	$ 3.6	$ 8.8	$ 13.1
Additional data:			
Loss ratio	49.6%	49.2%	44.9%
Expense ratio	57.0%	53.8%	54.5%

Year ended December 31, 2010 compared with the year ended December 31, 2009

Operating Revenues

Total premiums written during the year ended December 31, 2010 decreased by $4.1 million, or 2.5%, to $159.2 million, mostly in its commercial multi-peril product. The commercial business continues under soft market conditions, thus reducing premiums and increasing competition for renewals and new business. Also, economic conditions affected the construction activity affecting the volume of related insurance premiums.

Premiums ceded to reinsurers during the year ended December 31, 2010 decreased by approximately $3.8 million, or 5.6%, to $63.7 million. The ratio of premiums ceded to premiums written decreased by 1.3 percentage points, to 40.0% in 2010. This fluctuation was the result of the a reduction of reinsurance cessions in quota share contracts for commercial and personal property insurance risks of 3.0% and 2.2%, respectively.

The change in unearned premiums presented an increase of $3.3 million, to $3.7 million during the year ended December 31, 2010, primarily as the result of the lower volume of premiums written.

Claims Incurred

Claims incurred during the year ended December 31, 2010 increased by $1.9 million, or 4.0%, to $49.2 million. The loss ratio increased by 0.4 percentage points, to 49.6% during the year ended December 31, 2010, primarily due to an unfavorable loss experience in the Commercial Multi-peril, General Liability, and Personal Auto insurance.

Table of Contents

Underwriting and Other Expenses

Underwriting and other operating expenses for the year ended December 31, 2010 increased by $4.7 million, or 9.1%, to $56.5 million. This increase is primarily due to a higher amortization of deferred acquisition costs as a result of lower premiums. The operating expense ratio increased by 3.2 percentage points during the same period, to 57.0% in 2010 due to the lower volume of business of the segment.

Year ended December 31, 2009 compared with the year ended December 31, 2008

Operating Revenues

Total premiums written during the year ended December 31, 2009 decreased by $4.7 million, or 2.8%, to $163.3 million. This fluctuation is primarily due to a decrease in premiums written in the Commercial Auto, Dwelling and Property Mono-line, Commercial Multi-peril and Builder s Risk lines of business insurance policies of approximately $10.0 million, offset in part by increases in the General Liability and Personal Auto lines of business. The commercial business continues under soft market conditions, thus reducing premiums and increasing competition for renewals and new business. Also, the lower activity in auto and mortgage loan originations and in construction, due to the economic slowdown, has affected the volume in the market.

Premiums ceded to reinsurers during the year ended December 31, 2009 decreased by approximately $4.6 million, or 6.4%, to $67.5 million. The ratio of premiums ceded to premiums written decreased by 1.6 percentage points, to 41.3% in 2009. This fluctuation was the result of the a reduction of reinsurance cessions in quota share contracts for commercial and personal property insurance risks of 5.0% and 7.2%, respectively. This decrease is offset in part by the increase in the cost of non-proportional insurance treaties.

The change in unearned premiums presented an increase of $2.5 million, to $0.4 million during the year ended December 31, 2009, primarily as the result of the lower volume of premiums written.

Claims Incurred

Claims incurred during the year ended December 31, 2009 increased by $5.2 million, or 12.4%, to $47.3 million. The loss ratio increased by 4.3 percentage points, to 49.2% during the year ended December 31, 2009, primarily due to an unfavorable loss experience in the Commercial Multi-peril, Dwelling and Property Mono-line, and Personal Auto insurance.

Underwriting and Other Expenses

Underwriting and other operating expenses for the year ended December 31, 2009 increased by $0.7 million, or 1.4%, to $51.8 million. This increase is primarily due to an increase in net commissions due to lower reinsurance commissions received during the year. The operating expense ratio decreased by 0.7 percentage points during the same period, to 53.8% in 2009.

Table of Contents

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)	**2010**	**2009**	**2008**
Years ended December 31,			
Sources of cash:			
Net cash provided by operating activities	$ 37.7	$ 72.6	$
Proceeds from annuity contracts	10.7	4.3	8.0
Net proceeds from borrowings	40.6		
Other	0.2		18.3
Total sources of cash	89.2	76.9	26.3
Uses of cash:			
Net cash used in operating activities			(3.0)
Net purchases of investment securities	(23.7)	(17.3)	(178.6)
Capital expenditures	(19.2)	(18.7)	(22.4)
Payments of long-term borrowings	(26.4)	(1.6)	(1.6)
Surrenders of annuity contracts	(9.1)	(7.1)	(7.1)
Repurchase and retirement of common stock	(6.2)	(32.3)	(7.6)
Other		(5.6)	
Total uses of cash	(84.6)	(82.6)	(220.3)
Net increase (decrease) in cash and cash equivalents	$ 4.6	$ (5.7)	$(194.0)

Year ended December 31, 2010 compared to year ended December 31, 2009

Cash flows from operating activities decreased by $34.9 million during the year ended December 31, 2010 as compared to the year ended December 31, 2009, principally due to the increases claims paid and cash paid to suppliers and employees amounting to $23.7 million and $4.2 million, respectively, offset in part by the effect of increase in premiums collections by $12.3 million and lower income tax payments by $11.1 million. The increase in premiums collected is the result of a higher member months enrollment, mainly in the managed care segment s Commercial business offset in part by a higher amount in accounts receivable. The fluctuation in claims paid is primarily the result of the effect of the run-off of the Medicaid business and a higher volume in the Commercial business. The decrease in income tax payments results from the use of tax credits acquired during the year ended December 31, 2009.

Net acquisition of investment securities remained in line during the year ended December 31, 2010 when compared to the prior year.

Net proceeds from borrowings increased by $40.6 million during the year ended December 31, 2010. The increase in borrowings is the net result of proceeds from securities sold under agreements of repurchases amounting to $15.6 million and $25.0 million from a long-term repurchase agreement to partially repay a long-term borrowing. The higher repayments of long term borrowings amounting by $24.8 million results from the refinancing of $25.0 million of one of our senior unsecured notes with the long-term repurchase agreement to lower our overall interest expense.

Capital expenditures increased by $0.5 million as a result of the capitalization of costs related to the implementation of the new system in our managed care segment.

The net proceeds from policyholder deposits increased by $4.4 million during the year ended December 31, 2010 primarily due to deposits received during the period.

The increase in the other sources (uses) of cash of $5.8 million is attributed to changes in the amount of outstanding checks over bank balances in the 2010 period.

Table of Contents

On September 29, 2010 we announced the immediate commencement of a $30.0 million share repurchase program. We paid approximately $5.6 million under the stock repurchase program during the year ended December 31, 2010. During the year ended December 31, 2009 we paid approximately $32.3 million under the $40.0 million stock repurchase program that began in December 2008.

Year ended December 31, 2009 compared to year ended December 31, 2008

Cash flows from operating activities increased by $75.6 million for the year ended December 31, 2009 as compared to the year ended December 31, 2008, principally due to the effect of increase in premiums collections by $248.8 million, offset in part by increases claims paid and cash paid to suppliers and employees amounting of $127.8 million and $43.8 million, respectively. The increase in premiums collected is the result of a higher member months enrollment, mainly in the Medicare and Commercial businesses, particularly after the acquisition by TSS of LCA s membership. Also, the amount of premiums collected last year would have been higher when considering the $22.8 million of managed care premiums collected in December 2007 but corresponding to January 2008. The fluctuation in claims paid is primarily the result of the higher volume and increased utilization trends in our managed care segment, particularly in the Medicare and Commercial businesses.

Net acquisition of investment securities decreased by $161.3 million during the year ended December 31, 2009, principally as the result the effect of purchases of investments with trade date in December 2007 and a settlement date in January 2008, amounting to $117.5 million and cash used in financing activities.

The decrease in the other sources (uses) of cash of $23.9 million is attributed to changes in the amount of outstanding checks over bank balances in the 2009 period.

Capital expenditures increased by $3.7 million as a result of the capitalization of costs related to the implementation of the new system in our managed care segment.

The net proceeds from policyholder deposits decreased by $3.7 million during the year ended December 31, 2009 primarily due to the lower deposits received during the period.

On December 8, 2008 we announced the immediate commencement of a $40.0 million share repurchase program. We paid approximately $32.3 million under the stock repurchase program during the year ended December 31, 2009.

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, 2010, we had $215.0 million of available credit under these facilities. There were $15.6 millions outstanding short-term borrowing at December 31, 2010.

As of December 31, 2010, 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.

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 October 1, 2010 we repaid $25.0 million of the principal of these senior unsecured notes.

On September 30, 2004, TSS 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 and interest by us. The notes were privately placed to various institutional accredited investors.

Table of Contents

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 TSS. 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.

On November 1, 2010, we entered into a $25.0 million arrangement to sell securities under repurchase agreements that matures on November 2015. The repurchase agreement pays interest quarterly at 1.96%. The investment securities underlying such agreements were delivered to the financial institution with whom the agreement was transacted. The dealers may have loaned, or used as collateral such securities in the normal course of business operations. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on our consolidated balance sheet. At December 31, 2010 investment securities available for sale with fair value of $27.2 million (face value of $19.7 million) were pledged as collateral under this agreement. The proceeds obtained from this agreement were used to repay $25.0 million of the 6.6% notes.

The 6.3% notes, the 6.6% notes and the 6.7% notes contain certain non-financial covenants. At December 31, 2010, we and TSS, as applicable, understand are in compliance with these covenants.

In addition, as of December 31, 2010 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, 2010, this secured loan had an outstanding balance of $21.0 million and an average annual interest rate of 1.66%.

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 non-financial 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, 2010, we understand are in compliance with these covenants. Failure to meet these non-financial 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 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 the third quarter in 2011. Total external costs for the entire project are expected to amount approximately $55.0 million. Our managed care business expects to incur costs of approximately $15.9 million during 2011. We estimate that $2.2 million of the costs expected to be incurred in 2011 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:

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, 2010, we had $98.3 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, 2010, our policyholder deposits had a carrying amount of $49.9 million.

Table of Contents

Other long-term liabilities Due to the indeterminate nature of their cash outflows, $74.9 million of other long-term liabilities are not reflected in the following table, including $51.2 million of liability for pension benefits and $15.0 million in liabilities to the Federal Employees Health Benefits Plan Program.

		Contractual obligations by year					
(Dollar amounts in millions)	**Total**	**2011**	**2012**	**2013**	**2014**	**2015**	**Thereafter**
Short-term borrowings	$ 15.6	$ 15.6	$	$	$	$	$
Long-term borrowings (1)	266.8	11.7	12.1	12.3	12.5	38.8	179.4
Operating leases	36.0	7.5	7.8	7.9	8.1	1.8	2.9
Purchase obligations (2)	151.2	147.5	1.8	1.0	0.3	0.3	0.3
Claim liabilities (3)	328.8	238.2	59.2	9.8	10.4	3.5	7.7
Estimated obligation for future policy benefits (4)	954.8	75.6	64.0	60.1	56.7	53.9	644.5
	$1,753.2	$496.1	$144.9	$ 91.1	$ 88.0	$ 98.3	$ 834.8

(1) As of December 31, 2010, 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, a $25.0 million arrangement to sell securities under repurchase agreements which requires quarterly interest payments at 1.96%, 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 and the arrangement to sell securities under repurchase agreements, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity dates of the notes in 2019, 2020, 2021, and 2015 respectively. We may redeem the senior unsecured 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, 2010. The actual amount of interest payments of the loan payable will differ from the amount included in this schedule due to the loan s 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 $10.0 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, 2010. 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 $31.4 million of reserves had been ceded at December 31, 2010.

(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 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, 2010 and are gross of any

Table of Contents

reinsurance recoverable. The $954.8 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $236.5 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 and 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 (the Commissioner of Insurance 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. As of December 31, 2010, our insurance subsidiaries were in compliance with such minimum capital requirements.

Since 2009, local insurers and health organizations are required by the Insurance Code to submit to the Commissioner of Insurance Puerto Rico RBC reports following the NAIC s RBC Model Act and accordingly are subject to the relevant measures and actions as required based on their capital levels in relation to the determined risk based capital. In February 2010 Insurance Regulation No. 92 entered into effect establishing guidelines to implement the RBC requirements. Rule 92 provides for a gradual compliance and a five-year transition period, including dividend payment restriction and exemption to comply with requirements.

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 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, 2010, 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.

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 .

Table of Contents

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, 2010, 2009 and 2008, no assessment or payment was made in connection with insurance companies declared insolvent. 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 2010, 2009 and 2008, 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 2010, 2009 and 2008, the Association distributed the Company a dividend based on the good experience of the business amounting to $1.3 million, $1.2 million and $1.1 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 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.

Table of Contents

Claim Liabilities

Claim liabilities by segment as of December 31, 2010 were as follows:

(Dollar amounts in millions)

Managed care	$ 236.2
Life insurance	41.2
Property and casualty insurance	82.8
Consolidated	$ 360.2

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, 2010, claim liabilities for the managed care segment amounted to $236.2 million and represented 65.6% of our total consolidated claim liabilities and 20.7% of our total consolidated liabilities.

Claim liabilities 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 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 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

Table of Contents

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 which 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 earnings 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 incorporates 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, 2010 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

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)%	$ 8.7	(0.75)%	$ 9.4
(0.4)%	5.8	(0.50)%	6.3
(0.2)%	2.9	(0.25)%	3.2
0.2%	(2.9)	0.25%	(3.2)
0.4%	(5.7)	0.50%	(6.3)
0.6%	(8.6)	0.75%	(9.4)

(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 estimated. 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. Management has not noted any significant emerging trends in claim frequency and severity and the

normal fluctuations in enrollment and utilization trends from year to year.

Table of Contents

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 10 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	**2009**	**2008**	**2007**
Years ended December 31,			
Total incurred claims:			
As reported [1]	$ 1,512.1	$ 1,348.9	$ 1,156.8
On a retrospective basis	1,506.5	1,352.0	1,149.2
Variance	$ 5.6	$ (3.1)	$ 7.6
Variance to total incurred claims as reported	0.4%	-0.2%	0.7%

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

Management expects that substantially all of the development of the 2010 estimate of medical claims payable will be known during 2011 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, 2010, claim liabilities for the life insurance segment amounted to $41.2 million and represented 11.4% of total consolidated claim liabilities and 3.6% 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 monthly basis, in light of continually updated information. These reviews incorporate a variety of actuarial methods, judgments and analysis. We review reserves using 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 incurred 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 in the development of these estimates; however, in recent years our estimates have resulted in immaterial redundancies or deficiencies.

Table of Contents

Property and Casualty Insurance Segment

At December 31, 2010, claim liabilities for the property and casualty insurance segment amounted to $82.8 million and represented 23.0% of the total consolidated claim liabilities and 7.2% 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.

Claim reserve reviews are generally conducted on a quarterly basis, in light of continually updated information. Our actuary certifies 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, 2010, the actuarial reserve range determined by the actuaries was from $81 million to $91 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 $5.6 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 and active life reserves for accident and health products are computed by the net level premium method, using interest assumptions ranging from 5.0% to 5.4% and withdrawal, mortality, morbidity and maintenance expense assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health unpaid claim reserves are stated at amounts determined by estimates on individual claims and estimates of

Table of Contents

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, 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.

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 and deferred annuity 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 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 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. Management regularly monitors and evaluates the difference between the cost and estimated fair value of investments. For investments with a fair value below cost, the process includes evaluating: (1) the length of time and the extent to which the estimated fair value has been less than amortized cost for fixed maturity securities, or cost for equity securities, (2) the financial condition, near-term and long-term prospects for the issuer, including relevant industry conditions and trends, and implications of rating agency actions, (3) the Company s intent sell or the likelihood of a required sale prior to recovery, (4) the recoverability of principal and interest for fixed maturity securities, or cost for equity securities, and (5) other factors, as applicable. This process is not exact and further

requires consideration of risks such as credit and interest rate risks. Consequently, if an investment s cost exceeds its estimated fair value solely due to changes in interest rates, other-than temporary impairment may not be

Table of Contents

appropriate. Due to the subjective nature of our analysis, along with the judgment that must be applied in the analysis, it is possible that we could reach a different conclusion whether or not to impair a security if it had access to additional information about the investee. Additionally, it is possible that the investee s ability to meet future contractual obligations may be different than what we determined during its analysis, which may lead to a different impairment conclusion in future periods. If after monitoring and analyzing impaired securities, management determines that a decline in the estimated fair value of any available-for-sale or held-to-maturity security below cost is other than temporary, the carrying amount of the security is reduced to its fair value according to current accounting guidance. The new cost basis of an impaired security is not adjusted for subsequent increases in estimated fair value. In periods subsequent to the recognition of an other-than-temporary impairment, the impaired security is accounted for as if it had been purchased on the measurement date of the impairment. For debt securities, the discount (or reduced premium) based on the new cost basis may be accreted into net investment income in future periods based on prospective changes in cash flow estimates, to reflect adjustments to the effective yield.

Our process for identifying and reviewing invested assets for other-than temporary impairments during any quarter includes the following:

Identification and evaluation of securities that have possible indications of other-than-temporary impairment, which includes an analysis of all investments with gross unrealized investments losses that represent 20% or more of cost.

Review and evaluation of any other security based on the investee s current financial condition, liquidity, near-term recovery prospects, implications of rating agency actions, the outlook for the business sectors in which the investee operates and other factors. This evaluation is in addition to the evaluation of those securities with a gross unrealized investment loss representing 20% or more of cost.

Consideration of evidential matter, including an evaluation of factors or triggers that may or may not cause individual investments to qualify as having other-than-temporary impairments; and

Determination of the status of each analyzed security as other-than-temporary or not, with documentation of the rationale for the decision.

Management continues to review the investment portfolios under our impairment review policy. Given the current market conditions and the significant judgments involved, there is a continuing risk that further declines in fair value may occur and additional material other-than-temporary impairments may be recorded in future periods.

During the years ended December 31, 2010, 2009 and 2008 we recognized other-than-temporary impairments amounting to $3.0 million, $7.1 million and $16.5 million, respectively, on fixed income, equity securities and perpetual preferred stocks classified as available for sale. As of December 31, 2010, of the total amount of investments in securities of $1.1 billion, $51.1 million, or 4.6%, 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 $1.0 billion is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $873.1 million, or 83.2%, 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 remaining $175.8 million, or 16.8%, are from corporate fixed, equity securities and mutual funds. The net unrealized gain as of December 31, 2010 of the available-for-sale and held-to-maturity portfolios amounted to $39.4 million.

The impairment analysis as of December 31, 2010 indicated that, other than those securities for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was considered 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 and credit risk 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

Table of Contents

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, 2010 and 2009 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 $20.0 million and $25.2 million as of December 31, 2010 and 2009, 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 probable 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 April 2010, the FASB issued guidance to address the classification of an employee share-based payment award with an exercise price denominated in the currency of a market in which the underlying equity security trades. The guidance clarifies that a share-based payment award with an exercise price denominated in the currency of a market in which a substantial portion of the entity s equity securities trades should not be considered to contain a condition that is not a market, performance, or service condition. Therefore, such an award should not be classified as a liability if it otherwise qualifies as equity. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2010. We do not expect the adoption of this guidance to have an impact on our financial position or results of operations.

In October 2010, the FASB issued guidance to address diversity in practice regarding the interpretation of which costs relating to the acquisition of new or renewal insurance contracts qualify for deferral. This guidance specifies that the following costs incurred in the acquisition of new and renewal contracts should be capitalized: (1) Incremental direct costs of contract acquisition. Incremental direct costs are those costs that result directly from and are essential to the contract transaction and would not have been incurred by the insurance entity had the contract transaction not occurred. (2) Certain costs related directly to the following acquisition activities performed by the insurer for the contract: a. Underwriting, b. Policy issuance and processing, c. Medical and inspection, and d. Sales force contract selling. Advertising costs should be included in deferred acquisition costs only if the capitalization criteria in the direct-response advertising guidance in *Subtopic 340-20, Other Assets and Deferred Costs Capitalized Advertising Costs*, are met. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2011. The Company is currently evaluating the impact the adoption of this guidance will have on its financial position or results of operations.

In December 2010, the FASB issued guidance to modify Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is

Table of Contents

more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. This guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. We do not expect the adoption of this guidance to have a significant impact on our financial position or results of operations.

In December 2010, the FASB issued guidance to require a public entity to disclose pro forma information for business combinations that occurred in the current reporting period. The disclosures include pro forma revenue and earnings of the combined entity for the current reporting period as though the acquisition date for all business combinations that occurred during the year had been as of the beginning of the annual reporting period for all the periods presented. This guidance also expands the supplemental pro forma disclosures to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. This guidance is effective for business combinations for which the acquisition dates is on or after the beginning of the first annual reporting period beginning on or after December 15, 2010. We expect to adopt this guidance during 2011 as part of our disclosures related to our business combination.

