TRIPLE-S MANAGEMENT CORP
Form 10-K
March 20, 2007

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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, 2006

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 0-49762
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:
None
Securities registered pursuant to Section 12(g) of the Act:
Common Stock, $40.00 Par Value

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

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

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. YES þ NO o

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, or a non-accelerated filer. See definition of accelerated filer and large accelerated filer in Rule 12b-2 of the Exchange Act (Check one).

Large accelerated filer o Accelerated filer o Non-accelerated filer þ

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

The aggregate market value of common stock held by non-affiliates of the registrant as of December 31, 2006 was $356,440. *

The number of shares outstanding of the registrant s common stock as of March 15, 2007 was 8,913.

* Aggregate market value was determined at par because there is no

established
public trading
market for
TSM s common
stock.

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 29, 2007 are incorporated by reference into Part III of this Annual Report on Form 10-K.

Triple-S Management Corporation
FORM 10-K
For The Fiscal Year Ended December 31, 2006
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Part I
Item 1. Business.
General Description of Business and Recent Developments

Triple-S Management Corporation (we, TSM or the Corporation) is the largest managed care company in Puerto Rico, serving approximately one million members across all regions, and holds a leading market position covering approximately 25% of the population. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico and have over 45 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 and accident and health insurance (life insurance) and property and casualty insurance. As a result of our recent acquisition of Great American Life Assurance Company of Puerto Rico (GA Life), we are the leading provider of life insurance policies in Puerto Rico.

Effective January 31, 2006, we acquired 100% of the common stock of GA Life and effective June 30, 2006 merged the operations of Seguros de Vida Triple-S, Inc., our former life insurance subsidiary, into the operations of GA Life.

All 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.

Industry Overview

Managed Care

The managed care industry has experienced significant change in the last decade. An increasing focus on health care costs by employers, the government and consumers has led to the growth of alternatives to traditional indemnity health insurance, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), which managed care providers employ to attempt 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 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 federal government provides hospital and medical insurance benefits to eligible persons aged 65 and over as well as to certain other qualified persons pursuant to 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, 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 Blue Cross Blue Shield Association (BCBSA) had 39 independent licensees as of December 31, 2006. We are licensed by BCBSA to use the Blue Shield mark in Puerto Rico. Most of the BCBSA licensees have the right to use the Blue Shield and Blue Cross marks in their designated geographic territories. We are not licensed to use the Blue Cross mark in Puerto Rico. A difference BCBSA licensee has the right to use the Blued Cross mark in Puerto Rico. The number of people enrolled in Blue Cross Blue Shield (BCBS) plans has been steadily increasing, from 65.6 million in 1995 to 98.6 million at December 31, 2006, which represents 32.7% of the U.S. population. The Blue Cross Blue Shield 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 Blue Cross Blue Shield plans participate in the BlueCard program, which effectively creates a national Blue network. Each plan is able to take advantage of other Blue Cross Blue Shield 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. This program is referred to as BlueCard®, and 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.

Life Insurance

Total premiums in Puerto Rico for the life insurance market approximate $600 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. It is estimated that the life insurance market is underinsured.

Property and Casualty Insurance Segment

The total property and casualty market in Puerto Rico in terms of gross premiums written for 2005 was approximately $1.8 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 70% of the market is written by the top six companies in terms of market share, and approximately 80% 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 under $1.0 billion. As a result, the market is highly dependent on reinsurance and some local carriers have diversified their operations outside Puerto Rico, particularly to Florida.

Puerto Rico s Economy

The gross national product of Puerto Rico has grown by an average of 2.5% per annum over the last decade. The government of Puerto Rico has reported that factors contributing to this expansion include government-sponsored economic development programs, increases in the level of federal transfer payments and the relative low cost of borrowing. The government of Puerto Rico further reported that in some years, these factors experienced in Puerto Rico were aided by a significant expansion in construction investment driven by infrastructure projects, private investment, primarily in housing, and relatively low oil prices. Since the last recession in fiscal 2002 (from July 1, 2001 to June 30, 2002), the economy has been expanding at a moderate annual rate of 2.3%, but recently, as several key economic figures have begun to indicate a slowing of economic activity, the Puerto Rico Planning Board recently published a preliminary growth in gross national product of 0.7% for fiscal 2006 and lowered its real gross national product forecast from 2.5% to 0.6% for fiscal 2007. Among the variables contributing to the Puerto Rico Planning Board s downward revision in the forecast are the persistent high levels of oil prices, the upward trend in short-term

