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

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

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

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

COMMISSION FILE NUMBER 001-33865
Triple-S Management Corporation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DOCUMENTS INCORPORATED BY REFERENCE

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

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

Item 1. Business.

General Description of Business and Recent Developments

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

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

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

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

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

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

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

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

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Industry Overview

Managed Care

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

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

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

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Life Insurance

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

Property and Casualty Insurance Segment

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

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

Puerto Rico s Economy

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

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

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

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

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

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

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Products and Services

Managed Care

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

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

We currently offer the following managed care plans:

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

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

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

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

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

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

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

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

Life Insurance

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

Property and Casualty Insurance

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

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

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

catastrophic losses occurred in that year. Because there were fewer

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

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

Marketing and Distribution

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

Branding and Marketing

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

Distribution

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

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

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

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

Customers

Managed Care

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

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

Commercial Sector

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

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

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

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

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

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

Reform Sector

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

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

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

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

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

Medicare Advantage Sector

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

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

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

Life Insurance

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

Property and Casualty Insurance

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

Underwriting and Pricing

Managed Care

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

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

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

Life Insurance

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

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

Property and Casualty Insurance

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

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

Quality Initiatives and Medical Management

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

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

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

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

Information Systems

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

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

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

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

Provider Arrangements

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

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

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

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

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

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

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

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

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

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

Competition

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

Managed Care

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

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

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

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

Life Insurance

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

Property & Casualty Insurance

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

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

Blue Shield License

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

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

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

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

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

failure to satisfy state-mandated statutory net worth requirements;

impending financial insolvency; and

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

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

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

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

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

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

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

Claim Liabilities

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

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

Investments

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

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

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

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

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

Trademarks

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

Regulation

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

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

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

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

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

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

Reform and Medicare reform legislation;

local government plans and initiatives;

Reform and Medicare reform legislation; and

increased government concerns regarding fraud and abuse.; and

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

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

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

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

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

surcharges on payments to providers;

market conduct;

provider contract forms;

delegation of financial risk and other financial

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

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

Puerto Rico Insurance Laws

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

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

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

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

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

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