There were no other new accounting pronouncements issued that had or are expected to have 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.

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 79.3% of the total portfolio value as of December 31, 2010, of which 33.3% 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, mutual funds, investments in local stocks from well-known financial institutions and investments in corporate bonds.

Table of Contents

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.

Risk Measurement

Trading Portfolio

Our trading securities are a source of market risk. As of December 31, 2010, 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, 2010 and 2009, the hypothetical loss in the fair value of these investments would have been approximately $5.1 million and $4.4 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, 2010 approximately 94.5% 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

Table of Contents

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, 2010 and 2009.

(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2010:			
Base Scenario	$ 991.6		
+100 bp	940.4	(51.2)	(5.2)%
+200 bp	886.1	(105.5)	(10.6)%
+300 bp	836.5	(155.1)	(15.6)%
December 31, 2009:			
Base Scenario	$ 935.5		
+100 bp	885.4	(50.1)	(5.4)%
+200 bp	836.2	(99.3)	(10.6)%
+300 bp	786.7	(148.8)	(15.9)%

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 98.4% 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, 2010 and 2009, the hypothetical loss in the fair value of these investments would have been approximately $5.7 million and $6.5 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 a hybrid instrument, including a derivative component, with a market value of approximately $10.6 million and $11.2 million as of December 31, 2010 and 2009 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 current accounting guidance 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, 2010 and 2009, the fair value of the derivative component of the structured notes amounted to $0.7 million and $1.6 million, 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, 2010 and

Table of Contents

2009, the hypothetical loss in the estimated fair value of the derivative component of the structured notes would have been approximately $0.1 million and $0.2 million, respectively. The investment component of the structured notes, which had a fair value of $9.9 million and $9.6 million as of December 31, 2010 and 2009, 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, 2010 and 2009 and for each of the three years ended December 31, 2010 see Index to financial statements in Item 15. Exhibits and Financial Statements Schedules to this Annual Report on Form 10-K.

Selected Quarterly Financial Data

For the selected unaudited quarterly financial data corresponding to the years 2010 and 2009, see note 30 of the audited consolidated financial statements as of December 31, 2010 and 2009 and for the three years ended December 31, 2010.

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

There have been no changes in or disagreements with our independent registered public accounting firm on accounting or financial disclosures.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

In connection with the preparation of this Annual Report on Form 10-K, management, under the supervision and with the participation of the chief executive officer and chief financial officer, conducted an evaluation of the effectiveness of our disclosure controls and procedures (as such term is defined under Exchange Act Rule 13a-15(e)). 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 chief financial officer have concluded that as of December 31, 2010, which is the end of the period covered by this Annual Report on Form 10-K, our disclosure controls and procedures are effective to a reasonable level of assurance.

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

Table of Contents

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:

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

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

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, under the supervision and with the participation of the chief executive officer and chief financial officer, assessed the effectiveness of the Company s internal control over financial reporting as of December 31, 2010 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 effective as of December 31, 2010 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company s consolidated financial statements for external reporting purposes in accordance with GAAP.

PricewaterhouseCoopers LLP, the Company s independent registered public accounting firm, has audited the consolidated financial statements of the Company as of and for the year ended December 31, 2010, and has also issued an opinion dated March 9, 2011, on the effectiveness of the Company s internal control over financial reporting as of December 31, 2010, which is included in this Annual Report on Form 10-K.

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, 2010 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The effectiveness of our internal control over financial reporting as of December 31, 2010 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which is included in this Annual Report on Form 10-K.

Item 9B. Other Information

None.

Table of Contents

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 information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2011 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 11. Executive Compensation

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2011 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2011 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2011 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 14. Principal Accountant Fees and Services

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2011 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 15. Exhibits and Financial Statements Schedules

Financial Statements and Schedules

Financial Statements	*Description*
F-1	Reports of Independent Registered Public Accounting Firms
F-2	Consolidated Balance Sheets as of December 31, 2010 and 2009
F-3	Consolidated Statements of Earnings for the years ended December 31, 2010, 2009 and 2008
F-4	Consolidated Statements of Stockholders Equity and Comprehensive Income for the years ended December 31, 2010, 2009 and 2008
F-5	Consolidated Statements of Cash Flows for the years ended December 31, 2010, 2009 and 2008
F-7	Notes to Consolidated Financial Statements December 31, 2010, 2009 and 2008

Table of Contents

Financial Statements

Schedules	*Description*	
S-1	Schedule II	Condensed Financial Information of the Registrant
S-2	Schedule III	Supplementary Insurance Information
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 of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3.1 to TSM s Current Report on Form 8-K filed on June 11, 2010 (File No. 001-33865)).
10.1	Extension to the agreement between the Puerto Rico Health Insurance Administration and TSS to act as third party administrator in the Metro-North Region until September 30, 2010 (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the quarter ended June 30, 2010 (File No. 001-33865)).
10.2	Extension to the agreement between the Puerto Rico Health Insurance Administration and TSS for the provision of health insurance coverage to eligible population in the North and South-West Regions until September 30, 2010 (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the quarter ended June 30, 2010 (File No. 001-33865)).
10.3	Amendment to the Medicare Platino Contract (Medicare Wraparound) between the Puerto Rico Health Insurance Administration and TSS for the provision of wraparound coverage to health insurance dual-eligible population until December 31, 2011 (incorporated herein by reference to Exhibit 10.4 to TSM s Quarterly Report on Form 10-Q for the quarter ended September 30, 2010 (File No. 001-33865)).
10.4	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)).
10.5	

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)).

Table of Contents

Exhibits	**Description**
10.6	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)).
10.7	Non-Contributory Retirement Program (incorporated herein by reference to Exhibit 10.8 to TSM s General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.8	Blue Shield License Agreement by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.11 to TSM s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.9	Blue Shield Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.12 to TSM s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.10	Blue Cross License Agreements by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.13 to TSM s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.11	Blue Cross Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.14 to TSM s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.12	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)).
10.13	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)).
10.14	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)).
10.15	TSM 2007 Incentive Plan, dated October 16, 2007 (incorporated herein by reference to Exhibit C to TSM s 2007 Proxy Statement (File No. 001-33865)).
10.16	Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS 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)).

Table of Contents

Exhibits	**Description**
10.17	Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (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)).
10.18	Addendum Number Two to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (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)).
10.19	Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (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)).
10.20	Work Order Agreement between Quality Care Solutions, Inc. and TSS (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)).
10.21	Employment Contract between Ramón M. Ruiz Comas and TSM (incorporated herein by reference to Exhibit 10.24 to TSM s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
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*	List of Subsidiaries of TSM.
23.1*	Consent of Independent Registered Public Accounting Firm (PricewaterhouseCoopers LLP).
23.2*	Consent of Independent Registered Public Accounting Firm (KPMG LLP).
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.
99.1*	Incentive Compensation Recoupment Policy

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 9, 2011

Ramón M. Ruiz-Comas
President and Chief Executive Officer

By: /s/ Juan J. Román Date: March 9, 2011

Juan J. Román
Vice President of Finance and Chief Financial Officer
Principal Accounting 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 9, 2011

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

By: /s/ Vicente J. León-Irizarry Date: March 9, 2011

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

By: /s/ Jesús R. Sánchez-Colón Date: March 9, 2011

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

By: /s/ Adamina Soto-Martínez Date: March 9, 2011

Adamina Soto-Martínez
Director

By: /s/ Carmen Ana Culpeper-Ramírez Date: March 9, 2011

Carmen Ana Culpeper-Ramírez
Director

Table of Contents

By: /s/ Jorge L. Fuentes-Benejam Date: March 9, 2011

Jorge L. Fuentes-Benejam
Director

By: /s/ Antonio F. Faría-Soto Date: March 9, 2011

Antonio F. Faría-Soto
Director

By: /s/ Manuel Figueroa-Collazo Date: March 9, 2011

Manuel Figueroa-Collazo
Director

By: /s/ José Hawayek-Alemañy Date: March 9, 2011

José Hawayek-Alemañy
Director

By: /s/ Jaime Morgan-Stubbe Date: March 9, 2011

Jaime Morgan-Stubbe
Director

By: /s/ Roberto Muñoz-Zayas Date: March 9, 2011

Roberto Muñoz-Zayas
Director

By: /s/ Juan E. Rodríguez-Díaz Date: March 9, 2011

Juan E. Rodríguez-Díaz
Director

Table of Contents

Triple-S Management Corporation
Consolidated Financial Statements
December 31, 2010, 2009, and 2008

Table of Contents

Table of Contents

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Triple-S Management Corporation

In our opinion, the consolidated balance sheets and the related consolidated financial statements of earnings, stockholders equity and comprehensive income, and cash flows present fairly, in all material respects, the financial position of Triple-S Management Corporation and its subsidiaries (the Company) at December 31, 2010 and 2009, and the results of their operations and their cash flows for each of the two years in the period ended December 31, 2010 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules as of and for the years ended December 31, 2010 and 2009 listed in the index appearing under Item 15 present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2010, based on criteria established in *Internal Control Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company s management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management s Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company s internal control over financial reporting based on our integrated 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 audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included 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, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting 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 audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

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 (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 financial statements.

Table of Contents

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ PricewaterhouseCoopers LLP
San Juan, Puerto Rico
March 9, 2010
CERTIFIED PUBLIC ACCOUNTANTS
(OF PUERTO RICO)
License No. 216 Expires Dec. 1, 2013
Stamp 2493533 of the P.R. Society of
Certified Public Accountants has been
affixed to the file copy of this report

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 statements of earnings, stockholders equity and comprehensive income, and cash flows of Triple-S Management Corporation and Subsidiaries (the Company) for the year 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 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 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 results of operations and the cash flows of Triple-S Management Corporation and Subsidiaries for the year ended December 31, 2008, in conformity with U.S. generally accepted accounting principles.

/s/ KPMG LLP
March 18, 2009
Stamp No. 2530990 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
Consolidated Balance Sheets
December 31, 2010 and 2009
(dollar amounts in thousands, except per share data)

	2010	2009
Assets		
Investments and cash		
Equity securities held for trading, at fair value (cost of $43,832 in 2010 and $42,075 in 2009)	$ 51,099	$ 43,909
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $947,957 in 2010 and $911,362 in 2009)	977,586	918,977
Equity securities (cost of $47,750 in 2010 and $61,531 in 2009)	56,739	64,689
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $15,424 in 2010 and $16,490 in 2009)	14,615	15,794
Policy loans	5,887	5,940
Cash and cash equivalents	45,021	40,376
Total investments and cash	1,150,947	1,089,685
Premium and other receivables, net	325,780	272,932
Deferred policy acquisition costs and value of business acquired	146,086	139,917
Property and equipment, net	76,745	68,803
Deferred tax asset	29,445	37,551
Other assets	30,367	39,816
Total assets	$ 1,759,370	$ 1,648,704
Liabilities and Stockholders Equity		
Claim liabilities	360,210	360,446
Liability for future policy benefits	236,523	222,619
Unearned premiums	98,341	108,342
Policyholder deposits	49,936	47,563
Liability to Federal Employees Health Benefits Program	15,018	13,002
Accounts payable and accrued liabilities	136,567	139,161
Deferred tax liability	12,655	11,088
Short term borrowings	15,575	
Long term borrowings	166,027	167,667
Liability for pension benefits	51,246	41,044
Total liabilities	1,142,098	1,110,932
Commitments and contingencies		
Stockholders equity		
Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 9,042,809 at December 31, 2010 and 2009	9,043	9,043
	19,773	20,110

Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 19,772,614 and 20,110,391 shares at December 31, 2010 and 2009, respectively		
Additional paid-in capital	155,299	159,303
Retained earnings	427,693	360,892
Accumulated other comprehensive income (loss), net	5,464	(11,576)
Total stockholders equity	617,272	537,772
Total liabilities and stockholders equity	$ 1,759,370	$ 1,648,704

The accompanying notes are an integral part of these financial statements.

Table of Contents

Triple-S Management Corporation
Consolidated Statements of Earnings
Years Ended December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010	2009	2008
Revenues			
Premiums earned, net	$ 1,901,100	$ 1,869,084	$ 1,692,344
Administrative service fees	39,546	48,643	19,187
Net investment income	49,145	52,136	56,253
Total operating revenues	1,989,791	1,969,863	1,767,784
Net realized investment gains (losses):			
Total other-than-temporary impairment losses on securities	(2,997)	(7,118)	(16,494)
Net realized gains, excluding other-than-temporary impairment losses on securities	5,529	7,732	2,554
Total net realized investment gains (losses)	2,532	614	(13,940)
Net unrealized investment gains (losses) on trading securities	5,433	10,497	(21,064)
Other income (expense), net	889	1,237	(2,467)
Total revenues	1,998,645	1,982,211	1,730,313
Benefits and expenses			
Claims incurred	1,596,789	1,605,872	1,431,801
Operating expenses	304,995	279,418	251,887
Total operating costs	1,901,784	1,885,290	1,683,688
Interest expense	12,658	13,270	14,681
Total benefits and expenses	1,914,442	1,898,560	1,698,369
Income before taxes	84,203	83,651	31,944
Income tax expense (benefit)			
Current	14,348	19,197	11,542
Deferred	3,054	(4,326)	(4,388)
Total income taxes	17,402	14,871	7,154
Net income	$ 66,801	$ 68,780	$ 24,790
Basic net income per share	$ 2.30	$ 2.33	$ 0.77
Diluted net income per share	$ 2.28	$ 2.33	$ 0.77

The accompanying notes are an integral part of these financial statements.

Table of Contents

Triple-S Management Corporation
Consolidated Statements of Earnings
Years Ended December 31, 2010, 2009 and 2008
(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, 2007	$ 16,043	$ 16,266	$ 188,935	$ 267,336	$ (6,042)	$ 482,538
Conversion of Class A common stock to Class B common stock	(7,000)	7,000				
Share-based compensation			3,268			3,268
Grant of restricted Class B common stock		20				20
Repurchase and retirement of common stock		(1,181)	(12,699)			(13,880)
Other				(14)		(14)
Comprehensive income						
Net income				24,790		24,790
Net unrealized change in fair value of available for sale securities					(3,952)	(3,952)
Defined benefit pension plan						
Prior service credit, net					(266)	(266)
Actuarial loss					(7,349)	(7,349)
Net change in fair value of cash flow hedges					(56)	(56)
Total comprehensive income						13,167
Balance, December 31, 2008	9,043	22,105	179,504	292,112	(17,665)	485,099
Share-based compensation			3,897			3,897
Grant of restricted Class B common stock		27				27
Repurchase and retirement of common stock		(2,022)	(24,098)			(26,120)
Comprehensive income						
Net income				68,780		68,780

Net unrealized change in fair value of available for sale securities					3,539	3,539
Defined benefit pension plan						
Prior service credit, net					(273)	(273)
Actuarial gain					2,823	2,823
Total comprehensive income						74,869
Balance, December 31, 2009	9,043	20,110	159,303	360,892	(11,576)	537,772
Share-based compensation			1,878			1,878
Grant of restricted Class B common stock		16				16
Repurchase and retirement of common stock		(353)	(5,882)			(6,235)
Comprehensive income						
Net income				66,801		66,801
Net unrealized change in fair value of available for sale securities					23,602	23,602
Defined benefit pension plan						
Prior service credit, net					(265)	(265)
Actuarial loss					(6,297)	(6,297)
Total comprehensive income						83,841
Balance, December 31, 2010	$ 9,043	$ 19,773	$ 155,299	$ 427,693	$ 5,464	$ 617,272

The accompanying notes are an integral part of these financial statements

Table of Contents

Triple-S Management Corporation
Consolidated Statements of Earnings
Years Ended December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010	2009	2008
Cash flows from operating activities			
Net income	$ 66,801	$ 68,780	$ 24,790
Adjustments to reconcile net income to net cash provided by (used in) operating activities			
Depreciation and amortization	15,500	9,643	7,367
Net amortization of investments	4,511	744	952
Provision (reversal of provision) for doubtful receivables	(5,200)	10,489	(1,180)
Deferred tax expense (benefit)	3,054	(4,326)	(4,388)
Net realized investment (gains) losses	(2,532)	(614)	13,940
Net unrealized (gains) losses on trading securities	(5,433)	(10,497)	21,064
Share-based compensation	1,894	3,924	3,268
Proceeds from trading securities sold			
Equity securities	4,871	4,240	24,640
Acquisition of securities in trading portfolio			
Equity securities	(6,506)	(6,132)	(10,737)
Gain on sale of property and equipment (Increase) decrease in assets	6		11
Premium and other receivables, net	(47,648)	(46,263)	(32,210)
Deferred policy acquisition costs and value of business acquired	(6,169)	(13,570)	(9,108)
Other deferred taxes	6,658	900	(8,337)
Other assets	5,223	(1,593)	(933)
Increase (decrease) in liabilities			
Claim liabilities	(236)	36,736	(30,120)
Liability for future policy benefits	13,904	15,074	13,414
Unearned premiums	(10,001)	(1,799)	(22,458)
Policyholder deposits	733	1,665	1,902
Liability to FEHBP	2,016	1,845	(10,181)
Accounts payable and accrued liabilities	(3,790)	3,339	15,322
Net cash provided by (used in) operating activities	37,656	72,585	(2,982)

The accompanying notes are an integral part of these financial statements

Table of Contents

Triple-S Management Corporation
Consolidated Statements of Earnings
Years Ended December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010	2009	2008
Cash flows from investing activities			
Proceeds from investments sold or matured			
Securities available for sale			
Fixed maturities sold	$ 121,968	$ 241,368	$ 228,436
Fixed maturities matured	175,483	189,144	91,732
Equity securities sold	41,802	9,877	4,450
Securities held to maturity			
Fixed maturities matured	2,587	7,819	22,875
Acquisition of investments			
Securities available for sale			
Fixed maturities	(337,569)	(459,705)	(505,896)
Equity securities	(26,957)	(3,684)	(19,636)
Securities held to maturity			
Fixed maturities	(1,050)	(1,502)	(554)
Net (disbursements) repayment for policy loans	53	(489)	30
Capital expenditures	(19,222)	(18,706)	(22,411)
Net cash used in investing activities	(42,905)	(35,878)	(200,974)
Cash flows from financing activities			
Repurchase and retirement of common stock	(6,235)	(32,355)	(7,645)
Change in outstanding checks in excess of bank balances	281	(5,645)	18,353
Repayments of long-term borrowings	(26,367)	(1,640)	(1,639)
Net proceeds from short-term borrowings	15,575		
Proceeds from long-term borrowings	25,000		
Proceeds from annuity contracts	10,691	4,307	8,018
Surrenders of annuity contracts	(9,051)	(7,093)	(7,195)
Other			6
Net cash provided by (used in) financing activities	9,894	(42,426)	9,898
Net increase (decrease) in cash and cash equivalents	4,645	(5,719)	(194,058)
Cash and cash equivalents			
Beginning of year	40,376	46,095	240,153
End of year	$ 45,021	$ 40,376	$ 46,095

The accompanying notes are an integral part of these financial statements

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

1. Nature of Business

Triple-S Management Corporation (the Company or TSM) was incorporated under the laws of the Commonwealth of Puerto Rico on January 17, 1997 to engage, among other things, as the holding company of entities primarily involved in the insurance industry.

The Company has the following wholly owned subsidiaries that are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance): (1) Triple-S Salud, Inc. (TSS) a managed care organization that provides health benefits services to subscribers through contracts with hospitals, physicians, dentists, laboratories, and other organizations; (2) Triple-S Vida, Inc. (TSV), which is engaged in the underwriting of life and accident and health insurance policies and the administration of annuity contracts; and (3) Triple-S Propiedad, Inc. (TSP), which is engaged in the underwriting of property and casualty insurance policies. The Company and TSS are members of the Blue Cross and Blue Shield Association (BCBSA). The Company also has two other wholly owned subsidiaries, Interactive Systems, Inc. (ISI) and Triple-C, Inc. (TC). ISI is mainly engaged in providing data processing services to the Company and its subsidiaries. TC is mainly engaged as a third-party administrator for TSS in the administration of the Commonwealth of Puerto Rico Health Insurance Plan (Similar to Medicaid)(Medicaid) business. Also, TC provides healthcare advisory services to TSS and other health insurance-related services to the health insurance industry.

The contract with the Commonwealth of Puerto Rico (the government of Puerto Rico) that allowed us to provide services to Medicaid enrollees, expired by its own terms on September 30, 2010, thus effective October 1st, 2010 we no longer provide services to these enrollees. As a result, TC will cease to exist during 2011.