interest rates, the depreciation of the dollar (which affects the value of imports from foreign countries, accounting for approximately 50% of total imports to Puerto Rico), and the deceleration of public investment due to Puerto Rico s budget deficits (which served, together with other factors, to reduce activity in construction and other sectors). In April 2006, the government of Puerto Rico announced a possible lack of budgetary funds to complete the fiscal year ended June 30, 2006 with a balanced budget, as required by law. This situation was remedied prior to June 30, 2006 when the legislative and executive branches of government approved a loan to provide funding for the budget for that fiscal year. In order to raise additional funds in future fiscal years, the legislative and executive branches also approved a fiscal

reform and a tax reform. The tax reform, which took effect on November 15, 2006, imposes a 7% sales tax on the consumption of goods and services. The implementation of this tax reform is expected to alleviate Puerto Rico s fiscal difficulties by raising additional revenues but this, too, may reduce net disposable income even after giving effect to certain income tax reductions provided in the tax reform legislation.

The economy of Puerto Rico is closely linked to the continental United States economy, 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 economy 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 fiscal year 2005 (from July 1, 2004 to June 30, 2005) approximately 83% of Puerto Rico s exports went to the United States mainland, which was also the source of approximately 50% of Puerto Rico s imports.

The dominant sectors of the Puerto Rico economy 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, electronics, 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.

Products and Services

Managed Care

We offer a broad range of managed care products, including HMOs, PPOs, Medicare Supplement and Medicare Part D. Managed care products represented 88.6%, 92.7% and 92.3% of our consolidated premiums earned, net for the years ended December 31, 2006, 2005 and 2004. 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 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. During the third quarter of 2005, we launched Medicare Selecto, our Medicare Advantage product for dual eligibles (individuals that are eligible for both the Reform and Medicare Advantage), and in 2006 we launched a supplemental product sponsored by the government of Puerto Rico called Medicare Platino. We also recently launched our new HMO Medicare Advantage product for the non-dual eligible population.

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. As a PPO under the Medicare Advantage program, effective January 1, 2005 we launched Medicare Optimo, our PPO Medicare Advantage policy, under which we provide extended health coverage to Medicare beneficiaries.

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 Blue Cross Blue Shield plans in the continental United States and certain U.S. territories. In addition, the BlueCard

program offers our PPO members in-network coverage in over 50 countries through Europe and Latin America. We believe that the national and international coverage provided through this program allows us to compete effectively with large national insurers.

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 pursuant to our Medicare Advantage plans as well as on a stand-alone basis. Our PDP stand-alone product, called FarmaMed, was launched in 2006. In May 2005, we launched the Drug Discount Card for local government employees and individuals. As of December 31, 2006, we had enrolled approximately 17,000 members in this program. We plan to extend the program to members in group plans without drug coverage during 2007.

Government Services We serve as fiscal intermediary for the Medicare Part B program in Puerto Rico and the U.S. Virgin Islands, for which we receive reimbursement of all direct costs and allocated overhead expenses, based on an approved budget by the Centers for Medicare and Medicaid Services (CMS). This program is subject to change. 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. Among these are group life and life individual insurance products. Life insurance premiums represented 5.7%, 1.2% and 1.3% of our consolidated premiums earned, net for the years ended December 31, 2006, 2005 and 2004. GA Life 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 only 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. Property and casualty insurance premiums represented 5.9%, 6.3% and 6.6% of our consolidated premiums earned, net for the years ended December 31, 2006, 2005 and 2004. Our predominant lines of business are commercial multiple peril, commercial property mono-line policies, auto physical damage, auto liability and dwelling insurance. 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. In the first half of 2007, we intend to expand our auto insurance business, which will write personal auto policies at preferred rates.

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 has been affected by increased costs of reinsurance during the last year due to severe catastrophic losses in 2005, which are also expected to cause reinsurance costs to continue to increase in the near future.