A substantial majority of the Company s business activity is with insurers located throughout Puerto Rico, and as such, the Company is subject to the risks associated with the Puerto Rico economy.

2. Significant Accounting Policies

The following are the significant accounting policies followed by the Company and its subsidiaries:

Basis of Presentation

The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP).

The consolidated financial statements include the financial statements of the Company and its subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

Use of Estimates

The preparation of the consolidated financial statements in conformity with GAAP requires the Company to make a number of estimates and assumptions relating to the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates. The most significant items on the consolidated balance sheets that involve a greater degree of accounting estimates and actuarial determinations subject to changes in the near future are the assessment of other-than-temporary

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

impairments, allowance for doubtful receivables, deferred policy acquisition costs and value of business acquired, claim liabilities, the liability for future policy benefits, and liability for pension benefits. As additional information becomes available (or actual amounts are determinable), the recorded estimates are revised and reflected in operating results of the period they are determined. Although some variability is inherent in these estimates, the Company believes the amounts provided are adequate.

Reclassifications

Certain amounts in the 2009 and 2008 consolidated financial statements were reclassified to conform to the 2010 presentation.

Cash Equivalents

The Company considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents. Cash equivalents of $626 and $920 at December 31, 2010 and 2009, respectively, consist principally of obligations of government-sponsored enterprises and certificates of deposit with an initial term of less than three months.

Investments

Investment in securities at December 31, 2010 and 2009 consists mainly of obligations of government-sponsored enterprises, U.S. Treasury securities and obligations of U.S. government instrumentalities, obligations of the Commonwealth of Puerto Rico and its instrumentalities, municipal securities, obligations of states of the United States and political subdivisions of the states, corporate bonds, mortgage-backed securities, collateralized mortgage obligations, and equity securities. The Company classifies its debt and equity securities in one of three categories: trading, available for sale, or held to maturity. Trading securities are bought and held principally for the purpose of selling them in the near term. Securities classified as held to maturity are those securities in which the Company has the ability and intent to hold the security until maturity. All other securities not included in trading or held to maturity are classified as available for sale.

Trading and available-for-sale securities are recorded at fair value. The fair values of debt securities (both available for sale and held to maturity investments) and equity securities are based on quoted market prices for those or similar investments at the reporting date. Held-to-maturity debt securities are recorded at amortized cost, adjusted for the amortization or accretion of premiums and discounts, respectively. Unrealized holding gains and losses on trading securities are included in earnings. Unrealized holding gains and losses, net of the related tax effect, on available-for-sale securities are excluded from earnings and are reported as a separate component of other comprehensive income until realized. Realized gains and losses from the sale of available-for-sale securities are included in earnings and are determined on a specific-identification basis.

Transfers of securities between categories are recorded at fair value at the date of transfer. Unrealized holding gains and losses are recognized in earnings for transfers into trading securities. Unrealized holding gains or losses associated with transfers of securities from held to maturity to available for sale are recorded as a separate component of other comprehensive income. The unrealized holding gains or losses included in the separate component of other comprehensive income for securities transferred from available for sale to held to maturity, are maintained and amortized into earnings over the remaining life of the security as an adjustment to yield in a manner consistent with the amortization or accretion of premium or discount on the associated security.

If a fixed maturity security is in an unrealized loss position and the Company has the intent to sell the fixed maturity security, or it is more likely than not that the Company will have to sell the fixed

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is recorded to other-than-temporary impairment losses recognized in earnings in the Company s consolidated statements of earnings. For impaired fixed maturity securities that the Company does not intend to sell or it is more likely than not that such securities will not have to be sold, but the Company expects not to fully recover the amortized cost basis, the credit component of the other-than temporary impairment is recognized in other-than-temporary impairment losses recognized in earnings in the Company s consolidated statements of earnings and the non-credit component of the other-than-temporary impairment is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an other-than-temporary impairment is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting the Company s best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition.

The unrealized gains or losses on the Company s equity securities classified as available-for-sale are included in accumulated other comprehensive income as a separate component of stockholders equity, unless the decline in value is deemed to be other-than-temporary and the Company does not have the intent and ability to hold such equity securities until their full cost can be recovered, in which case such equity securities are written down to fair value and the loss is charged to other-than-temporary impairment losses recognized in earnings.

A decline in the fair value of any available-for-sale or held-to-maturity security below cost that is deemed to be other-than-temporary results in an impairment to reduce the carrying amount to fair value. The impairment is charged to earnings and a new cost basis for the security is established. To determine whether an impairment is other-than-temporary, the Company considers whether it has the ability and intent to hold the investment until a market price recovery and considers whether evidence indicating the cost of the investment is recoverable outweighs evidence to the contrary. Evidence considered in this assessment includes the reasons for the impairment, the severity and duration of the impairment, market conditions, changes in value subsequent to year-end, forecasted performance of the investee, and the general market condition in the geographic area or industry the investee operates in.

Premiums and discounts are amortized or accreted over the life of the related held-to-maturity or available-for-sale security as an adjustment to yield using the effective interest method. Dividend and interest income are recognized when earned.

The Company regularly invests in mortgaged-backed securities and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount for mortgaged-backed securities is based on historical experience and estimates of future payment speeds on the underlying mortgage loans. Actual prepayment speeds will differ from original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Revenue Recognition

a. Managed Care

Subscriber premiums on the managed care business are billed in advance of their respective coverage period. Managed care premiums are billed in the month prior to the effective date of the policy with a grace period of up to two months. If the insured fails to pay, the policy can be canceled at the end of the grace period at the option of the Company. Managed care premiums are reported as earned when due.

Premiums for the Medicare Advantage (MA) business are based on a bid contract with the Centers for Medicare and Medicaid Services (CMS) and billed in advance of the coverage period. MA contracts provide for a risk factor to adjust premiums paid for members that represent a higher or lower risk to the Company. Retroactive rate adjustments are made periodically based on the aggregate health status and risk scores of the Company s MA membership. These risk adjustments are evaluated quarterly based on actuarial estimates. Actual results could differ from these estimates. As additional information becomes available, the recorded estimate is revised and reflected in operating results.

TSS offers prescription drug coverage to Medicare eligible beneficiaries as part of its MA plans (MA-PD) and on a stand-alone basis (stand-alone PDP). Premiums are based on a bid contract with CMS that considers the estimated costs of providing prescription drug benefits to enrolled participants. MA-PD and stand-alone PDP premiums are subject to adjustment, positive or negative, based upon the application of risk corridors that compare the estimated prescription drug costs included in the bids to CMS to actual prescription drug costs. Variances exceeding certain thresholds may result in CMS making additional payments to the TSS or in TSS refunding CMS a portion of the premiums collected. TSS estimates and records adjustments to earned premiums related to estimated risk corridor payments based upon actual prescription drug costs for each reporting period as if the annual contract were to end at the end of each reporting period.

Administrative service fees include revenue from certain groups which has managed care contracts that provide for the group to be at risk for all or a portion of their claims experience. For these groups, the Company is not at risk and only handles the administration of the insurance coverage for an administrative service fee. The Company pays claims under self-funded arrangements from its own funds, and subsequently receives reimbursement from these groups. Claims paid under self-funded arrangements are excluded from the claims incurred in the accompanying consolidated financial statements. Administrative service fees under the self-funded arrangements are recognized based on the group s membership or incurred claims for the period multiplied by an administrative fee rate plus other fees. In addition, some of these self-funded groups purchase aggregate and/or specific stop-loss coverage. In exchange for a premium, the group s aggregate liability or the group s liability on any one episode of care is capped for the year. Premiums for the stop-loss coverage are actuarially determined based on experience and other factors and are recorded as earned over the period of the contract in proportion to the coverage provided. This fully insured portion of premiums is included within the premiums earned, net in the accompanying consolidated statements of earnings. The Medicaid contract with the Government of Puerto Rico contained a savings-sharing provision whereby the Government of Puerto Rico shares with TSS a portion of the medical cost savings obtained with the administration of the region served on an administrative service basis. Any savings-sharing amount is recorded when

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

earned as administrative service fees in the accompanying consolidated statements of earnings.

b. Life and Accident and Health Insurance

Premiums on life insurance policies are billed in advance of their respective coverage period and the related revenue is recorded as earned when due. Premiums on accident and health and other short-term policies are recognized as earned primarily on a pro rata basis over the contract period. Premiums on credit life policies are recognized as earned in proportion to the amounts of insurance in-force. Revenues from universal life and interest sensitive policies represent amounts assessed against policyholders, including mortality charges, surrender charges actually paid, and earned policy service fees. The revenues for limited payment contracts are recognized over the period that benefits are provided rather than on collection of premiums.

c. Property and Casualty Insurance

Premiums on property and casualty contracts are billed in advance of their respective coverage period and they are recognized as earned on a pro rata basis over the policy term. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheets as unearned premiums and is transferred to premium revenue as earned.

Allowance for Doubtful Receivables

The allowance for doubtful receivables is based on management s evaluation of the aging of accounts and such other factors, which deserve current recognition. Actual results could differ from these estimates. Receivables are charged against their respective allowance accounts when deemed to be uncollectible.

Deferred Policy Acquisition Costs and Value of Business Acquired

Certain direct costs for acquiring life and accident and health, and property and casualty insurance business are deferred by the Company. Substantially all acquisition costs related to the managed care business are expensed as incurred.

In the life and accident and health business deferred acquisition costs consist of commissions and certain expenses related to the production of life, annuity, accident and health, and credit business. In the event that future premiums, in combination with policyholder reserves and anticipated investment income, could not provide for all future maintenance and settlement expenses, the amount of deferred policy acquisition costs would be reduced to provide for such amount. The related amortization is provided over the anticipated premium-paying period of the related policies in proportion to the ratio of annual premium revenue to expected total premium revenue to be received over the life of the policies. Interest is considered in the amortization of deferred policy acquisition cost and value of business acquired. For these contracts interest is considered at a level rate at the time of issue of each contract, 5.4% for 2010 and 2009, and, in the case of the value of business acquired, at the time of any acquisition. For certain other long-duration contracts, deferred amounts are amortized at historical and forecasted credited interest rates. Expected premium revenue is estimated by using the same mortality and withdrawal assumptions used in computing liabilities for future policy benefits. The method followed in computing deferred policy acquisition costs limits the amount of such deferred costs to their estimated net realizable value. In determining estimated net realizable value, the computations give effect to the premiums to be earned, related investment income, losses and loss-adjustment expenses, and certain other

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

costs expected to be incurred as the premium is earned. Costs deferred on universal life and interest sensitive products are amortized as a level percentage of the present value of anticipated gross profits from investment yields, mortality, expenses and surrender charges. Estimates used are based on the Company s experience as adjusted to provide for possible adverse deviations. These estimates are periodically reviewed and compared with actual experience. When it is determined that future expected experience differs significantly from that assumed, the estimates are revised for current and future issues.

The value assigned to the insurance in-force of TSV at the date of the acquisition is amortized using methods similar to those used to amortize the deferred policy acquisition costs of the life and accident and health business. In the 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.

Property and Equipment

Property and equipment are stated at cost. Maintenance and repairs are expensed as incurred. Depreciation is calculated on the straight-line method over the estimated useful lives of the assets. Costs of computer equipment, programs, systems, installations, and enhancements are capitalized and amortized straight-line over their estimated useful lives. The following is a summary of the estimated useful lives of the Company s property and equipment:

Asset Category	Estimated Useful Life
Buildings	20 to 50 years
Building improvements	3 to 5 years
Leasehold improvements	Shorter of estimated useful life or lease term
Office furniture	5 years
Computer software	3 to 10 years
Computer equipment, equipment, and automobiles	3 years

Software Development Costs

Costs related to software developed or obtained for internal use that is incurred in the preliminary project stage are expensed as incurred. Once capitalization criteria are met, directly attributable development costs are capitalized and amortized over the expected useful life of the software. Upgrade and maintenance costs are expensed as incurred. During the year ended December 31, 2010 and 2009 the Company capitalized approximately $11,647 and $10,993 associated with the implementation of new software.

Long-Lived Assets

Long-lived assets, such as property and equipment, and purchased intangible assets subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

disposed of would be separately presented in the balance sheets and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposal group classified as held for sale would be presented separately in the appropriate asset and liability sections of the consolidated balance sheets.

Goodwill and intangible assets that have indefinite useful lives are tested annually for impairment, and are tested for impairment more frequently if events and circumstances indicate that the asset might be impaired. An impairment loss is recognized to the extent that the carrying amount exceeds the asset s fair value. For goodwill, the impairment determination is made at the reporting unit level and consists of two steps. First, the Company determines the fair value of a reporting unit and compares it to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit s goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation. The residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

Claim Liabilities

Claim liabilities for managed care policies represent the estimated amounts to be paid to providers based on experience and accumulated statistical data. Loss-adjustment expenses related to such claims are currently accrued based on estimated future expenses necessary to process such claims.

TSS contracts with various independent practice associations (IPAs) for certain medical care services provided to some policies subscribers. The IPAs are compensated on a capitation basis. In the Medicaid business and one of the MA policies, TSS retains a portion of the capitation payments to provide for incurred but not reported losses. At December 31, 2010 and 2009, total withholdings and capitation payable amounted to $22,428 and $25,568, respectively, which are recorded as part of the claim liabilities in the accompanying consolidated balance sheets.

Claim liabilities include unpaid claims and loss-adjustment expenses of the life and accident and health business based on a case-basis estimate for reported claims, and on estimates, based on experience, for unreported claims and loss-adjustment expenses. The liability for policy and contract claims and claims expenses has been established to cover the estimated net cost of insured claims.

Also included within the claim liabilities is the liability for losses and loss-adjustment expenses for the property and casualty business which represents individual case estimates for reported claims and estimates for unreported losses, net of any salvage and subrogation based on past experience modified for current trends and estimates of expenses for investigating and settling claims.

Claim liabilities are necessarily based on estimates and, while management believes that the amounts are adequate, the ultimate liability may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed, and any adjustments are reflected in the consolidated statements of earnings in the period determined.

Future Policy Benefits

The liability for future policy benefits has been computed using the level-premium method based on estimated future investment yield, mortality, morbidity and withdrawal experience. The interest rate assumption ranges between 5.0% and 5.40% for all years in issue. Mortality has been calculated

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

principally on select and ultimate tables in common usage in the industry. Withdrawals have been determined principally based on industry tables, modified by Company s experience.

Policyholder Deposits

Amounts received for annuity contracts are considered deposits and recorded as a liability along with the accrued interest and reduced for charges and withdrawals. Interest incurred on such deposits, which amounted to $1,688, $1,665, and $1,902, during the years ended December 31, 2010, 2009, and 2008, respectively, is recorded as interest expense in the accompanying consolidated statements of earnings.

Reinsurance

In the normal course of business, the insurance-related subsidiaries seek to limit their exposure that may arise from catastrophes or other events that cause unfavorable underwriting results by reinsuring certain levels of risk in various areas of exposure with other insurance enterprises or reinsurers.

Reinsurance premiums, commissions, and expense reimbursements, related to reinsured business are accounted for on bases consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Accordingly, reinsurance premiums are reported as prepaid reinsurance premiums and amortized over the remaining contract period in proportion to the amount of insurance protection provided.

Premiums ceded and recoveries of losses and loss-adjustment expenses have been reported as a reduction of premiums earned and losses and loss-adjustment expenses incurred, respectively. Commission and expense allowances received by TSP in connection with reinsurance ceded have been accounted for as a reduction of the related policy acquisition costs and are deferred and amortized accordingly. Amounts recoverable from reinsurers are estimated in a manner consistent with the claim liability associated with the reinsured policy.

Derivative Instruments and Hedging Activities

The Company recognizes all derivative instruments, including certain derivative instruments embedded in other contracts, whether or not designated in hedging relationships, as either assets or liabilities in the balance sheet at their respective fair values. Changes in the fair value of derivative instruments are recorded in earnings, unless specific hedge accounting criteria are met in which case the change in fair value of the instrument is recorded within other comprehensive income for cash flow hedges.

On the date the derivative contract designated as a hedging instrument is entered into, the Company designates the instrument as either a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment (fair-value hedge), a hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability (cash-flow hedge), a foreign currency fair-value or cash-flow hedge (foreign-currency hedge), or a hedge of a net investment in a foreign operation. For all hedging relationships the Company formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the hedged item, the nature of the risk being hedged, how the hedging instrument s effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking all derivatives that are designated as fair-value, cash-flow, or foreign-currency hedges to specific assets and liabilities on the balance sheet or to specific firm commitments or forecasted transactions. The Company also formally assesses, both at the hedge s inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

offsetting changes in fair values or cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a fair-value hedge, along with the loss or gain on the hedged asset or liability or unrecognized firm commitment of the hedged item that is attributable to the hedged risk, are recorded in earnings. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in other comprehensive income to the extent that the derivative is effective as hedge, until earnings are affected by the variability in cash flows of the designated hedged item. Changes in the fair value of derivatives that are highly effective as hedges and that are designated and qualify as foreign-currency hedges are recorded in either earnings or other comprehensive income, depending on whether the hedge transaction is a fair-value hedge or a cash-flow hedge. However, if a derivative is used as a hedge of a net investment in a foreign operation, its changes in fair value, to the extent effective as a hedge, are recorded in the cumulative translation adjustments account within other comprehensive income. The ineffective portion of the change in fair value of a derivative instrument that qualifies as either a fair-value hedge or a cash-flow hedge is reported in earnings. Changes in the fair value of derivative trading instruments are reported in current period earnings.

The Company discontinues hedge accounting prospectively when it is determined that the derivative is no longer effective in offsetting changes in the fair value or cash flows of the hedged item, the derivative expires or is sold, terminated, or exercised, the derivative is de-designated as a hedging instrument, because it is unlikely that a forecasted transaction will occur, a hedged firm commitment no longer meets the definition of a firm commitment, or management determines that designation of the derivative as a hedging instrument is no longer appropriate.

In all situations in which hedge accounting is discontinued and the derivative is retained, the Company continues to carry the derivative at its fair value on the balance sheet and recognizes any subsequent changes in its fair value in earnings. When hedge accounting is discontinued because it is determined that the derivative no longer qualifies as an effective fair-value hedge, the Company no longer adjusts the hedged asset or liability for changes in fair value. The adjustment of the carrying amount of the hedged asset or liability is accounted for in the same manner as other components of the carrying amount of that asset or liability. When hedge accounting is discontinued because the hedged item no longer meets the definition of a firm commitment, the Company removes any asset or liability that was recorded pursuant to recognition of the firm commitment from the balance sheet, and recognizes any gain or loss in earnings. When it is probable that a forecasted transaction will not occur, the Company discontinues hedge accounting if not already done and recognizes immediately in earnings gains and losses that were accumulated in other comprehensive income.

Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the consolidated statements of earnings in the period that includes the enactment date. The Company recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

The Company records any interest and penalties related to unrecognized tax benefits within the operating expenses in the consolidated statement of earnings.

Insurance-Related Assessments

The Company records a liability for insurance-related assessments when the following three conditions are met: (1) the assessment has been imposed or the information available prior to the issuance of the financial statements indicates it is probable that an assessment will be imposed; (2) the event obligating an entity to pay (underlying cause of) an imposed or probable assessment has occurred on or before the date of the financial statements; and (3) the amount of the assessment can be reasonably estimated. A related asset is recognized when the paid or accrued assessment is recoverable through either premium taxes or policy surcharges.

Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, and penalties and other sources are recorded when it is probable that a liability has been incurred and the amount of the assessment and/or remediation can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred. Recoveries of costs from third parties, which are probable of realization, are separately recorded as assets, and are not offset against the related liability.

Share-Based Compensation

Share-based compensation is measured at the fair value of the award and recognized as an expense in the financial statements over the vesting period. The Company recognizes compensation expense for its stock options based on estimated grant date fair value using the Black-Scholes option-pricing model.

Earnings Per Share

Basic earnings per share excludes dilution and is computed by dividing net income available to all classes of common stockholders by the weighted average number of all classes of common shares outstanding for the period, excluding non-vested restricted stocks. Diluted earnings per share is computed in the same manner as basic earnings per share except that the number of shares is increased to include the number of additional common shares that would have been outstanding if the potentially dilutive common shares had been issued. Dilutive common shares are included in the diluted earnings per share calculation using the treasury stock method.

Fair Value

The fair value information of financial instruments in the accompanying consolidated financial statements was determined as follows:

a. Cash and Cash Equivalents

The carrying amount approximates fair value because of the short-term nature of such instruments.

b. Investment in Securities

The fair value of investment securities is estimated based on quoted market prices for those or similar investments. Additional information pertinent to the estimated fair value of investment in securities is included in note 3 and note 9.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

c. Policy Loans

Policy loans have no stated maturity dates and are part of the related insurance contract. The carrying amount of policy loans approximates fair value because their interest rate is reset periodically in accordance with current market rates.

d. Receivables, Accounts Payable, and Accrued Liabilities

The carrying amount of receivables, accounts payable, and accrued liabilities approximates fair value because they mature and should be collected or paid within 12 months after December 31.

e. Policyholder Deposits

The fair value of policyholder deposits is the amount payable on demand at the reporting date, and accordingly, the carrying value amount approximates fair value.

f. Short-term Borrowings

The carrying amount of securities sold under agreements to repurchase approximates fair value due to its short-term nature.

g. Long-term Borrowings

The carrying amounts and fair value of the Company s long-term borrowings are as follows:

	2010		2009	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Loans payable to bank	21,027	21,027	22,667	22,667
6.3% senior unsecured notes payable	50,000	49,625	50,000	48,000
6.6% senior unsecured notes payable	35,000	34,388	60,000	57,420
6.7% senior unsecured notes payable	35,000	35,000	35,000	33,320
1.96% repurchase agreement	25,000	24,575		
	$ 166,027	$ 164,615	$ 167,667	$ 161,407

The carrying amount of the loans payable to bank approximates fair value due to its floating interest-rate structure. The fair value of the senior unsecured notes payable and the repurchase agreement was determined using market quotations. Additional information pertinent to borrowings is included in Note 13.

h. Derivative Instruments

Current market pricing models were used to estimate fair value of structured notes agreements. Fair values were determined using market quotations provided by outside securities consultants or prices provided by market makers. Additional information pertinent to the estimated fair value of derivative instruments is included in note 14.

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Recently Issued Accounting Standards

In April 2010, the FASB issued guidance to address the classification of an employee share-based payment award with an exercise price denominated in the currency of a market in which the underlying equity security trades. The guidance clarifies that a share-based payment award with an exercise price denominated in the currency of a market in which a substantial portion of the entity s equity securities trades should not be considered to contain a condition that is not a market, performance, or service condition. Therefore, such an award should not be classified as a liability if it otherwise qualifies as equity. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2010. We do not expect the adoption of this guidance to have an impact on our financial position or results of operations.

In October 2010, the FASB issued guidance to address diversity in practice regarding the interpretation of which costs relating to the acquisition of new or renewal insurance contracts qualify for deferral. This guidance specifies that the following costs incurred in the acquisition of new and renewal contracts should be capitalized:

(1) Incremental direct costs of contract acquisition. Incremental direct costs are those costs that result directly from and are essential to the contract transaction and would not have been incurred by the insurance entity had the contract transaction not occurred. (2) Certain costs related directly to the following acquisition activities performed by the insurer for the contract: a. Underwriting, b. Policy issuance and processing, c. Medical and inspection, and d. Sales force contract selling. Advertising costs should be included in deferred acquisition costs only if the capitalization criteria in the direct-response advertising guidance in *Subtopic 340-20, Other Assets and Deferred Costs Capitalized Advertising Costs*, are met. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2011. The Company is currently evaluating the impact the adoption of this guidance will have on its financial position or results of operations.

In December 2010, the FASB issued guidance to modify Step 1 of the goodwill impairment test for reporting units with zero or negative carrying amounts. For those reporting units, an entity is required to perform Step 2 of the goodwill impairment test if it is more likely than not that a goodwill impairment exists. In determining whether it is more likely than not that a goodwill impairment exists, an entity should consider whether there are any adverse qualitative factors indicating that an impairment may exist. This guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. We do not expect the adoption of this guidance to have a significant impact on our financial position or results of operations.

In December 2010, the FASB issued guidance to require a public entity to disclose pro forma information for business combinations that occurred in the current reporting period. The disclosures include pro forma revenue and earnings of the combined entity for the current reporting period as though the acquisition date for all business combinations that occurred during the year had been as of the beginning of the annual reporting period for all the periods presented. This guidance also expands the supplemental pro forma disclosures to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. This guidance is effective for business combinations for which the acquisition dates is on or after the beginning of the first annual reporting period beginning on or after December 15, 2010. We expect to adopt this guidance during 2011 as part of our disclosures related to our business combination. Additional information pertinent to the business combination is included in note 28.

There were no other new accounting pronouncements issued that had or are expected to have a material impact on our financial position, operating results or disclosures.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

3. Investment in Securities

The amortized cost for debt and equity securities, gross unrealized gains, gross unrealized losses, and estimated fair value for trading, available-for-sale, and held-to-maturity securities by major security type and class of security at December 31, 2010 and 2009 were as follows:

	2010			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Trading securities				
Equity securities	$ 43,832	$ 10,738	$ (3,471)	$ 51,099

	2009			
	Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Trading securities				
Equity securities	$ 42,075	$ 7,064	$ (5,230)	$ 43,909

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities available for sale				
Fixed maturities				
Obligations of government-sponsored enterprises	$ 124,735	$ 6,650	$	$ 131,385
U.S. Treasury securities and obligations of U.S. government instrumentalities	47,427	5,451		52,878
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	117,519	3,115	(10)	120,624
Municipal securities	272,383	3,979	(2,798)	273,564
Corporate bonds	102,184	7,698	(250)	109,632
Residential mortgage-backed securities	12,560	801	(1)	13,360
Collateralized mortgage obligations	271,149	6,158	(1,164)	276,143
Total fixed maturities	947,957	33,852	(4,223)	977,586
Equity securities				
Common stocks	901	3,430		4,331
Preferred stocks	4,298	68	(737)	3,629
Perpetual preferred stocks	1,000		(94)	906
Mutual funds	41,551	6,632	(310)	47,873
Total equity securities	47,750	10,130	(1,141)	56,739
Total	$ 995,707	$ 43,982	$ (5,364)	$ 1,034,325

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2009			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities available for sale				
Fixed maturities				
Obligations of government-sponsored enterprises	$ 252,513	$ 2,240	$ (3,325)	$ 251,428
U.S. Treasury securities and obligations of U.S. government instrumentalities	48,190	3,148		51,338
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	154,754	3,113	(1,919)	155,948
Municipal securities	107,441	1,117	(1,851)	106,707
Corporate bonds	102,547	3,546	(728)	105,365
Residential mortgage-backed securities	16,605	677	(1)	17,281
Collateralized mortgage obligations	229,312	4,237	(2,639)	230,910
Total fixed maturities	911,362	18,078	(10,463)	918,977
Equity securities				
Common stocks	4,074	3,435		7,509
Preferred stocks	4,000		(1,325)	2,675
Perpetual preferred stocks	2,849		(270)	2,579
Mutual funds	50,608	4,150	(2,832)	51,926
Total equity securities	61,531	7,585	(4,427)	64,689
Total	$ 972,893	$ 25,663	$ (14,890)	$ 983,666

	2010			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities held to maturity				
Obligations of government-sponsored enterprises	$ 1,793	$ 151	$	$ 1,944
U.S. Treasury securities and obligations of U.S. government instrumentalties	1,478	203		1,681
Corporate bonds	9,443	414		9,857
Residential mortgage-backed securities	660	41		701
Certificates of deposits	1,241			1,241
	$ 14,615	$ 809	$	15,424

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2009			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities held to maturity				
Obligations of government-sponsored enterprises	$ 925	$ 6	$	$ 931
U.S. Treasury securities and obligations of U.S. government instrumentalties	3,786	132		3,918
Corporate bonds	9,063	534		9,597
Residential mortgage-backed securities	1,256	25	(1)	1,280
Certificates of deposits	764			764
	$ 15,794	$ 697	$ (1)	16,490

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, 2010 and 2009 were as follows:

	2010								
	Less than 12 months			12 months or longer			Total		
	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities
Securites available for sale									
Fixed maturities									
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	$ 2,483	$ (10)	5	$	$		$ 2,483	$ (10)	5
Municipal securities	105,280	(2,652)	53	692	(146)	1	105,972	(2,798)	54
Corporate bonds	5,828	(250)	3				5,828	(250)	3
Residential mortgage-backed securities				36	(1)	1	36	(1)	1
Collateralized mortgage obligations	77,417	(1,144)	12	1,953	(20)	1	79,370	(1,164)	13
Total fixed maturities	191,008	(4,056)	73	2,681	(167)	3	193,689	(4,223)	76

Equity securities									
Preferred stocks				3,263	(737)	1	3,263	(737)	1
Perpetual preferred stocks				906	(94)	1	906	(94)	1
Mutual funds	2,337	(310)	2				2,337	(310)	2
Total equity securities	2,337	(310)	2	4,169	(831)	2	6,506	(1,141)	4
Total for securities available for sale	$ 193,345	$ (4,366)	75	$ 6,850	$ (998)	5	$ 200,195	$ (5,364)	80

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2009								
	Less than 12 months			12 months or longer			Total		
	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities
Securites available for sale									
Fixed maturities									
Obligations of government-sponsored enterprises	$ 110,602	$ (2,264)	21	$ 25,468	$ (1,061)	5	$ 136,070	$ (3,325)	26
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	12,944	(201)	10	58,866	(1,718)	22	71,810	(1,919)	32
Municipal securities	62,292	(1,841)	39	173	(10)	1	62,465	(1,851)	40
Corporate bonds	10,997	(215)	4	7,975	(513)	6	18,972	(728)	10
Residential mortgage-backed securities				36	(1)	1	36	(1)	1
Collateralized mortgage obligations	101,265	(1,732)	21	7,171	(907)	10	108,436	(2,639)	31
Total fixed maturities	298,100	(6,253)	95	99,689	(4,210)	45	397,789	(10,463)	140
Equity securities									
Preferred stocks				2,675	(1,325)	1	2,675	(1,325)	1
Perpetual preferred stocks				730	(270)	1	730	(270)	1
Mutual funds	9,994	(907)	4	21,667	(1,925)	15	31,661	(2,832)	19
Total equity securities	9,994	(907)	4	25,072	(3,520)	17	35,066	(4,427)	21
Total for securities available for sale	$ 308,094	$ (7,160)	99	$ 124,761	$ (7,730)	62	$ 432,855	$ (14,890)	161
Securities held to maturity									

Residential mortgage-backed securities	$ 55	$ (1)	1	$ 55	$ (1)	1		

The Company regularly monitors and evaluates the difference between the cost and estimated fair value of investments. For investments with a fair value below cost, the process includes evaluating: (1) the length of time and the extent to which the estimated fair value has been less than amortized cost for fixed maturity securities, or cost for equity securities, (2) the financial condition, near-term and long-term prospects for the issuer, including relevant industry conditions and trends, and implications of rating agency actions, (3) the Company s intent to sell or the likelihood of a required sale prior to recovery, (4) the recoverability of principal and interest for fixed maturity securities, or cost for equity securities, and (5) other factors, as applicable. This process is not exact and further requires consideration of risks such as credit and interest rate risks. Consequently, if an investment s cost exceeds its estimated fair value solely due to changes in interest rates, other-than temporary impairment may not be appropriate. Due to the subjective nature of the Company s analysis, along with the judgment that must be applied in the analysis, it is possible that the Company could reach a different conclusion whether or not to impair a security if it had access to additional information about the investee. Additionally, it is possible that the investee s ability to meet future contractual obligations may be different than what the Company determined during its analysis, which may lead to a different impairment conclusion in future periods. If after monitoring and analyzing impaired securities, the Company determines that a decline in the estimated fair value of any available-for-sale or held-to-maturity security below cost is other-than-temporary, the carrying amount of the security is reduced to its fair value in accordance with current accounting guidance. The new cost basis of an impaired security is not adjusted for subsequent increases in estimated fair value. In periods subsequent to the recognition of an other-than-temporary impairment, the impaired security is accounted for as if it had been purchased on the measurement date of the impairment. For debt securities, the discount (or reduced premium) based on the new cost basis may be accreted into net investment income in future periods based on prospective changes in cash flow estimates, to reflect adjustments to the effective yield.

The Company s process for identifying and reviewing invested assets for other-than temporary impairments during any quarter includes the following:

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Identification and evaluation of securities that have possible indications of other-than- temporary impairment, which includes an analysis of all investments with gross unrealized investments losses that represent 20% or more of their cost and all investments with an unrealized loss greater than $50.

Review and evaluation of any other security based on the investee s current financial condition, liquidity, near-term recovery prospects, implications of rating agency actions, the outlook for the business sectors in which the investee operates and other factors. This evaluation is in addition to the evaluation of those securities with a gross unrealized investment loss representing 20% or more of cost.

Consideration of evidential matter, including an evaluation of factors or triggers that may or may not cause individual investments to qualify as having other-than-temporary impairments; and

Determination of the status of each analyzed security as other-than-temporary or not, with documentation of the rationale for the decision.

The Company continues to review the investment portfolios under the Company s impairment review policy. Given the current market conditions and the significant judgments involved, there is a continuing risk that further declines in fair value may occur and additional material other-than-temporary impairments may be recorded in future periods.

Obligations of States of the United States and Political Subdivisions of the States, and Obligations of the Commonwealth of Puerto Rico and its Instrumentalities: The unrealized losses on the Company s investments in obligations of states of the United States and political subdivisions of the states, and in obligations of the Commonwealth of Puerto Rico and its instrumentalities were mainly caused by fluctuations in interest rate and general market conditions. The contractual terms of these investments do not permit the issuer to settle the securities at a price less than the par value of the investment. In addition, most of these investments have investment grade ratings. Because the decline in fair value is attributable to changes in interest rates and not credit quality; because the Company does not intend to sell the investments and it is not more likely than not that the Company will be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Company expects to collect all contractual cash flows, these investments are not considered other-than-temporarily impaired.

Corporate Bonds: The unrealized losses of these bonds were principally caused by fluctuations in interest rates and general market conditions. All corporate bonds included in this table have investment grade ratings and have been in an unrealized position for less than three months. Because the decline in estimated fair value is principally attributable to changes in interest rate; the Company does not intend to sell the investments and its is not more likely than not that the Company will be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Company expects to collect all contractual cash flows, these investments are not considered other-than-temporarily impaired.

Residential Mortgage-Backed Securities and Collateralized Mortgage Obligations: The unrealized losses on investments in residential mortgage-backed securities and collateralized mortgage obligations (CMO s) were caused by fluctuations in interest rates. The contractual cash flows of these securities, other than private CMOs, are guaranteed by a U.S. government-sponsored enterprise. The Company also has investments in private CMOs with amortized cost amounting to

$5,785 and $7,608 in 2010 and 2009, respectively (fair value of $6,106 and $6,701, respectively). Any loss in these securities is determined according to the seniority level of each tranche, with the

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

least senior (or most junior), typically the unrated residual tranche, taking any initial loss. The investment grade credit rating of our securities reflects the seniority of the securities that the Company owns. Because the decline in fair value is attributable to changes in interest rates and not credit quality; the Company does not intend to sell the investments and it is not more likely than not that the Company will be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Company expects to collect all contractual cash flows, these investments are not considered other-than-temporarily impaired.

Preferred Stocks: Because the estimated fair value of this investment has experienced a significant improvement in market value during the past year, the issuer s capital ratios are above regulatory levels, this particular instrument has a specified maturity, the issuer has continued dividend payments on this instrument and in all of its outstanding debt instruments, the issuer does not have the ability to call the security at a price lower than its stated value, the Company expects to collect all contractual cash flows, the Company does not have the intent to sell the investment, and it is not more likely than not that the Company will be required to sell the investment before market price recovery or maturity and because the Company expects to collect all contractual cash flows, this investments is not considered other-than-temporarily impaired.

Perpetual Preferred Stocks: Because this security has experienced a significant improvement during the past year, the issuers capital ratios are above regulatory levels, the Company does not have the intent to sell the investment, and the Company has the intent and ability to hold the investments until a market price recovery, this investment is not considered other-than-temporarily impaired.

Mutual Funds: Most of the unrealized losses in the Company s investment in one fund that has been in an unrealized loss position less than nine months. Because these funds have been in an unrealized loss position for less than nine months, the Company does not have the intent to sell these investment, and the Company has the ability to hold the investments until a market price recovery, these investments are not considered other-than-temporarily impaired.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Maturities of investment securities classified as available for sale and held to maturity were as follows at December 31, 2010:

	Amortized Cost	Estimated Fair Value
Securities available for sale		
Due in one year or less	$ 10,288	$ 10,466
Due after one year through five years	92,110	95,731
Due after five years through ten years	203,723	213,045
Due after ten years	358,127	368,841
Residential mortgage-backed securities	12,560	13,360
Collateralized mortgage obligations	271,149	276,143
	$ 947,957	$ 977,586
Securities held to maturity		
Due in one year or less	$ 1,241	$ 1,241
Due after one year through five years	9,443	9,857
Due after ten years	3,271	3,625
Residential mortgage-backed securities	660	701
	$ 14,615	$ 15,424

Expected maturities may differ from contractual maturities because some issuers have the right to call or prepay obligations with or without call or prepayment penalties.

Investments with an amortized cost of $4,493 and $4,642 (fair value of $4,702 and 4,758) at December 31, 2010 and 2009, respectively, were deposited with the Commissioner of Insurance to comply with the deposit requirements of the Insurance Code of the Commonwealth of Puerto Rico (the Insurance Code). Investment with an amortized cost of $500 and $577 (fair value of $500 and $577) at December 31, 2010 and 2009, respectively, were deposited with the Commissioner of Insurance of the Government of the U.S. Virgin Islands.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Information regarding realized and unrealized gains and losses from investments for the years ended December 31, 2010, 2009, and 2008 is as follows:

	2010	2009	2008
Realized gains (losses)			
Fixed maturity securities			
Securities available for sale			
Gross gains from sales	$ 1,947	$ 5,323	$ 1,876
Gross losses from sales	(505)	(4)	(225)
Gross losses from other-than-temporary impairments	(95)	(1,711)	(3,872)
Total fixed maturity securities	1,347	3,608	(2,221)
Equity securities			
Trading securities:			
Gross gains from sales	1,083	717	3,358
Gross losses from sales	(961)	(1,381)	(3,160)
	122	(664)	198
Securities available for sale			
Gross gains from sales	5,051	3,468	881
Gross losses from sales	(1,086)	(391)	(176)
Gross losses from other-than-temporary impairments	(2,902)	(5,407)	(12,622)
	1,063	(2,330)	(11,917)
Total equity securities	1,185	(2,994)	(11,719)
Net realized gains (losses) on securities	$ 2,532	$ 614	$ (13,940)

The other-than-temporary impairments on fixed maturity securities are attributable to credit losses.

Changes in unrealized gains (losses)			
Recognized in income			
Equity securities trading	$ 5,433	$ 10,497	$ (21,064)
Recognized in accumulated other comprehensive loss			
Fixed maturities available for sale	22,014	(406)	928
Equity securities available for sale	5,831	4,583	(5,734)
	$ 27,845	$ 4,177	$ (4,806)
Not recognized in the consolidated financial statements			
Fixed maturities held to maturity	$ 113	$ (614)	$ 1,152

The deferred tax liability (asset) on unrealized gains and (losses) recognized in accumulated other comprehensive income during the years 2010, 2009, and 2008 aggregated $(4,243), $(638), and $854, respectively.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

As of December 31, 2010 and 2009 no individual investment in securities exceeded 10% of stockholders equity.

4. Net Investment Income

Components of net investment income were as follows:

	Years ended December 31		
	2010	**2009**	**2008**
Fixed maturities	$ 44,371	$ 46,285	$ 48,197
Equity securities	3,452	4,077	5,451
Policy loans	441	411	387
Cash equivalents and interest-bearing deposits	197	577	1,003
Other	684	786	1,215
Total	$ 49,145	$ 52,136	$ 56,253

5. Premium and Other Receivables, Net

Premium and other receivables, net as of December 31 were as follows:

	2010	**2009**
Premium	$ 144,501	$ 98,429
Self-funded group receivables	73,750	70,315
FEHBP	11,001	10,297
Agent balances	37,262	37,888
Accrued interest	9,781	9,287
Reinsurance recoverable	47,342	43,951
Other	22,177	27,999
	345,814	298,166
Less allowance for doubtful receivables:		
Premium	13,106	20,280
Other	6,928	4,954
	20,034	25,234
Premium and other receivables, net	$ 325,780	$ 272,932

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

6. Deferred Policy Acquisition Costs and Value of Business Acquired

The movement of deferred policy acquisition costs (DPAC) and value of business acquired (VOBA) for the years ended December 31, 2010, 2009, and 2008 is summarized as follows:

	DPAC	VOBA	Total
Balance, December 31, 2007	$ 53,215	$ 64,024	$ 117,239
Additions	49,470		49,470
VOBA interest at an average rate of 5.40%		3,425	3,425
Amortization	(33,442)	(10,345)	(43,787)
Net change	16,028	(6,920)	9,108
Balance, December 31, 2008	69,243	57,104	126,347
Additions	55,632		55,632
VOBA interest at an average rate of 5.29%		3,066	3,066
Amortization	(35,923)	(9,205)	(45,128)
Net change	19,709	(6,139)	13,570
Balance, December 31, 2009	88,952	50,965	139,917
Additions	54,247		54,247
VOBA interest at an average rate of 5.24%		2,752	2,752
Amortization	(42,324)	(8,506)	(50,830)
Net change	11,923	(5,754)	6,169
Balance, December 31, 2010	$ 100,875	$ 45,211	$ 146,086

The amortization expense of the deferred policy acquisition costs and value of business acquired is included within the operating expenses in the accompanying consolidated statement of earnings.