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. 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 200 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 (52% in 2006) through direct selling to customers in their homes. As of December 31, 2006, GA Life employed over 500 full-time active agents and managers and utilized approximately 570 independent agents and brokers. We pay commissions on a monthly basis based on premiums paid. In addition, GA Life has over 200 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 20 general agencies, including our insurance agency, Signature Insurance Agency, Inc. (SIA), where business is placed by independent insurance agents and brokers. SIA placed approximately 52%, 52% and 53% of our property and casualty insurance subsidiary, Seguros Triple-S, Inc. (STS), total premium volume during the years ended December 31, 2006, 2005 and 2004, respectively. As of December 31, 2006, SIA was the third largest insurance agency in Puerto Rico in terms of premiums written. 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 four distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2006:

Market Sector	Enrollment at December 31, 2006	Percentage of Total Enrollment

Commercial	580,850	59.3
Reform	357,515	36.5
Medicare Advantage	27,078	2.8
Stand-Alone Prescription Drug Plan	14,063	1.4
Total	979,506	100.0

Commercial Sector

The commercial accounts sector includes corporate accounts, individual accounts, Medicare Supplement, Federal government employees and local government employees.

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.

Federal Government Employees. For more than 40 years, we have maintained our leadership in the provision of managed care to 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 segment, 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.

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 geographical area is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2006, 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 has adopted several measures to control the increase of Reform expenditures, which represented approximately 15.0% of total government expenditures during its fiscal year ended June 30, 2006, 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 in one of the eight geographical areas under which it contracted services on an ASO basis instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us until October 31, 2006. All other areas that we currently serve remain with the fully-insured model however; there can be no assurance that the government will not implement such a program in the future. If it is adopted in any areas served by us during the contract period, we would not generate

premiums in the Reform business but instead 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 traditional Medicare programs, such as the deductibles and co-payments of prescription drug benefits. All qualified Reform participants began moving to the

government-sponsored plan in January 2006, and approximately 61,000 of such participants did so in the year ended December 31, 2006.

We provide managed care services to Reform members in the North and Southwest regions. We have participated in the Reform program since 1995. The premium rates for each Reform contract are negotiated annually. The contracts include a provision, however, that if the net income for any given contract year, as defined therein, resulting from the provision of services there under exceeds 2.5% of earned premiums, the insurance company is required to return 75.0% of the excess to the government. 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 our revenues .

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 Reform Act, started promoting a managed care organizations (MCOs) sponsored Medicare product that offers benefits similar or better than the traditional Medicare product, but where the risk is assumed by the MCOs. This 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.

Stand-Alone Prescription Drug Plan Sector

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 pursuant to 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 insurance customers consist primarily of individuals, which hold approximately 320,000 policies, and 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.

Provider Arrangements

Approximately 98% of member services are provided through one of our contracted provider networks and the remaining 2% 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, 2006, we had provider contracts with 4,285 primary care physicians, 2,992 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 93% for the last two years.

In the Reform sector, we have a network of Independent Practice Associations (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 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 Blue Cross Blue Shield Association, 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, a third-party national provider network.

Subcontracting. We subcontract our triage call center, utilization management and disease 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. At the moment, 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 980,000 members enrolled in our managed care segment at December 31, 2006, representing approximately 25% of the population of Puerto Rico. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 26% for the year ended December 31, 2006. 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

nearest competitor is Medical Card Systems Inc., which had a market share of approximately 17% as of December 31, 2006. Our other largest competitors in the managed care segment are Aveta Inc. (or MMM Healthcare) and Humana Inc.

Life Insurance

As a result of the GA Life acquisition, we are the leading provider of life insurance products in Puerto Rico. 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 particular from Cooperativa de Seguros de Vida de Puerto Rico and National Life Insurance Company. In the ordinary life sector, our main competitors are National Life Insurance Company and Americo Financial Life and Annuity Insurance Company. In group life insurance, our main competitors are Hartford Life, Inc., Universal Life Insurance Company and Metropolitan Life Insurance Company. In the cancer sector, our main competitors are National Life Insurance Company, Trans-Oceanic Life Insurance Company, Universal Life Insurance Company and American Family Insurance.