The estimated amount of the year-end VOBA balance expected to be amortized during the next five years is as follows:

Year ending December 31:	
2011	$ 7,404
2012	6,602
2013	5,895
2014	5,184
2015	4,561

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

7. Property and Equipment, Net

Property and equipment, net as of December 31 are composed of the following:

	2010	2009
Land	$ 7,309	$ 7,309
Buildings and leasehold improvements	45,472	45,034
Office furniture and equipment	14,401	16,821
Computer equipment and software	89,266	69,652
Automobiles	525	513
	156,973	139,329
Less accumulated depreciation and amortization	80,228	70,526
Property and equipment, net	$ 76,745	$ 68,803

8. Acquired Intangible Asset

On July 1, 2009, the Company, through TSS, entered into an Asset Purchase Agreement (the Agreement) to acquire certain managed care assets of La Cruz Azúl de Puerto Rico, Inc. (LCA) in Puerto Rico and the U.S. Virgin Islands on such date, generating an intangible asset. Such intangible asset, net as of December 31, 2010 and 2009 amounted to $3.9 and $5.6 million, respectively, and is included within other assets in the accompanying consolidated balance sheets. Amortization expense recorded during 2010 and 2009 amounted to $3.6 and $1.3 million. The intangible asset is amortized over the expected life of the acquired assets, which is estimated between 1 and 6 years. The Company may be required to make additional payments depending upon certain conditions as defined in the Agreement, which would have the effect of increasing the intangible asset.

9. Fair Value Measurements

Assets recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

Level Input: Input Definition:

Level 1 Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.

Level 2 Inputs other than quoted prices included in Level 1 that are observable for the asset or liability through corroboration with market data at the measurement date.

Level 3 Unobservable inputs that reflect management s best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The Company uses observable inputs when available. Fair value is based upon quoted market prices when available. If market prices are not available, the Company employs internally-developed models that primarily use market-based inputs including yield curves, interest rates, volatilities, and credit curves, among others. The

Company limits valuation adjustments to those

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

deemed necessary to ensure that the security or derivative s fair value adequately represents the price that would be received or paid in the marketplace. Valuation adjustments may include consideration of counterparty credit quality and liquidity as well as other criteria. The estimated fair value amounts are subjective in nature and may involve uncertainties and matters of significant judgment for certain financial instruments. Changes in the underlying assumptions used in estimating fair value could affect the results. The fair value measurement levels are not indicative of risk of investment. The following table summarizes fair value measurements by level at December 31, 2010 and 2009 for assets measured at fair value on a recurring basis:

	2010			
	Level 1	**Level 2**	**Level 3**	**Total**
Equity securities held for trading	$ 51,099	$	$	$ 51,099
Securities available for sale				
Fixed maturity securities				
Obligations of government-sponsored enterprises		131,385		131,385
U.S. Treasury securities and obligations of U.S. government instrumentalities	52,878			52,878
Obligations of the Commonwealth of Puerto Rico and its instrumentalities		120,624		120,624
Municipal securities		273,564		273,564
Corporate Bonds		109,632		109,632
Residential agency mortgage-backed securities		13,360		13,360
Collaterized mortgage obligations		276,143		276,143
Total fixed maturities	52,878	924,708		977,586
Equity securities				
Common stocks	4,331			4,331
Preferred stocks	3,629			3,629
Perpetual preferred stocks	906			906
Mutual funds	27,858	18,971	1,044	47,873
Total equity securities	36,724	18,971	1,044	56,739
Derivatives (reported within other assets in the consolidated balance sheets)		748		748
	$ 140,701	$ 944,427	$ 1,044	$ 1,086,172

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2009			
	Level 1	Level 2	Level 3	Total
Equity securities held for trading	$ 43,909	$	$	$ 43,909
Securities available for sale				
Fixed maturity securities				
Obligations of government-sponsored enterprises		251,428		251,428
U.S. Treasury securities and obligations of U.S. government instrumentalities	51,338			51,338
Obligations of the Commonwealth of Puerto Rico and its instrumentalities		155,948		155,948
Municipal securities		106,707		106,707
Corporate Bonds		105,365		105,365
Residential agency mortgage-backed securities		17,281		17,281
Collaterized mortgage obligations		230,910		230,910
Total fixed maturities	51,338	867,639		918,977
Equity securities				
Common stocks	7,509			7,509
Preferred stocks	2,675			2,675
Perpetual preferred stocks	2,579			2,579
Mutual funds	6,961	44,190	775	51,926
Total equity securities	19,724	44,190	775	64,689
Derivatives (reported within other assets in the consolidated balance sheets)		1,608		1,608
	$ 114,971	$ 913,437	$ 775	$ 1,029,183

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the years ended December 31, 2010 and 2009 is as follows:

	Fixed Maturity Securities	Equity Securities	Total
Begining balance December 31, 2008	$ 1,281	$ 1,086	$ 2,367
Total gains or losses:			
Realized in earnings	(1,281)		(1,281)
Unrealized in other accumulated comprehensive income			
Purchases and sales		(1,086)	(1,086)
Transfers in and/or out of Level 3		775	775
Ending balance December 31, 2009	$	$ 775	$ 775
Total gains or losses:			
Realized in earnings			
Unrealized in other accumulated comprehensive income		(299)	(299)
Purchases and sales		568	568
Transfers in and/or out of Level 3			
Ending balance December 31, 2010	$	$ 1,044	$ 1,044

Realized gains or losses on Level 3 investments are included within net realized gains, excluding other-than-temporary impairment losses on securities in the consolidated statements of earnings.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

10. Claim Liabilities

The activity in claim liabilities during 2010, 2009, and 2008 is as follows:

	2010	2009	2008
Claim liabilities at beginning of year	$ 360,446	$ 323,710	$ 353,830
Reinsurance recoverable on claim liabilities	(30,712)	(30,432)	(54,834)
Net claim liabilities at beginning of year	329,734	293,278	298,996
Claims incurred			
Current period insured events	1,594,977	1,594,814	1,429,730
Prior period insured events	(10,067)	(1,887)	(9,918)
Total	1,584,910	1,592,927	1,419,812
Payments of losses and loss-adjustment expenses			
Current period insured events	1,316,321	1,309,304	1,192,301
Prior period insured events	269,562	247,167	233,229
Total	1,585,883	1,556,471	1,425,530
Net claim liabilities at end of year	328,761	329,734	293,278
Reinsurance recoverable on claim liabilities	31,449	30,712	30,432
Claim liabilities at end of year	$ 360,210	$ 360,446	$ 323,710

As a result of differences between actual amounts and estimates of insured events in prior years, the amounts included as incurred claims for prior period insured events differ from anticipated claims incurred.

The credits in the claims incurred and loss-adjustment expenses for prior period insured events for 2010, 2009 and 2008 are due primarily to better than expected utilization trends. Reinsurance recoverable on unpaid claims is reported as premium and other receivables, net in the accompanying consolidated financial statements.

The claims incurred disclosed in this table exclude the portion of the change in the liability for future policy benefits amounting to $11,879, $12,945, and $11,989 that is included within the consolidated claims incurred during the years ended December 31, 2010, 2009 and 2008, respectively.

11. Federal Employees Health Benefits Program (FEHBP)

TSS entered into a contract, renewable annually, with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits Act of 1959, as amended, to provide health benefits under the FEHBP. The FEHBP covers postal and federal employees residing in the Commonwealth of Puerto Rico and the United States Virgin Islands as well as retirees and eligible dependents. The FEHBP is financed through a negotiated

contribution made by the federal government and employees payroll deductions.

The accounting policies for the FEHBP are the same as those described in the Company s summary of significant accounting policies. Premium rates are determined annually by TSS and approved by the federal government. Claims are paid to providers based on the guidelines

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

determined by the federal government. Operating expenses are allocated from TSS s operations to the FEHBP based on applicable allocation guidelines (such as, the number of claims processed for each program).

The operations of the FEHBP do not result in any excess or deficiency of revenue or expense as this program has a special account available to compensate any excess or deficiency on its operations to the benefit or detriment of the federal government. Any transfer to/from the special account necessary to cover any excess or deficiency in the operations of the FEHBP is recorded as a reduction/increment to the premiums earned. The contract with OPM provides that the cumulative excess of the FEHBP earned income over health benefits charges and expenses represents a restricted fund balance denoted as the special account. Upon termination of the contract and satisfaction of all the FEHBP s obligations, any unused remainder of the special reserve would revert to the Federal Employees Health Benefit Fund. In the event that the contract terminates and the special reserve is not sufficient to meet the FEHBP s obligations, the FEHBP contingency reserve will be used to meet such obligations. If the contingency reserve is not sufficient to meet such obligations, the Company is at risk for the amount not covered by the contingency reserve.

The contract with OPM allows for the payment to the Company of service fees as negotiated between TSS and OPM. Service fees, which are included within the other income (expense), net in the accompanying consolidated statements of earnings, for each of the years in the three-year period ended December 31, 2010 amounted to $998, $988, and $931, respectively.

The Company also has funds available related to the FEHBP amounting to $28,093 and $22,797 as of December 31, 2010 and 2009, respectively and are included within the cash and cash equivalents in the accompanying consolidated balance sheets. Such funds must only be used to cover health benefits charges, administrative expenses and service charges required by the FEHBP.

A contingency reserve is maintained by the OPM at the U.S. Treasury, and is available to the Company under certain conditions as specified in government regulations. Accordingly, such reserve is not reflected in the accompanying consolidated balance sheets. The balance of such reserve as of December 31, 2010 and 2009 was $28,092 and $20,483, respectively. The Company received $5,161, $6,343, and $2,540, of payments made from the contingency reserve fund of OPM during 2010, 2009, and 2008, respectively.

The claim payments and operating expenses charged to the FEHBP are subject to audit by the U.S. government. Management is of the opinion that an adjustment, if any, resulting from such audits will not have a significant effect on the accompanying financial statements. The claim payments and operating expenses reimbursed in connection with the FEHBP have been audited through 2004 by OPM.

12. Short-Term Borrowings

Short-term borrowings of $15,575 at December 31, 2010 represent securities sold under agreements to repurchase. The agreement outstanding at December 31, 2010 matured in January 3, 2011 and accrued interest at fixed rate of 0.50%. The weighted average interest rate for short-term borrowings in 2010 amounted to 0.38%.

The investment securities underlying such agreements were delivered to the dealers with whom the agreements were transacted. The dealers may have sold, loaned, or otherwise disposed of such

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

securities in the normal course of business operations, but have agreed to resell to the Company substantially the same securities on the maturity dates of the agreements.

At December 31, 2010 investment securities available for sale with fair value of $16,199 (face value of $14,630) were pledged as collateral under these agreements.

13. Long-Term Borrowings

A summary of the borrowings entered by the Company at December 31, 2010 and 2009 is as follows:

	2010	2009
Senior unsecured notes payable of $50,000 issued on September 2004; due September 2019. Interest is payable semiannually at a fixed rate of 6.30%.	$ 50,000	$ 50,000
Senior unsecured notes payable of $60,000 issued on December 2005; due December 2020. Interest is payable monthly at a fixed rate of 6.60%.	35,000	60,000
Senior unsecured notes payable of $35,000 issued on January 2006; due January 2021. Interest is payable monthly at a fixed rate of 6.70%.	35,000	35,000
Secured loan payable of $41,000, payable in monthly installments of $137 through July 1, 2024, plus interest at a rate reset periodically of 100 basis points over selected LIBOR maturity (which was 1.29% and 1.28% at December 31, 2010, and 2009, respectively).	21,027	22,667
Repurchase agreement of $25.0 million entered on November 2010, due November 2015. Interest is payable quarterly at a fixed rate of 1.96%.	25,000	
Total borrowings	$ 166,027	$ 167,667

Aggregate maturities of the Company s borrowings as of December 31, 2010 are summarized as follows:

Year ending December 31	
2011	$ 1,640
2012	1,640
2013	1,640
2014	1,640
2015	26,640
Thereafter	132,827
	$ 166,027

All of the Company s senior notes may be prepaid at par, in total or partially, five years after issuance as determined by the Company. The Company s senior unsecured notes contain certain

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

non- financial covenants with which TSS and the Company have complied with at December 31, 2010. On October 1, 2010 we repaid $25.0 million of the principal of 6.60% senior unsecured note.

Debt issuance costs related to each of the Company s senior unsecured notes were deferred and are being amortized over the term of its respective senior note. Unamortized debt issuance costs related to these senior unsecured notes as of December 31, 2010 and 2009 amounted to $781 and $1,041, respectively and are included within other assets in the accompanying consolidated balance sheets.

The secured loan payable previously described is guaranteed by a first position held by the bank on the Company s land, building, and substantially all leasehold improvements, as collateral for the term of the loan under a continuing general security agreement. This secured loan contains certain non-financial 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.

The repurchase agreement has pledged as collateral investment securities available for sale with fair value of $28,453 (face value of $23,918). The investment securities underlying such agreements were delivered to the financial institution with whom the agreement was transacted. The dealers may have loaned, or used as collateral securities in the normal course of business operations. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on the accompanying consolidated balance sheets.

Interest expense on the above borrowings amounted to $9,210, $9,870, and $10,451, for the years ended December 31, 2010, 2009, and 2008, respectively.

14. Derivative Instruments and Hedging Activities

By using derivative financial instruments the Company exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty is obligated to the Company, which creates credit risk for the Company. When the fair value of a derivative contract is negative, the Company owes the counterparty and, therefore, it does not possess credit risk. The Company minimizes the credit risk in derivative instruments by entering into transactions with high-quality counterparties.

Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates, currency exchange rates, commodity prices, or market indexes. The market risk associated with derivative instruments is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

The Company has invested in certain derivative instruments in order to diversify its investment in securities and participate in the foreign stock market.

During 2005 the Company invested in two structured note agreements amounting to $5,000 each, maturing in May 25, 2012, where the interest income received is linked to the performance of the Dow Jones Euro STOXX 50 and Nikkei 225 Equity Indexes (the Indexes). Under these agreements the principal invested by the Company is protected, the only amount that varies according to the performance of the Indexes is the interest to be received upon the maturity of the instruments. Should the Indexes experience a negative performance during the holding

period of

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

the structured notes, no interest will be received. The contingent interest payment component within the structured note agreements meets the definition of an embedded derivative. In accordance with the provisions of current accounting guidance, the embedded derivative component of the structured notes is separated from the structured notes and accounted for separately as a derivative instrument.

The changes in the fair value of the embedded derivative component are recorded as gains or losses in earnings in the period of change. During the years ended December 31, 2010, 2009 and 2008 the Company recorded a loss associated with the change in the fair value of this derivative component of $859, $66, and $4,658, respectively. The change in the fair value of the embedded derivative component is included within the other income, net in the accompanying consolidated statement of earnings.

As of December 31, 2010 and 2009, the fair value of the derivative component of the structured notes amounted to $748, and $1,608, respectively, and is included within the Company s other assets in the accompanying consolidated balance sheets. The investment component of the structured notes is accounted for as held-to-maturity debt securities and is included within the investment in securities in the accompanying consolidated balance sheets. As of December 31, 2010 the fair value and amortized cost of the investment component of both structured notes amounted to $9,857, and $9,443, respectively. As of December 31, 2009 the fair value and amortized cost of the investment component of both structured notes amounted to $9,597 and $9,063, respectively.

15. Agency Contract and Expense Reimbursement

TSS processed and paid claims as fiscal intermediary for the Medicare Part B Program until February 2009, the contract termination date. TSS was reimbursed for administrative expenses incurred in performing this service. For the years ended December 31, 2010, 2009, and 2008, TSS billed $21, $1,842, and $8,678, respectively, for such services, which are deducted from operating expenses in the accompanying consolidated statements of earnings.

The operating expense reimbursements in connection with processing Medicare claims have been audited through 2005 by federal government representatives. Management is of the opinion that no significant adjustments will be made affecting cost reimbursements through December 31, 2010.

On September 12, 2008, the Centers for Medicare and Medicaid Services (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 proposed TSS as a subcontractor in MAC Jurisdiction 9 to perform certain provider customer service functions, subject to terms and conditions negotiated between FSCO and TSS. Pursuant to this, TSS billed $2,829 and $2,650 for performing the customer service functions during the years ended December 31, 2010 and 2009, respectively.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

16. Reinsurance Activity

The effect of reinsurance on premiums earned and claims incurred is as follows:

	Premiums Earned			Claims Incurred[1]		
	2010	2009	2008	2010	2009	2008
Gross	$ 1,981,700	$ 1,950,097	$ 1,777,652	$ 1,611,289	$ 1,611,675	$ 1,439,933
Ceded	(80,600)	(81,013)	(85,308)	(26,379)	(18,748)	(20,121)
Net	$ 1,901,100	$ 1,869,084	$ 1,692,344	$ 1,584,910	$ 1,592,927	$ 1,419,812

(1) The claims incurred disclosed in this table exclude the portion of the change in the liability for future policy benefits amounting to $11,879, $12,945, and $11,989 that is included within the consolidated claims incurred during the years ended December 31, 2010, 2009 and 2008, respectively.

TSS, TSP and TSV, in accordance with general industry practices, annually purchase reinsurance to protect them from the impact of large unforeseen losses and prevent sudden and unpredictable changes in net income and stockholders equity of the Company. Reinsurance contracts do not relieve any of the subsidiaries from their obligations to policyholders. In the event that all or any of the reinsuring companies might be unable to meet their obligations under existing reinsurance agreements, the subsidiaries would be liable for such defaulted amounts. During 2010, 2009 and 2008 TSP placed 14.37%, 13.53%, and 11.84% of its reinsurance business with one reinsurance company.

TSS has two excess of loss reinsurance treaties whereby it cedes a portion of its premiums to third parties. Reinsurance contracts are primarily for periods of one year, and are subject to modifications and negotiations in each renewal date. Premiums ceded under these contracts amounted to $11,206, $7,341, and $5,623 in 2010, 2009 and 2008, respectively. Claims ceded amounted to $9,519, $3,870, and $8,407 in 2010, 2009 and 2008, respectively. Principal reinsurance agreements are as follows:

Organ transplant excess of loss treaty covering 100% of the claims up to a maximum of $1,000 per person, per life.

Routine medical care excess of loss treaty covering 100% of claims from the amount of $100 and up to a maximum of $900 per covered person, per contract year.

TSP has a number of pro rata and excess of loss reinsurance treaties whereby the subsidiary retains for its own account all loss payments for each occurrence that does not exceed the stated amount in the agreements and a catastrophe cover, whereby it protects itself from a loss or disaster of a catastrophic nature. Under these treaties, TSP ceded premiums of $63,746, $67,541, and $72,115, in 2010, 2009, and 2008, respectively.

Reinsurance cessions are made on excess of loss and on a proportional basis. Principal reinsurance agreements are as follows:

Property quota share treaty covering for a maximum of $20,000 for any one risk. Under this treaty 32% of the risk is ceded to reinsurers. The remaining exposure is covered by a

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

property per risk excess of loss treaty that provides reinsurance in excess of $500 up to a maximum of $10,000, or the remaining 68% for any one risk. In addition, TSP has an additional property catastrophe excess of loss contract that provides protection for losses in excess of $8,000 resulting from any catastrophe, subject to a maximum loss of $10,000.

Personal property catastrophe excess of loss. This treaty provides protection for losses in excess of $5,000 resulting from any catastrophe, subject to a maximum loss of $80,000.

Commercial property catastrophe excess of loss. This treaty provides protection for losses in excess of $5,000 resulting from any catastrophe, subject to a maximum loss of $205,000.

Property catastrophe excess of loss. This treaty provides protection for $185,000 in excess of $80,000 and $205,000 with respect to personal and commercial lines, respectively, resulting from any catastrophe, subject to a maximum loss of $160,000 in respect of the ceded portion of the Commercial Lines Quota Share.