Property & Casualty Insurance

The property and casualty insurance market in Puerto Rico is extremely competitive. In addition, soft market conditions prevailed during 2006 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 2006, we rank among the top five largest companies in the property and casualty insurance market in Puerto Rico, as measured by direct premiums, with a market share of approximately 8.5%. Our nearest competitors in the property and casualty insurance market in Puerto Rico in 2006 were National Insurance Company and Integrand Assurance Company. 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. 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:

- 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 Blue Cross Blue Shield Association, 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 Blue Cross Blue Shield Association or a violation of the Blue Cross Blue Shield Association voting and ownership limitations on our capital stock.

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

Each license requires an annual fee to be paid to the Blue Cross Blue Shield Association. The fee is determined based on a per-contract charge from products using the Blue Shield name and mark. During the years ended December 31,

2006 and, 2005, we paid fees to the Blue Cross Blue Shield Association in the amount of $964,956 and $791,587, respectively. The Blue Cross Blue Shield Association is a national trade association of 39 Blue Cross Blue Shield licensees (also known as Member Plans), the primary function of which is to promote and preserve the integrity of the Blue Cross Blue Shield names and marks, as well as to provide certain coordination among the Member Plans. Each Blue Cross Blue Shield 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.

BlueCard. Under the rules and license standards of the Blue Cross Blue Shield Association, other Blue Cross Blue Shield 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 Plans that are at least as great as the discounts that the providers give to the Host Plan s local members. The Blue Cross Blue Shield Association requires us to pay fees to any Host Blue Cross Blue Shield 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 Blue Cross Blue Shield Plans who receive care in our service area.

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 of the U.S. Department of Health and Human Services, the Office of Civil Rights, the U.S. Department of Justice, and the Office of Personnel Management. 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 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 increase healthcare regulation, including efforts to expand the tort liability of health plans;
- local government plans and initiatives;
- Medicare reform legislation; and
- Increase government concerns regarding fraud and abuse.

The U.S. Congress is continuing to develop legislation 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 2007 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.

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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;
- 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;
- 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;

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) 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 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.

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 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.

Capital and Reserve Requirements

In addition to the capital and reserve requirements set forth below, the Commissioner of Insurance requires our managed care subsidiary to maintain minimum capital of $1.0 million, our life insurance subsidiary to maintain minimum capital of $2.5 million and our property and casualty insurance subsidiary to maintain minimum capital of $3.0 million. 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 National Association of Insurance Commissioners (NAIC) RBC Model Act. These capital and surplus requirements are intended to assess capital adequacy taking into account the risk characteristics of an insurer s investments and products. The RBC Model Act set forth the formula for calculating the risk-based capital requirements, which are designed to take into account risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company s business. We and our insurance subsidiaries currently meet 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. Natural disasters have affected Puerto Rico greatly over the past 10 years and have prompted the local government to mandate property and casualty insurance reserves. In addition to its catastrophic reinsurance coverage, we are required by local regulatory authorities to establish and maintain a trust fund (the Trust) to protect us from our dual exposure to hurricanes and earthquakes. The Trust is intended to be used as our first layer of catastrophe protection whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust are determined by a rate (1% in 2006 and 2005), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2006 and 2005, we had $27.1 million and $25.1 million, respectively, invested in securities deposited in the Trust. The income generated by investment securities deposited in the Trust becomes part of the Trust fund balance. For additional details see note 19 of the audited consolidated financial statements.

Federal Regulation

The Medicare Program and Medicare Advantage

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 Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in

Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a $125 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often purchase Medicare supplement products, commonly known as Medigap , to cover deductibles, co-payments, and coinsurance.

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, an individual can choose any licensed physician and use the services of any hospital, healthcare provider, or facility certified by Medicare. CMS reimburses providers if Medicare covers the service and CMS considers it medically necessary . There is currently no fee-for-service coverage for certain preventive services, including annual physicals and well visits, eyeglasses, hearing aids, dentures and most dental services.