Personal lines quota share. This treaty provides protection of 2.3% on all ground-up losses, subject to a limit of $1,000 for any one risk.

Reinstatement premium protection. This treaty provides a maximum limit of approximately $5,000 for personal lines and $13,800 in commercial lines to cover the necessity of reinstating the catastrophe program in the event it is activated.

Casualty excess of loss treaty. This treaty provides reinsurance for losses in excess of $225 up to a maximum of $12,000.

Medical malpractice excess of loss. This treaty provides reinsurance in excess of $150 up to a maximum of $1,500 per incident.

Builders risk quota share and first surplus covering contractors risk. This treaty provides protection on a 20/80 quota share basis for the initial $2,500 and a first surplus of $10,000 for a maximum of $12,000 for any one risk.

Surety quota share treaty covering contract and miscellaneous surety bond business. This treaty provides reinsurance of up to $5,000 for contract surety bonds, subject to an aggregate of $10,000 per contractor and $3,000 per miscellaneous surety bond.

Facultative reinsurance is obtained when coverage per risk is required. All principal reinsurance contracts are for a period of one year, on a calendar basis, and are subject to modifications and negotiations in each renewal.

The ceded unearned reinsurance premiums on TSP arising from these reinsurance transactions amounted to $13,264, and $16,746 at December 31, 2010 and 2009, respectively, and are reported as other assets in the accompanying consolidated balance sheets.

TSV also cedes insurance with various reinsurance companies under a number of pro rata, excess of loss and catastrophe treaties. Under these treaties, TSV ceded premiums of $5,648, $6,131, and $7,570, in 2010, 2009, and 2008, respectively. Principal reinsurance agreements are as follows:

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Group life pro rata agreement, reinsuring 50% of the risk up to $250 on the life of any participating individual of certain groups insured. This contract was cancelled on June 30, 2009.

Group life insurance facultative agreement, reinsuring risk in excess of $25 of certain group life policies and a combined pro rata and excess of loss agreement effective July 1, 2008, reinsuring 50% of the risk up to $200 and ceding the excess.

Group life insurance facultative excess of loss agreements in which TSV retains a portion of the losses on the life of any participating individual of certain groups insured. Any excess will be recovered from the reinsurer. This agreement provides for various retentions ($25, $50 and $75) of the losses. The contract was cancelled during December 2009.

Facultative pro rata agreements for the long-term disability insurance, reinsuring 65% of the risk.

Accidental death catastrophic reinsurance covering each and every accident arising out of one event or occurrence resulting in the death or dismemberment of five or more persons. The retention for each event is $250 with a maximum of $1,000 for each event and $2,000 per year.

Several reinsurance agreements, mostly on an excess of loss basis up to a maximum retention of $50. For certain new life products that have been issued after 1999, the retention limit is $175.

17. Income Taxes

Under Puerto Rico income tax law, the Company is not allowed to file consolidated tax returns with its subsidiaries. The Company and its subsidiaries are subject to Puerto Rico income taxes. The Company s insurance subsidiaries are also subject to U.S. federal income taxes for foreign source dividend income. As of December 31, 2010, tax years 2005 through 2010 of the Company and its subsidiaries are subject to examination by Puerto Rico taxing authorities.

TSS and TSP are taxed essentially the same as other corporations, with taxable income primarily determined on the basis of the statutory annual statements filed with the insurance regulatory authorities. Also, operations are subject to an alternative minimum income tax, which is calculated based on the formula established by existing tax laws. Any alternative minimum income tax paid may be used as a credit against the excess, if any, of regular income tax over the alternative minimum income tax in future years.

TSV operates as a qualified domestic life insurance company and is subject to the alternative minimum tax and taxes on its capital gains.

Federal income taxes recognized by the Company s insurance subsidiaries amounted to approximately $97, $125, and $112, in 2010, 2009, and 2008, respectively.

TSM, TC, and ISI are subject to Puerto Rico income taxes as a regular corporation, as defined in the P.R. Internal Revenue Code, as amended.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

On July 10, 2009 the Governor of Puerto Rico signed into law Puerto Rico s Act No. 37, which requires certain corporations to pay a 5% additional special tax over the tax obligation through December 31, 2011. The effective tax rate includes the additional special tax, as enacted.

Recently, the Government of Puerto Rico adopted a comprehensive tax reform in two phases. The first phase of the tax reform was enacted in the last quarter of 2010 and was mostly related to reducing the income tax burden to individuals. In 2010 only, corporations received an income tax credit amounting to 7% of the tax determined, defined as the tax liability less certain credits. The second phase of the reform, which was approved on January 31, 2011, provides for the reduction of the maximum corporate income tax rate from 40.95% to approximately 30%, including the elimination of the above mentioned 5% additional special tax for corporations, as well as adding several tax credits and deductions, among other tax reliefs and changes.

The income tax expense differs from the amount computed by applying the Puerto Rico statutory income tax rate to the income before income taxes as a result of the following:

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010	2009	2008
Income before taxes	$ 84,203	$ 83,651	$ 31,944
Statutory tax rate	40.95%	40.95%	39.0%
Income tax expense at statutory rate	34,481	34,255	12,458
Increase (decrease) in taxes resulting from			
Exempt interest income	(11,955)	(13,201)	(13,561)
Effect of taxing life insurance operations as a qualified domestic life insurance company instead of as a regular corporation	(5,336)	(4,759)	(1,336)
Effect of using earnings under statutory accounting principles instead of GAAP for TSS and TSP	(1,430)	(3,089)	6,406
Effect of taxing capital gains at a preferential rate	907	446	(237)
Dividends received deduction	(221)	(262)	(810)
Adjustment to deferred tax assets and liabilities for changes in effective tax rates		(239)	
Other adjustments to deferred tax assets and liabilities	(132)	(771)	(300)
Tax credit benefit	(1,569)	(2,386)	(1,286)
Other permanent disallowances, net:			
Effect of capital gains preferential rate on impairments		1,385	2,916
Disallowance of expenses related to exempt interest income	1,115	871	1,792
Disallowed interest expense	597	730	1,014
Other	423	1,404	(158)
Total other permanent differences	2,135	4,390	5,564
Other adjustments	522	487	256
Total Income Tax Expense	$ 17,402	$ 14,871	$ 7,154

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Deferred income taxes reflect the tax effects of temporary differences between carrying amounts of assets and liabilities for financial reporting purposes and income tax purposes. The net deferred tax asset at December 31, 2010 and 2009 of the Company and its subsidiaries is composed of the following:

	2010	2009
Deferred tax assets		
Allowance for doubtful receivables	$ 7,679	$ 9,869
Liability for pension benefits	17,443	13,161
Employee benefits plan	2,509	3,142
Postretirement benefits	1,434	1,668
Deferred compensation	2,185	1,952
Accumulated depreciation	289	312
Impairment loss on investments	2,891	3,654
Contingency reserves	214	214
Share-based compensation	10	592
Unrealized loss on derivative instruments	175	89
Alternative minimum income tax credit	955	955
Purchased tax credits	42	7,388
Other	1,135	754
Gross deferred tax assets	36,961	43,750
Deferred tax liabilities		
Deferred policy acquisition costs	(7,359)	(8,103)
Catastrophe loss reserve trust fund	(6,247)	(5,935)
Unrealized gain upon acquisition of GA Life	(539)	(982)
Unrealized gain on trading securities	(1,135)	(285)
Unrealized gain on securities available for sale	(4,658)	(1,626)
Unamortized bond issue costs	(224)	(318)
Other	(9)	(38)
Gross deferred tax liabilities	(20,171)	(17,287)
Net deferred tax asset	$ 16,790	$ 26,463

The net deferred tax asset shown in the table above at December 31, 2010 and 2009 is reflected in the consolidated balance sheets as $29,445 and $37,551, respectively, in deferred tax assets and $12,655 and $11,088, in deferred tax liabilities, respectively, reflecting the aggregate deferred tax assets or liabilities of individual tax-paying subsidiaries of the Company.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management believes that it is more likely than not that the Company will realize the benefits of these deductible differences.

45

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

18. Pension Plans

Noncontributory Defined-Benefit Pension Plan

The Company sponsors a noncontributory defined-benefit pension plan for all of its employees and for the employees for certain of its subsidiaries. Pension benefits begin to vest after five years of vesting service, as defined, and are based on years of service and final average salary, as defined. The funding policy is to contribute to the plan as necessary to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, plus such additional amounts as the Company may determine to be appropriate from time to time. The measurement date used to determine pension benefit measures for the pension plan is December 31.

The following table sets forth the plan s benefit obligations, fair value of plan assets, and funded status as of December 31, 2010 and 2009, accordingly:

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010	2009
Change in benefit obligation		
Projected benefit obligation at beginning of year	$ 90,888	$ 84,776
Service cost	4,975	4,912
Interest cost	6,033	5,712
Benefit payments	(3,963)	(7,004)
Actuarial losses	15,979	2,492
Projected benefit obligation at end of year	$ 113,912	$ 90,888
Accumulated benefit obligation at end of year	$ 85,858	$ 67,825
Change in fair value of plan assets		
Fair value of plan assets at beginning of year	$ 53,433	$ 44,100
Actual return on assets (net of expenses)	8,260	8,337
Employer contributions	9,800	8,000
Benefit payments	(3,963)	(7,004)
Fair value of plan assets at end of year	$ 67,530	$ 53,433
Funded status at end of year	$ (46,382)	$ (37,455)
Amounts in accumulated other comprehensive income not yet recognized as a component of net periodic pension cost		
Development of prior service credit		
Balance at beginning of year	$ (4,922)	$ (5,372)
Amortization	449	450
Net prior service credit	(4,473)	(4,922)
Development of actuarial loss		
Balance at beginning of year	38,245	42,559
Amortization	(2,400)	(2,487)
(Gain)/Loss arising during the year	11,980	(1,827)
Actuarial net loss	47,825	38,245
Sum of deferrals	$ 43,352	$ 33,323
Net amount recognized	$ (3,029)	$ (4,132)

The amounts recognized in the balance sheets as of December 31, 2010 and 2009 consist of the following:

	2010	2009
Pension liability	$ 46,382	$ 37,455
	27,821	20,379

Accumulated other comprehensive loss, net of a deferred tax of $16,373 and $12,944 in 2010 and 2009, respectively

The components of net periodic benefit cost income for 2010, 2009, and 2008 were as follows:

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	2010	2009	2008
Components of net periodic benefit cost			
Service cost	$ 4,976	$ 4,912	$ 5,287
Interest cost	6,033	5,712	5,458
Expected return on assets	(4,262)	(4,018)	(5,027)
Amortization of prior service (benefit) cost	(450)	(450)	(450)
Amortization of actuarial loss	2,400	2,487	1,788
Net periodic benefit cost	$ 8,697	$ 8,643	$ 7,056

Net periodic pension expense may include settlement charges as a result of retirees selecting lump-sum distributions. Settlement charges may increase in the future if the number of eligible participants deciding to receive distributions and the amount of their benefits increases.

The estimated net loss and prior service benefit that will be amortized from accumulated other comprehensive loss into net periodic pension benefits cost during the next twelve months is as follows:

Prior service cost	$ (450)
Actuarial loss	3,129

The following assumptions were used on a weighted average basis to determine benefit obligations of the plan and in computing the periodic benefit cost as of and for the years ended December 31, 2010, 2009, and 2008:

	2010	2009	2008
Discount rate	6.00%	6.75%	6.75%
Expected return on plan assets	7.75%	7.75%	8.00%
Rate of compensation increase	Graded; 3.50% to 8.00%	Graded; 3.50% to 8.00%	Graded; 3.50% to 8.00%

As of December 31, 2010, the basis of the overall expected long-term rate of return on assets assumption is a forward-looking approach based on the current long-term capital market outlook assumptions of the assets categories the trust invests in and the trust s target asset allocation. At December 31, 2010, the assumed target asset allocation for the program is: 44%-56% equity securities, 35%-45% debt securities, and 6%-14% other securities. Using a mean-variance model to project return over 15-years horizon under the target asset allocation, the 35% to 65% percentile range of annual rates of return is 6.4%-8.4%. The Company selected a rate from within this range of 7.75%, which reflects the Company s best estimate for this assumption based on the data described above, information on the historical returns on assets invested in the pension trust, and expected future conditions. This rate is net of both investment related expenses and a 0.10% reduction for other administrative expenses charged to the trust.

The assumed discount rate of 6.00% at December 31, 2010 reflects the hypothetical rate at which the projected benefit obligations could be effectively settled or paid out to participants on that date. The Company determined the discount rate based on a range of factors, including a yield curve comprised of the rates of return on high-quality, fixed-income corporate bonds available at the measurement date and the related expected duration for the obligations.

48

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Plan Assets

Plan assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value. For level inputs and input definition, see note 9.

The following table summarizes fair value measurements by level at December 31, 2010 for assets measured at fair value on a recurring basis.

	Level 1	Level 2	Level 3	Total
Equity Investments				
Domestic Large Cap	$ 203	$ 12,934	$ 1,241	$ 14,378
Domestic Small Cap		3,760		3,760
Global equities	2,364	2,562		4,926
International Large Cap	2	8,194		8,196
International Small Cap	2,700			2,700
Emerging Markets		2,871		2,871
Fixed Income Investments				
High Yield	176	2,608	346	3,130
Core	(19)	13,786	28	13,795
Long Duration	51	7,865		7,916
Real Estate Investments				
REIT	(2)	957	2,575	3,530
Real Estate Assets	21	2,307		2,328
	$ 5,496	$ 57,844	$ 4,190	$ 67,530

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended December 31, 2010 is as follows:

	Domestic Large Cap	Fixed Income High Yield	Fixed Income Core	Real Estate	Total
Beginning Balance at December 31, 2009	$ 961	$ 277	$ 28	$ 2,290	$ 3,556
Actual return on program assets:					
Relating to assets still held at the reporting date	180	(7)		275	448
Relating to assets sold during the period		(66)		(112)	(178)
Purchases	100	147		122	369
Transfer in and/or out		(5)			(5)
Ending balance at December 31, 2010	$ 1,241	$ 346	$ 28	$ 2,575	$ 4,190

The Company s plan assets are invested in the National Retirement Trust. The National Retirement Trust was formed to provide financial and legal resources to help members of the BCBSA offer retirement benefits to their employees.

The investment program for the National Retirement Trust is based on the precepts of capital market theory that are generally followed by institutional investors, who by definition are long-term oriented investors. This philosophy holds that:

Increasing risk is rewarded with compensating returns over time, and therefore, prudent risk taking is justifiable for long-term investors.

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Risk can be controlled through diversification of asset classes and investment approaches, as well as diversification of individual securities.

Risk is reduced by time, and over time the relative performance of different asset classes is reasonably consistent. Over the long-term, equity investments have provided and should continue to provide superior returns over other security types. Fixed-income securities can dampen volatility and provide liquidity in periods of depressed economic activity. Lengthening duration of fixed income securities may reduce surplus volatility.

The strategic or long-term allocation of assets among various asset classes is an important driver of long-term returns.

Relative performance of various asset classes is unpredictable in the short-term and attempts to shift tactically between asset classes are unlikely to be rewarded.

Investments will be made for the sole interest of the participants and beneficiaries of the programs participating in the National Retirement Trust. Accordingly, the assets of the National Retirement Trust shall be invested in accordance with these objectives:

Ensure assets are available to meet current and future obligations of the participating programs when due.

Invest assets with consideration of the liability characteristics in order to better align assets and liabilities.

Earn the maximum return that can be realistically achieved in the markets over the long-term at a specified and controlled level of risk in order to minimize future contributions.

Invest the assets with the care, skill, and diligence that a prudent person acting in a like capacity would undertake. In the process, the Administration of the Trust has the objective of controlling the costs involved with administering and managing the investments of the National Retirement Trust.

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Cash Flows

The Company expects to contribute $10,000 to its pension program in 2011.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Year ending December 31	
2011	$ 4,333
2012	4,791
2013	5,795
2014	6,393
2015	7,212
2016 2020	53,965

Noncontributory Supplemental Pension Plan

In addition, the Company sponsors a noncontributory supplemental pension plan. This plan covers employees with qualified defined benefit retirement plan benefits limited by the U.S. Internal Revenue Code maximum compensation and benefit limits. At December 31, 2010 and 2009, the Company has recorded a pension liability of $4,865 and $3,589, respectively. The charge to accumulated other comprehensive loss related to the noncontributory pension plan at December 31, 2010 and 2009 amounted to $498 and 339, respectively, net of a deferred tax asset of $318 and $217, respectively.

19. Catastrophe Loss Reserve and Trust Fund

In accordance with Chapter 25 of the Insurance Code, as amended, TSP is required to record a catastrophe loss reserve. This catastrophe loss reserve is supported by a trust fund for the payment of catastrophe losses. The reserve increases by amounts determined by applying a contribution rate, not in excess of 5%, to catastrophe written premiums as instructed annually by the Commissioner of Insurance, unless the level of the reserve exceeds 8% of catastrophe exposure, as defined. The reserve also increases by an amount equal to the resulting return in the supporting trust fund and decreases by payments on catastrophe losses or authorized withdrawals from the trust fund. Additions to the catastrophe loss reserve are deductible for income tax purposes.

This trust may invest its funds in securities authorized by the Insurance Code, but not in investments whose value may be affected by hazards covered by the catastrophic insurance losses. The interest earned on these investments and any realized gains (loss) on investment transactions are part of the trust fund and are recorded as income (expense) of the Company. An amount equal to the investment returns is recorded as an addition to the trust fund.

The interest earning assets in this fund, which amounted to $35,721 and $33,489 as of December 31, 2010 and 2009, respectively, are to be used solely and exclusively to pay catastrophe losses covered under policies written in Puerto Rico.

TSP is required to contribute to the trust fund, if any, on or before January 31 of the following year. Contributions are determined by a rate imposed by the Commissioner of Insurance for the

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

catastrophe policies written in that year. Additions in 2010 and 2009, amounting to $761 and $810, respectively, were determined by applying a rate of 1% to catastrophe premiums written.

The amount in the trust fund may be withdrawn or released in the case that TSP ceases to underwrite risks subject to catastrophe losses. Also, authorized withdrawals are allowed when the catastrophe loss reserve exceeds 8% of the catastrophe exposure, as defined.

Retained earnings are restricted in the accompanying consolidated balance sheets by the total catastrophe loss reserve balance, which as of December 31, 2010 and 2009 amounted to $35,975 and $34,411, respectively.

20. Stockholders Equity

a. Common Stock

On December 8, 2008, the Company converted 7 million issued and outstanding Class A shares into Class B shares, 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.

For a period of five years after the completion of the IPO on December 7, 2007, subject to the extension or shortening under certain circumstances, each holder of Class B common stock will benefit from anti-dilution protections provided in the Company s amended and restated certificate of incorporation.

b. Stock Repurchase Program

The Company repurchased shares of its common stock under a $40,000 share repurchase program authorized by the Company s Board in October 2008. Repurchases were conducted through open-market purchases of Class B shares only, in accordance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. During 2009 the Company repurchased and retired 2,021,960 shares at an average per share price of $12.92, for an aggregate cost of $26,120. This repurchase program was completed during 2009.

On September 2010, the Company s Board approved another repurchase program of its common stock amounting to $30,000. Repurchases were conducted through open-market purchases of Class B shares only, in accordance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. During 2010, the Company repurchased and retired 352,791 shares at an average per share price of $17.80, for an aggregate cost of $6,235.

c. Preferred Stock

Authorized capital stock includes 100,000,000 of preferred stock with a par value of $1.00 per share. As of December 31, 2010 and 2009, there are no issued and outstanding preferred shares.

d. Liquidity Requirements

As members of the BCBSA, the Company and TSS are required by membership standards of the association to maintain liquidity as defined by BCBSA. That is, to maintain net worth exceeding the Company Action Level as defined in the National Association of Insurance Commissioners (NAIC) Risk-Based Capital for Insurers Model Act. The companies are in compliance with this requirement.

52

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

21. Comprehensive Income

The accumulated balances for each classification of other comprehensive income (loss) are as follows:

	Unrealized Gains on securities	Liability for Pension Benefits	Accumulated Other Comprehensive Income
Beginning balance at December 31, 2009	$ 9,141	$ (20,717)	$ (11,576)
Net current period change	25,717	(6,562)	19,155
Reclassification adjustments for gains and losses reclassified in income	(2,115)		(2,115)
Ending balance at December 31, 2010	$ 32,743	$ (27,279)	$ 5,464

The related deferred tax effects allocated to each component of other comprehensive income in the accompanying consolidated statements of stockholders equity and comprehensive income in 2010, 2009 and 2008 are as follows:

	Before-Tax Amount	2010 Deferred Tax (Expense) Benefit	Net-of-Tax Amount
Unrealized holding gains on securities arising during the period	$ 30,255	$ (5,749)	$ 24,506
Less reclassification adjustment for gains and losses realized in income	(2,410)	1,506	(904)
Net change in unrealized gain	27,845	(4,243)	23,602
Liability for pension benefits	(10,844)	4,282	(6,562)
Net current period change	$ 17,001	$ 39	$ 17,040

	Before-Tax Amount	2009 Deferred Tax (Expense) Benefit	Net-of-Tax Amount
Unrealized holding losses on securities arising during the period	$ 5,455	$ (825)	$ 4,630
Less reclassification adjustment for gains and losses realized in income	(1,278)	187	(1,091)
Net change in unrealized loss	4,177	(638)	3,539

Liability for pension benefits	4,070	(1,520)	2,550
Net current period change	$ 8,247	$ (2,158)	$ 6,089

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

	Before-Tax Amount	2008 Deferred Tax (Expense) Benefit	Net-of-Tax Amount
Unrealized holding losses on securities arising during the period	$ (18,944)	$ 2,088	$ (16,856)
Less reclassification adjustment for gains and losses realized in income	14,138	(1,234)	12,904
Net change in unrealized loss	(4,806)	854	(3,952)
Liability for pension benefits	(12,411)	4,796	(7,615)
Cash-flow hedges	(93)	37	(56)
Net current period change	$ (17,310)	$ 5,687	$ (11,623)

22. Share-Based Compensation

In December 2007 the Company adopted the 2007 Incentive Plan (the Plan), which permits the Board the grant of stock options, restricted stock awards and performance awards to eligible officers, directors and key employees. The Plan authorizes grants to issue up to 4,700,000 of Class B common shares of authorized but unissued stock. At December 31, 2010, there were 3,282,969 shares available for the Company to grant under the Plan. Stock options can be granted with an exercise price at least equal the stock s fair market value at the date of grant. The stock option awards vest in equal annual installments over 3 years and its expiration date cannot exceed 7 years. The restricted stock and performance awards are issued at the fair value of the stock on the grant date with vesting periods ranging from one to three years. Restricted stock awards vest in installments, as stipulated in each restricted stock agreement. Performance awards vest on the last day of the performance period, provided that at least minimum performance standards were achieved.

The fair value of each option award is estimated on the date of grant using the Black-Scholes option-pricing model that used the weighted average assumptions in the following table. In absence of adequate historical data, the Company estimates the expected life of the option using the simplified method allowed by Staff Accounting Bulletin (SAB) No. 107. Since the Company was a newly public entity, expected volatility was computed based on the average historical volatility of similar entities with publicly traded shares. The risk-free rate for the expected term of the option was based on the U.S. Treasury zero-coupon bonds yield curve in effect at the time of grant. The following assumptions were used in the development of fair value of option awards:

	2010	2009	2008
Expected dividend yield			
Expected volatility (per year)	43.00%	53.85%	
Expected term (in years)	4.50	4.50	
Risk-free interest rate	1.12%	1.47%	

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Stock option activity during the year ended December 31, 2010 is as follows:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Contractual Term (Years)	Aggregate Intrinsic Value
Outstanding balance at January 1, 2010	1,012,630	$ 14.47		
Grants	4,032	$ 16.85		
Exercised during the year	(21,982)	$ 14.50		
Canceled during the year	(7,242)	$ 14.50		
Outstanding balance at December 31, 2010	987,438	$ 14.48	3.96	$ 4,539,767
Exercisable at December 31, 2010	974,525	$ 14.49	3.94	$ 4,472,252

The weighted average grant date fair value of options granted during 2010 and 2009 was $6.20 and $5.63, respectively. No options were granted in 2008. There were 21,982 exercised options during 2010. There were no options exercised during the years ended December 31, 2009 and 2008.

A summary of the status of the Company s nonvested restricted and performance shares as of December 31, 2010, and changes during the year ended December 31, 2010, are presented below:

	Restricted Awards		Performance Awards	
	Number of Shares	Weighted Average Fair Value	Number of Shares	Weighted Average Exercise Price
Outstanding balance at January 1, 2010	81,675	$ 13.77	167,142	$ 14.46
Granted	16,221	19.26	741	16.85
Vested				
Lapsed	(78,467)	13.79	(65,479)	14.50
Forefeited	(1,207)	14.50	(98,661)	14.50
Outstanding balance at December 31, 2010	18,222	$ 18.52	3,743	$ 13.35

The weighted average grant date fair value of restricted shares granted during the year 2010, 2009 and 2008 were $19.26, $12.33, and $18.81, respectively. Total fair value of restricted stock vested during the year ended December 31, 2010 and 2009 was $1,480 and $1,158, respectively. There were no restricted shares vested during the year ended 2008.

At December 31, 2010 there was $240 of total unrecognized compensation cost related to nonvested share-based compensation arrangements granted under the Plan. That cost is expected to be recognized over a weighted average period of 0.97 years. The Company currently uses authorized and unissued Class B common shares to satisfy share award exercises.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

23. Net Income Available to Stockholders and Basic Net Income per Share

The following table sets forth the computation of basic and diluted earnings per share for the three-year period ended December 31, 2010.

	2010	2009	2008
Numerator for earnings per share			
Net income available to stockholders	$ 66,801	$ 68,780	$ 24,790
Denominator for basic earnings per share			
Weighted average of common shares	29,034,442	29,494,468	32,120,461
Effect of dilutive securities	207,911	68,862	42,094
Denominator for diluted earnings per share	$ 29,242,353	$ 29,563,330	$ 32,162,555
Basic net income per share	$ 2.30	$ 2.33	$ 0.77
Diluted net income per share	$ 2.28	$ 2.33	$ 0.77

During the years ended December 31, 2010, 2009 and 2008, the weighted average of all stock option shares of 1,027, 1,012,594, and 999,309, respectively, were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive.

24. Commitments

The Company leases its regional offices, certain equipment, and warehouse facilities under noncancelable operating leases. Minimum annual rental commitments at December 31, 2010 under existing agreements are summarized as follows:

Year ending December 31	
2011	$ 7,461
2012	7,798
2013	7,907
2014	8,109
2015	1,779
Thereafter	2,993
Total	$ 36,047

Rental expense for 2010, 2009, and 2008 was $4,546, $4,690, and $3,532, respectively, after deducting the amount of $112, $132, and $265, respectively, reimbursed by CMS for the administration of the Medicare Part B Program (see note 15).

25. Contingencies

Legal Proceedings

The Corporation 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.

56

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

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 the 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 been asserted to date, 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.

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 Company, the Company s subsidiary TSS and others in the Court of First Instance for San Juan, Superior Section (the Court of First Instance), 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. After extensive discovery, Plaintiffs amended their complaint for the third time and dropped all claims predicated on violations of the antitrust and RICO laws and the Puerto Rico Insurance Code. In addition, the Plaintiffs voluntarily dismissed with prejudice any and all claims against officers of the Corporation and TSS. Two of the original plaintiffs were also eliminated from the Third Amended Complaint (TAC). The TAC only alleges breach of seven share acquisition agreements, breach of the provider contract by way of discriminatory audits and improper payment of services rendered. Against former President of the Company, Plaintiffs allege a claim for libel and slander. Discovery is ongoing. The Company intends to vigorously defend this claim.

Dentists Association Litigation

On February 11, 2009, the Puerto Rico Dentists Association (Colegio de Cirujanos Dentistas de Puerto Rico) filed a complaint in the Court of First Instance against 24 health plans operating in Puerto Rico that offer dental health coverage. The Company and two of its subsidiaries, TSS and TCI 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

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Puerto Rico Insurance Companies Association 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 Corporation intends to vigorously defend this claim.

Two codefendant plans, whose main operations are outside Puerto Rico, removed the case to federal court in Florida, which the plaintiffs and the other codefendants, including the Corporation, opposed. The federal district court in Florida decided that it lacked jurisdiction under the Class Action Fairness Act (CAFA) and remanded the case to state court. The removing defendants petitioned to appeal to the First Circuit Court of Appeals. Having accepted the appeal, the First Circuit Court of Appeals issued an order in late October 2009 which found the lower court s decision premature. The Court of Appeals remanded the case to the federal district court in Puerto Rico (the DC) and allowed limited discovery to determine whether the case should be heard in federal court pursuant to CAFA. The parties completed the limited discovery in August 2010 and supplemented their previous filings.

On February 8, 2011 the DC issued its Opinion and Order, denying plaintiff s motion to remand the case to state court because the injuries alleged in the complaint could be suffered outside Puerto Rico. It also decided to retain jurisdiction.

The Company plans to petition the DC to reconsider its ruling, pointing to clear evidence that the removing defendants are not primary defendants for purposes of CAFA and therefore, the case should be heard in state court.

Colón Litigation

On October 15, 2007, José L. Colón-Dueño, a former holder of one share of TSS predecessor stock, filed suit against TSS and the Puerto Rico Commissioner of Insurance (the Commissioner) in the Court of First Instance. 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 TSS shareholders was voided. TSS, however, appealed the Commissioner s order before the Puerto Rico Court of Appeals, which upheld the order on March 31, 2000. Plaintiff requests that the court direct TSS to return his share of stock and compensate him for alleged damages in excess of $500,000 plus attorney s fees. On January 13, 2011 case was dismissed [with prejudice] and plaintiff filed an appeal on the Puerto Rico Court of Appeals. The Company is vigorously contesting this lawsuit because, among other reasons, the Commissioner s order is final and cannot be collaterally attacked in this litigation.

Claims by Heirs of Former Shareholders

The Company and TSS are defending five individual lawsuits, all filed in state court, from persons who claim to have inherited a total of 71 shares of the Corporation or one of its predecessors or affiliates (before giving effect to the 3,000-for-one stock split). While each case presents unique facts and allegations, the lawsuits generally allege that the redemption of the shares by the Corporation pursuant to transfer and ownership restrictions contained in the Company s (or its predecessors or affiliates) articles of incorporation and bylaws was improper. One of the cases is in its initial stage; one case was dismissed [with prejudice] and plaintiff filed a request for reconsideration; in the other cases, discovery has been completed and the parties are awaiting trial. Management believes all these claims are time barred under one or more statutes of limitations and other grounds and is vigorously defending them. This belief is supported by the outcome of a similar claim brought by non-medical heirs against us in 2009. The Puerto Rico Court of Appeals

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

dismissed that case as time barred under the two year statute of limitations contained in the local securities law, and the Puerto Rico Supreme Court denied the plaintiffs petition for certiorari in January 2011.

ACODESE Investigation

During April 2010, each of the Company s wholly-owned insurance subsidiaries received subpoenas for documents from the U.S. Attorney for the Commonwealth of Puerto Rico (the U.S. Attorney) and the Puerto Rico Department of Justice (PRDOJ) requesting information principally related to the Asociación de Compañías de Seguros de Puerto Rico, Inc. (ACODESE by its Spanish acronym). Also in April, the Company s insurance subsidiaries received a request for information from the Office of the Commissioner of Insurance of Puerto Rico (OCI) related principally to ACODESE. The Company s insurance subsidiaries are members of ACODESE, an insurance trade association established in Puerto Rico since 1975, and their current presidents have participated over the years on ACODESE s board of directors.

The Company believes similar subpoenas and information requests were issued to other member companies of ACODESE in connection with the investigation of alleged payments by the former Executive Vice President of ACODESE to members of the Puerto Rico Legislative Assembly beginning in 2005. The Company, however, has not been informed of the specific subject matter of the investigations being conducted by the U.S. Attorney, the PRDOJ or the OCI. The Company is fully complying with the subpoenas and the request for information and intends to cooperate with any related government investigation. The Company at this time cannot reasonably assess the outcome of these investigations or their impact on the Company.

Intrusions into TCI s Internet IPA Database

On September 21, 2010, the Company learned from a competitor that a specific internet database managed by our subsidiary TCI, containing information pertaining to individuals previously insured by TSS under the Government of Puerto Rico s Health Insurance Plan (HIP) and to independent practice associations (IPAs) that provided services to those individuals, had been accessed without authorization by certain of the Company s competitor s employees from September 9 to September 15, 2010. TCI served as a third-party administrator for TSS in the administration of its HIP contracts until September 30, 2010. The Company conducted a thorough investigation with the assistance of external resources, and identified the information that was accessed and downloaded into the competitor s system. The September 2010 intrusions may have potentially compromised protected health information of approximately 398,000 beneficiaries in the North and Metro-North regions of the HIP. Our investigation also revealed that protected health information of approximately 5,500 HIP beneficiaries, 2,500 Medicare beneficiaries and IPA data from all three HIP regions previously serviced by TSS was accessed through multiple, separate intrusions into the TCI IPA database from October 2008 to August 2010. The Company has no evidence indicating that the stolen information included Social Security numbers. The Company attempted to notify by mail all such beneficiaries whose information may have been compromised by these intrusions and established a toll-free call center to address inquiries and complaints from the individuals to whom notice was provided. The Company has received a total of approximately 1,530 inquiries and no complaints from these individuals.

The Company s investigation revealed that the security breaches were the result of unauthorized use of one or more active user IDs and passwords specific to the TCI IPA database, and not the result of breaches of TCI s, TSS s or the Company s system security features. Nonetheless, we took measures to strengthen the TCI server security and credentials management procedures and

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

conducted an assessment of our system-wide data and facility security to prevent the occurrence of a similar incident in the future.

The Company was unable to determine the purpose of these breaches and do not know the extent of any fraudulent use of the information or its impact on the potentially affected individuals and IPAs. According to representations made by the Company s competitor, however, the target was financial information related to IPAs rather than the individuals information.

The Company notified the appropriate Puerto Rico and federal government agencies of these events, including and issued public notice of the breaches as required under Puerto Rico and federal law. The Company received a number of inquiries and requests for information related to these events from these government agencies and are cooperating with them.

The Puerto Rico government agency that oversees the HIP has levied a fine of $100 on TSS in connection with these incidents, but following our request for reconsideration, the agency decided to withdraw the fine until the pertinent federal authorities conclude their investigations of this matter. The Compnay does not have sufficient information at this time to predict whether any future action by government entities or others as a result of the data breaches would adversely affect our business, financial condition or results of operations.

26. Statutory Accounting

TSS, TSV and TPS (collectively known as the regulated subsidiaries) are regulated by the Commissioner of Insurance. The regulated subsidiaries are required to prepare financial statements using accounting practices prescribed or permitted by the Commissioner of Insurance, which differ from GAAP.

The accumulated earnings of TSS, TSV, and TSP are restricted as to the payment of dividends by statutory limitations applicable to domestic insurance companies. Such limitations restrict the payment of dividends by insurance companies generally to unrestricted unassigned surplus funds reported for statutory purposes. As more fully described in note 19, a portion of the accumulated earnings of TSP are also restricted by the catastrophe loss reserve balance (amounting to $35,975 and $34,411 as of December 31, 2010 and 2009, respectively) as required by the Insurance Code.

The combined net admitted assets, unassigned surplus and net income of the regulated subsidiaries at December 31, 2010, 2009 and 2008 are as follows:

(dollar amounts in millions)	**2010**	**2009**	**2008**
Net admitted assets	$ 1,347	$ 1,298	$ 1,197
Capital and surplus	458	416	260
Net income	58	43	30

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

27. Supplementary Information on Cash Flow Activities

	2010	2009	2008
Supplementary information			
Noncash transactions affecting cash flows activities			
Change in net unrealized gain on securities available for sale, including deferred income tax (asset)/liability of $4,243, $(638), and $854 in 2010, 2009, and 2008, respectively	$ (23,602)	$ 3,539	$ (3,952)
Change in cash-flow hedges, including deferred income tax liability of $37	$	$	$ (56)
Change in liability for pension benefits, and deferred income tax (liability)/asset of $(4,282), $(1,520), $4,796, in 2010, 2009, and 2008, respectively	$ (6,562)	$ 2,550	$ (7,615)
Unsettled shares repurchases	$	$	$ 6,235
Unsettled investment sales	$	$	$ (1,500)
Other			
Income taxes paid	$ 3,187	$ 15,552	$ 25,597
Interest paid	$ 11,925	$ 11,605	$ 14,330

28. Business Combination

On February 7, 2011 the Company announced that its subsidiary, TSS, completed the acquisition of 100% of the outstanding capital stock of Socios Mayores en Salud Holdings, Inc. (SMSH) for approximately $83.0 million in a transaction funded with unrestricted cash. SMSH is the parent company of American Health, Inc., a provider of Medicare Advantage managed care services to over 40,000 dual and non-dual eligible members in Puerto Rico. After this acquisition the Company expects to be better positioned for continued growth in the Medicare Advantage business. The results of operations of SMSH are not reflected in the accompanying consolidated financial statements since the effective date of the transaction is not until 2011. The Company is in the process of obtaining third-party valuations of certain intangible assets; thus, as of this date it is not possible to determine the allocation of the purchase price to the net assets acquired.

29. Segment Information

The operations of the Company are conducted principally through three business segments: Managed Care, Life Insurance, and Property and Casualty Insurance. Business segments were identified according to the type of insurance products offered and consistent with the information provided to the chief operating decision maker. These segments and a description of their respective operations are as follows:

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

Managed Care segment TSS is engaged in the sale of managed care products to the Commercial, Medicare and Medicaid market sectors. The Commercial accounts sector includes corporate accounts, U.S. federal government employees, individual accounts, local government employees, and Medicare supplement. The following represents a description of the major contracts by sector:

TSS is a qualified contractor to provide health coverage to federal government employees within Puerto Rico. Earned premiums revenue related to this contract amounted to $130,803, $125,994, and $124,239 for the three-year period ended December 31, 2010, 2009, and 2008, respectively (see note 11).

Under its commercial business, TSS also provides health coverage to certain employees of the Commonwealth of Puerto Rico and its instrumentalities. Earned premium revenue related to such health plans amounted to $63,353, $46,114, and $40,686, for the three-year period ended December 31, 2010, 2009, and 2008, respectively.

TSS provides services through its Medicare health plans pursuant to a limited number of contracts with CMS. Earned premium revenue related to the Medicare business amounted to $468,401, $513,823, and $438,723, for the three-year period ended December 31, 2010, 2009, and 2008, respectively.

TSS participated in the Medicaid program to provide health coverage to medically indigent citizens in Puerto Rico, as defined by the laws of the Commonwealth of Puerto Rico, up to September 30, 2010. TSS provided managed care services to Medicaid members in the North and Southwest regions on a fully-insured basis and in the Metro-North region on an Administrative Service Only (ASO) basis. Earned premium revenue related to this business amounted to $284,815, $348,096, and $340,123, for three-year period ended December 31, 2010, 2009, and 2008, respectively. Administrative service fee for the Metro-North Region for the year ended December 31, 2010 and 2009 amounted to $12,535 and $23,299; which is included in the Administrative service fee in the accompanying consolidated statement of earnings.

Life Insurance segment This segment offers primarily life and accident and health insurance coverage, and annuity products. The premiums for this segment are mainly subscribed through TSV s internal sales force and a network of independent brokers and agents.

Property and Casualty Insurance segment The predominant insurance lines of business of this segment are commercial multiple peril, auto physical damage, auto liability, and dwelling. The premiums for this segment are originated through a network of independent insurance agents and brokers. Agents or general agencies collect the premiums from the insureds, which are subsequently remitted to TSP, net of commissions. Remittances are due 60 days after the closing date of the general agent s account current.

The Company evaluates performance based primarily on the operating revenues and operating income of each segment. Operating revenues include premiums earned, net, administrative service fees and net investment income. Operating costs include claims incurred and operating expenses. The Company calculates operating income or loss as operating revenues less operating costs.

The accounting policies for the segments are the same as those described in the summary of significant accounting policies included in the notes to consolidated financial statements. The financial data of each segment is accounted for separately; therefore no segment allocation is

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands, except per share data)

necessary. However, certain operating expenses are centrally managed, therefore requiring an allocation to each segment. Most of these expenses are distributed to each segment based on different parameters, such as payroll hours, processed claims, or square footage, among others. In addition, some depreciable assets are kept by one segment, while allocating the depreciation expense to other segments. The allocation of the depreciation expense is based on the proportion of asset used by each segment. Certain expenses are not allocated to the segments and are kept within TSM s operations.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008

The following tables summarize the operations by operating segment for each of the years in the three-year period ended December 31, 2010, 2009, and 2008.

	2010	2009	2008
Operating revenues			
Managed care			
Premiums earned, net	$ 1,697,083	$ 1,673,762	$ 1,506,665
Fee revenue	39,546	48,643	19,187
Intersegment premiums/fee revenue	6,852	5,995	6,538
Net investment income	19,799	21,641	23,091
Total managed care	1,763,280	1,750,041	1,555,481
Life			
Premiums earned, net	105,437	99,726	92,469
Intersegment premiums	382	386	374
Net investment income	17,130	16,763	16,482
Total life	122,949	116,875	109,325
Property and casualty			
Premiums earned, net	98,580	95,596	93,211
Intersegment premiums	613	613	610
Net investment income	10,132	11,679	12,545
Total property and casualty	109,325	107,888	106,366
Other segments*			
Intersegment service revenues	45,852	52,997	46,578
Operating revenues from external sources	2		
Total other segments	45,854	52,997	46,578
Total business segments	2,041,408	2,027,801	1,817,750
TSM operating revenues from external sources	2,082	2,053	4,135
Elimination of intersegment premiums	(7,847)	(6,994)	(7,523)
Elimination of intersegment service revenue	(45,852)	(52,997)	(46,578)
Consolidated operating revenues	$ 1,989,791	$ 1,969,863	$ 1,767,784

* Includes segments that are not required to be reported separately, primarily the data processing services organization as well as the third-party administrator of health insurance services.

64

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008

	2010	2009	2008
Operating income			
Managed care	$ 63,798	$ 57,193	$ 52,632
Life	17,334	14,555	12,489
Property and casualty	3,579	8,746	13,147
Other segments*	1,161	1,482	985
Total business segments	85,872	81,976	79,253
TSM operating revenues from external sources	2,082	2,053	4,135
TSM unallocated operating expenses	(9,566)	(9,004)	(9,283)
Elimination of TSM charges	9,619	9,548	9,991
Consolidated operating income	88,007	84,573	84,096
Consolidated net realized investment gains (losses)	2,532	614	(13,940)
Consolidated net unrealized gain (loss) on trading securities	5,433	10,497	(21,064)
Consolidated interest expense	(12,658)	(13,270)	(14,681)
Consolidated other income (expense), net	889	1,237	(2,467)
Consolidated income before taxes	$ 84,203	$ 83,651	$ 31,944

	2010	2009	2008
Depreciation expense			
Managed care	$ 12,282	$ 6,640	$ 4,339
Life	674	663	656
Property and casualty	1,680	1,477	1,450
Total business segments	14,636	8,780	6,445
TSM depreciation expense	864	863	922
Consolidated depreciation expense	$ 15,500	$ 9,643	$ 7,367

* Includes segments that are not required to be reported separately, primarily the data processing services organization as well as the third-party administrator of health insurance services.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008

	2010	2009
Assets		
Managed care	$ 790,485	$ 746,674
Life	523,246	487,290
Property and casualty	339,955	351,793
Other segments*	16,842	14,193
Total business segments	1,670,528	1,599,950
Unallocated amounts related to TSM		
Cash, cash equivalents, and investments	62,841	39,029
Property and equipment, net	20,712	21,577
Other assets	20,600	4,780
	104,153	65,386
Elimination entries intersegment receivables and others	(15,002)	(16,632)
Consolidated total assets	$ 1,759,679	$ 1,648,704

	2010	2009
Significant noncash items		
Net change in unrealized gain on securities available for sale		
Managed care	$ (8,512)	$ (282)
Life	(7,746)	(2,427)
Property and casualty	(2,328)	(489)
Other segments*	(196)	
Total business segments	(18,782)	(3,198)
Amount related to TSM	(4,820)	(341)
Consolidated net change in unrealized gain on securities available for sale	$ (23,602)	$ (3,539)

* Includes segments that are not required to be reported separately, primarily the data processing services organization as well as the third-party administrator of health insurance services.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008
30. Quarterly Financial Information (Unaudited)

	2010				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$ 494,177	$ 502,761	$ 496,511	$ 407,651	$ 1,901,100
Administrative service fees	12,498	12,166	10,195	4,687	39,546
Net investment income	12,423	12,671	12,794	11,257	49,145
Total operating revenues	519,098	527,598	519,500	423,595	1,989,791
Net realized investment (losses) gains	(1,379)	1,433	(313)	2,791	2,532
Net unrealized investment (losses) gains on trading securities	2,030	(6,010)	4,611	4,802	5,433
Other (loss) income, net	152	(324)	576	485	889
Total revenues	519,901	522,697	524,374	431,673	1,998,645
Benefits and expenses					
Claims incurred	425,828	424,838	421,514	324,609	1,596,789
Operating expenses	76,871	76,720	74,111	77,293	304,995
Total operating costs	502,699	501,558	495,625	401,902	1,901,784
Interest expense	3,228	3,372	3,026	3,032	12,658
Total benefits and expenses	505,927	504,930	498,651	404,934	1,914,442
Income before taxes	13,974	17,767	25,723	26,739	84,203
Income tax expense (benefit)					
Current	3,544	4,877	6,040	(113)	14,348
Deferred	(762)	(2,167)	(805)	6,788	3,054
Total income taxes	2,782	2,710	5,235	6,675	17,402
Net income	$ 11,192	$ 15,057	$ 20,488	$ 20,064	$ 66,801
Basic net income per share	$ 0.38	$ 0.52	$ 0.70	$ 0.70	$ 2.30
Diluted net income per share	$ 0.38	$ 0.51	$ 0.70	$ 0.69	$ 2.28

Table of Contents

Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2010, 2009 and 2008

	2009				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$ 451,438	$ 463,072	$ 476,269	$ 478,305	$ 1,869,084
Administrative service fees	8,866	11,319	9,797	18,661	48,643
Net investment income	12,541	13,360	12,955	13,280	52,136
Total operating revenues	472,845	487,751	499,021	510,246	1,969,863
Net realized investment (losses) gains	(1,727)	(1,625)	2,150	1,816	614
Net unrealized investment (losses) gains on trading securities	(2,476)	5,652	4,860	2,461	10,497
Other (loss) income, net	(379)	704	67	845	1,237
Total revenues	468,263	492,482	506,098	515,368	1,982,211
Benefits and expenses					
Claims incurred	393,486	395,271	412,392	404,723	1,605,872
Operating expenses	68,252	68,603	71,205	71,358	279,418
Total operating costs	461,738	463,874	483,597	476,081	1,885,290
Interest expense	3,264	3,357	3,338	3,311	13,270
Total benefits and expenses	465,002	467,231	486,935	479,392	1,898,560
Income before taxes	3,261	25,251	19,163	35,976	83,651
Income tax expense (benefit)					
Current	451	9,090	2,096	7,560	19,197
Deferred	(1,122)	(2,499)	(1,017)	312	(4,326)
Total income taxes	(671)	6,591	1,079	7,872	14,871
Net income	$ 3,932	$ 18,660	$ 18,084	$ 28,104	$ 68,780
Basic net income per share	$ 0.13	$ 0.64	$ 0.62	$ 0.96	$ 2.33
Diluted net income per share	$ 0.13	$ 0.63	$ 0.62	$ 0.96	$ 2.33

31. Subsequent Events

The Company evaluated subsequent events through the date the financial statements were issued. No events, other than those described in these notes, have occurred that require disclosure pursuant to current Accounting Standard Codification.

Table of Contents

Triple-S Management Corporation
Schedule II
Condensed Financial Information of Triple-S Management Corporation
(Registrant)
Balance Sheets

(in thousands)	As of December 31, 2010	2009
Assets:		
Cash and cash equivalents	$ 167	$ 361
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $45,753 in 2010 and $31,914 in 2009)	49,649	32,242
Equity Securities (cost of $11,444 in 2010 and $7,800 in 2009)	12,172	6,426
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $974 in 2010)	1,017	
Investment in subsidiaries	661,886	579,588
Note receivable and accrued interest from subsidiary	44,140	46,354
Due from subsidiaries		2,552
Deferred tax assets	18,829	14,984
Other assets	23,139	24,152
Total assets	$ 810,999	$ 706,659
Liabilities:		
Due to subsidiary	4,182	4,335
Short-term borrowings	15,575	
Long-term borrowings	116,027	117,667
Liability for pension benefits	51,246	41,044
Other liabilities	6,697	5,841
Total liabilities	193,727	168,887
Stockholders equity:		
Common stock, class A	9,043	9,043
Common stock, class B	19,773	20,110
Additional paid-in-capital	155,299	159,303
Retained earnings	427,693	360,892
Accumulated other comprehensive income (loss), net	5,464	(11,576)
Total stockholder s equity	617,272	537,772
Total liabilities and stockholder s equity	$ 810,999	$ 706,659

The accompanying notes are an integral part of these condensed financial statements

Table of Contents

Triple-S Management Corporation
Schedule II
Condensed Financial Information of Triple-S Management Corporation
Triple-S Management Corporation
Statements of Earnings

(in thousands)	2010	2009	2008
Investment income	$ 4,588	$ 5,068	$ 7,324
Other revenues	11,385	8,690	8,215
Total revenues	15,973	13,758	15,539
Operating expenses:			
General and administrative expenses	9,566	9,004	9,283
Interest expense	6,038	6,693	7,301
Total operating expenses	15,604	15,697	16,584
(Loss) income before income taxes	369	(1,939)	(1,045)
Income tax (benefit) expense	529	(463)	268
(Loss) Income of parent company	(160)	(1,476)	(1,313)
Equity in income of subsidiaries	66,961	70,256	26,103
Net income	$ 66,801	$ 68,780	$ 24,790

The accompanying notes are an integral part of these condensed financial statements

Table of Contents

Triple-S Management Corporation
Schedule II
Condensed Financial Information of Triple-S Management Corporation
(Registrant)
Statements of Cash Flows

(in thousands)	12/31/2010	12/31/2009	12/31/2008
Net income	$ 66,801	$ 68,780	$ 24,790
Adjustment to reconcile net income to net cash (used in) provided by operating activities:			
Equity in net income of subsidiaries	(66,961)	(70,256)	(26,103)
Depreciation and amortization	865	863	922
Shared- based compensation	1,894	3,924	3,268
Deferred income tax (expense) benefit	392	(644)	(363)
Dividends received from subsidiary	15,000		
Other	(314)	934	1,965
Changes in assets and liabilities:			
Accrued interest from subisidiary	2,214	1,985	(3,188)
Due from subsidiaries	2,552	6,404	(8,359)
Other assets	148	(175)	(1,173)
Due to subsidiary	(153)	4,138	(5,818)
Other liabilities	(768)	(85)	2,343
Net cash provided by (used in) operating activities	21,670	15,868	(11,716)
Cash flows from investing activities:			
Acquisition of investment in securities classified as available for sale	(95,346)	(40,996)	(70,684)
Proceeds from sale and maturities of investment in securities classified as available for sale	71,782	58,324	45,905
Capitalization of subsidiary	(6,000)		
Net (acquisition) retirement of property and equipment		(792)	(47)
Net cash (used in) provided by investing activities	(29,564)	16,536	(24,826)
Cash flow from financing activities:			
Repayments of borrowings	(26,640)	(1,640)	(1,639)
Net proceeds from short-term borrowings	15,575		
Proceeds from long-term borrowings	25,000		
Repurchase of common stock	(6,235)	(32,355)	(7,645)
Other			6
Net cash provided by (used in) financing activities	7,700	(33,995)	(9,278)
Net decrease in cash and cash equivalents	(194)	(1,591)	(45,820)
Cash and cash equivalents, beginning of year	361	1,952	47,772
Cash and cash equivalents, end of year	$ 167	$ 361	$ 1,952

The accompanying notes are an integral part of these condensed financial statements

Table of Contents

Triple-S Management Corporation
(Parent Company Only)
Notes to Condensed Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands)

The accompanying notes to the condensed financial statements should be read in conjunction with the consolidated financial statements and the accompanying notes thereto included in Item 15 to the Annual Report on Form 10-K.

(1) For purposes of these condensed financial statements, Triple-S Management Corporation s (the Company or TSM) investment in its wholly owned subsidiaries is recorded using the equity basis accounting.

(2) Significant Accounting Policies

The significant accounting policies followed by the Company are set forth in the notes to the consolidated financial statements and the accompanying notes thereto. Refer to Item 15 to the Annual Report of Form 10-K.

(3) Reclassifications

Certain amounts in the 2009 financial statements were reclassified to conform to the 2010 presentation. We reclassified certain allocations made to subsidiaries related to the liability for pension benefits.

(4) Long-Term Borrowings

A summary of the long-term borrowings entered into by the Company at December 31, 2009 and 2008 follows:

	2010	**2009**
Senior unsecured notes payable of $60,000 issued on December 2005; due December 2020. Interest is payable monthly at a fixed rate of 6.60%.	$ 35,000	$ 60,000
Senior unsecured notes payable of $35,000 issued on January 2006; due January 2021. Interest is payable monthly at a fixed rate of 6.70%.	35,000	35,000
Secured loan payable of $41,000, payable in monthly installments of $137 through July 1, 2024, plus interest at a rate reset periodically of 100 basis points over selected LIBOR maturity (which was 1.29% and 1.28% at December 31, 2010, and 2009, respectively).	21,027	22,667
Repurchase agreement of $25.0 million entered on November 2010, due November 2015. Interest is payable quarterly at a fixed rate of 1.96%.	25,000	
Total borrowings	$ 116,027	$ 117,667

Table of Contents

Triple-S Management Corporation
(Parent Company Only)
Notes to Condensed Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands)

Aggregate maturities of the Company s long term borrowings as of December 31, 2010 are summarized as follows:

Year ending December 31	
2011	$ 1,640
2012	1,640
2013	1,640
2014	1,640
2015	26,640
Thereafter	82,827
	$ 116,027

All of the Company s senior notes can be prepaid at par, in total or partially, five years after issuance as determined by the Company.

Debt issuance costs related to each of the Company s senior unsecured notes were deferred and are being amortized over the term of its respective senior note. Unamortized debt issuance costs related to these senior unsecured notes as of December 31, 2010 and 2009 amounted to $431 and $651, respectively, and are included within the other assets in the accompanying condensed balance sheets.

The secured loan note payable previously described is guaranteed by a first position held by the bank on the Company s and its subsidiaries land, building, and substantially all leasehold improvements, as collateral for the term of the loans under a continuing general security agreement. This secured loan contains certain non-financial covenants, which are customary in this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitation on changes in control.

The repurchase agreement has pledged as collateral investment securities available for sale with fair value of $28,453 (face value of $23,918). The investment securities underlying such agreements were delivered to the financial institution with whom the agreement was transacted. The dealers may have loaned, or used as collateral securities in the normal course of business operations. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on the accompanying consolidated balance sheets.

Table of Contents

Triple-S Management Corporation
(Parent Company Only)
Notes to Condensed Financial Statements
December 31, 2010, 2009 and 2008
(dollar amounts in thousands)

(5) Transactions with Related Parties

The following are the significant related-party transactions made for the three-year period ended December 31, 2010, 2009 and 2008:

	2010	2009	2008
Rent charges to subsidiaries	$ 7,468	$7,422	$7,286
Interest charged to subsidiary on note receivable	2,786	3,015	3,189
Transfers in due to investments purchased	83,502	3,230	
Transfers out due to investments sold	59,911	6,274	

As of December 31, 2010 the Company has a note receivable from a subsidiary amounting to $37,000 pursuant to the provisions of Article 29.30 of the Puerto Rico Insurance Code. The note receivable from subsidiary is due on demand; however, pursuant to the requirements established by the Commissioner of Insurance, the parties agreed that no payment of the total principal nor the interest due on the loan will be made without first obtaining written authorization from the Commissioner of Insurance within at least 60 days prior to the proposed payment date. This note bears interest at 6.6% at December 31, 2010 and 2009, respectively. Accrued interest at December 31, 2010 and 2009 amounted to $7,140 and $9,354, respectively.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Schedule III Supplementary Insurance Information
For the years ended December 31, 2010, 2009 and 2008

(Amounts in thousands) Segment	Deferred Policy Acquisition Costs and Value of Business Acquired	Claim Liabilities	Liability for Future Policy Benefits	Unearned Premiums	Other Policy Claims and Benefits Payable	Net Premium Revenue	Investment Income	Claims Incurred	Amortization of Deferred Policy Acquisition Costs and Value of Business Acquired	Other Operating Expenses	P
care	$	$ 236,170	$	$ 4,600	$	$ 1,700,252	$ 19,799	$ 1,497,756	$	$ 201,726	$
ance	121,555	41,179	236,523	3,724		105,819	17,130	49,804	15,168	40,643	
nd casualty insurance	24,531	82,861		90,017		99,193	10,132	49,229	32,861	23,656	
-reportable segments, mpany operations and idating entries						(4,164)	2,084			(9,059)	
	$ 146,086	$ 360,210	$ 236,523	$ 98,341	$	$ 1,901,100	$ 49,145	$ 1,596,789	$ 48,029	$ 256,966	$
care	$	$ 236,366	$	$ 6,996	$	$ 1,677,080	$ 21,641	$ 1,508,185	$	$ 184,663	$
ance	112,908	40,100	222,619	4,163		100,112	16,763	50,353	16,844	35,123	
nd casualty insurance	27,009	83,980		97,183		96,209	11,679	47,334	28,284	23,524	
-reportable segments, mpany operations and idating entries						(4,317)	2,053			(9,020)	
	$ 139,917	$ 360,446	$ 222,619	$ 108,342	$	$ 1,869,084	$ 52,136	$ 1,605,872	$ 45,128	$ 234,290	$
care	$	$ 201,849	$	$ 5,585	$	$ 1,509,912	$ 23,091	$ 1,342,258	$	$ 160,591	$
ance	101,243	39,948	207,545	3,370		92,843	16,482	47,432	16,404	33,000	
nd casualty insurance	25,104	81,913		101,186		93,821	12,546	42,111	27,383	23,725	
-reportable segments, mpany operations and						(4,232)	4,134			(9,216)	

idating entries

$ 126,347	$ 323,710	$ 207,545	$ 110,141	$	$ 1,692,344	$ 56,253	$ 1,431,801	$ 43,787	$ 208,100	$

See accompanying independent registered public accounting firm s report and notes to financial statements.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Schedule IV Reinsurance
For the years ended December 31, 2010, 2009 and 2008

(Dollar amounts in thousands)	Gross Amount	Ceded to Other Companies (1)	Assumed from Other Companies	Net Amount	Percentage of Amount Assumed to Net
2010					
Life insurance in force	$ 8,926,668	$ 2,987,054	$	$ 5,939,614	0.0%
Premiums:					
Life insurance	$ 111,085	$ 5,648	$	$ 105,437	0.0%
Accident and health insurance	1,708,289	11,206		1,697,083	0.0%
Property and casualty insurance	162,326	63,746		98,580	0.0%
Total premiums	$ 1,981,700	$ 80,600	$	$ 1,901,100	0.0%
2009					
Life insurance in force	$ 10,714,252	$ 2,937,377	$	$ 7,776,875	0.0%
Premiums:					
Life insurance	$ 106,243	$ 6,131	$	$ 100,112	0.0%
Accident and health insurance	1,680,496	7,341		1,673,155	0.0%
Property and casualty insurance	163,358	67,541		95,817	0.0%
Total premiums	$ 1,950,097	$ 81,013	$	$ 1,869,084	0.0%
2008					
Life insurance in force	$ 10,503,170	$ 2,823,647	$	$ 7,679,523	0.0%
Premiums:					
Life insurance	$ 100,413	$ 7,570	$	$ 92,843	0.0%
Accident and health insurance	1,509,257	5,623		1,503,634	0.0%
Property and casualty insurance	167,982	72,115		95,867	0.0%
Total premiums	$ 1,777,652	$ 85,308	$	$ 1,692,344	0.0%

(1) Premiums ceded on the life insurance business are net of commission income on reinsurance amounting to $42 and $287 for the years ended December 31, 2009 and 2008. None for the year ended December 31, 2010.

See accompanying independent registered public accounting firm s report and notes to financial statements.

Table of Contents

Triple-S Management Corporation and Subsidiaries
Schedule V Valuation and Qualifying Accounts
For the years ended December 31, 2010, 2009 and 2008
(Dollar amounts in thousands)

	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Additions Charged (Reversal) To Other Accounts - Describe (1)	Deductions - Describe (2)	Balance at End of Period
2010					
Allowance for doubtful receivables	$ 25,234	7,118	(9,967)	(2,351)	$ 20,034
2009					
Allowance for doubtful receivables	$ 14,745	2,149	10,065	(1,725)	$ 25,234
2008					
Allowance for doubtful receivables	$ 15,925	821		(2,001)	$ 14,745

(1) Represents premiums adjustment to provide for unresolved reconciliation items with the Government of Puerto Rico and other entities.

(2) Deductions represent the write-off of accounts deemed uncollectible.

See accompanying independent registered public accounting firm s report and notes to financial statements.