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

Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans members. One of CMS s primary directives in establishing the Medicare+Choice program was to make it more attractive to managed care plans to enroll members with higher intensity illnesses. To accomplish this, CMS implemented a risk adjustment payment system for Medicare health plans pursuant to the Balanced Budget Act of 1997, or BBA. This payment system was further modified pursuant to the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, or BIPA. CMS is phasing in this risk adjustment payment methodology with a model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors including hospital inpatient diagnoses, additional diagnosis data from ambulatory treatment settings, hospital outpatient department and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS s internal database. Under this system, the risk adjusted portion of the total CMS payment to the Medicare Advantage plans will equal the local rate set forth in the traditional demographic rate book, adjusted to reflect the plan s average gender, age, and disability demographics. During 2003, risk adjusted payments accounted for only 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional demographic rate book. The portion of risk adjusted payments was increased to 30% in 2004, 50%, in 2005 and 75% in 2006, and will increase to 100% in 2007.

The 2003 Medicare Modernization Act

Overview. In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act, or MMA. The MMA increased the amounts payable to Medicare Advantage plans such as ours, expanded Medicare beneficiary healthcare options by, among other things, creating a transitional temporary prescription drug discount card program for 2004 and 2005 and added a Medicare Part D

prescription drug benefit beginning in 2006, as further described below.

One of the goals of the MMA was to reduce the costs of the Medicare program by increasing participation in the Medicare Advantage program. Effective January 1, 2004, the MMA adjusted Medicare Advantage statutory payment rates to 100% of Medicare s expected cost per beneficiary under the traditional fee-for-service program. Generally, this adjustment resulted in an increase in payments per member to Medicare Advantage plans. Medicare Advantage plans are required to use these increased payments to improve the healthcare benefits that are offered, to reduce premiums or to strengthen provider networks. The reforms proposed by the MMA, including in particular the increased reimbursement rates to Medicare Advantage plans, have allowed and will continue to allow Medicare Advantage plans to offer more comprehensive and attractive benefits, including better preventive care and dental and vision benefits, while also reducing out-of-pocket expenses for beneficiaries.

Prescription Drug Benefit. As part of the MMA, every Medicare recipient is able to select a prescription drug plan through Medicare Part D. Medicare Part D replaced the Medicaid Prescription Drug Coverage for beneficiaries eligible for participation under both the Medicare and Medicaid programs, or dual-eligibles. The Medicare Part D prescription drug benefit is largely subsidized by the federal government and is additionally supported by risk-sharing with 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 subsidy is based on the national weighted average monthly bid for this 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.

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, or MA-PD, while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan, or 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. Under the standard Part D drug coverage for 2006, beneficiaries enrolled in a stand-alone PDP will pay a $250 deductible, co-insurance payments equal to 25% of the drug costs between $250 and the initial annual coverage limit of $2,250 and all drug costs between $2,250 and $5,100, which is commonly referred to as the Part D doughnut hole . After the beneficiary has incurred $3,600 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 mirror these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to the standard drug coverage delineated in the MMA. The deductible, co-pay and coverage amounts will be adjusted by CMS on an annual basis. Each Medicare Advantage plan will be required to offer a Part D drug prescription plan as part of its benefits. We currently offer prescription drug benefits through our Medicare Advantage plans and also offer a stand-alone PDP.

Dual-Eligible Beneficiaries. A dual-eligible beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Reform, because of economic status. Health plans that serve dual-eligible beneficiaries receive a higher premium from CMS and the government of Puerto Rico for dual-eligible members. Currently, CMS pays an additional premium, generally ranging from 30% to 45% more per member per month, for a dually-eligible beneficiary. This additional premium is based upon the estimated incremental cost CMS incurs, on average, to care for dual-eligible beneficiaries. The government of Puerto Rico has implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. All qualified Reform participants could begin moving to the government-sponsored plan beginning in January 2006, and as of December 31, 2006 approximately 61,000 such participants did so. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dually-eligible members. The MMA provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, as of January 1, 2006 dual-eligible individuals receive their drug coverage from the Medicare program rather than the Reform program. Companies offering stand-alone PDPs with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within the applicable region.

2006 Bidding Process. Although Medicare Advantage plans will continue to be paid on a capitated, or PMPM, basis, as of January 1, 2006 CMS uses a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS s estimated per beneficiary fee-for-service expenses, was relabeled as the benchmark amount, and local Medicare

Advantage plans will annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that year, Medicare will pay the plan its bid amount, risk adjusted based on its risk scores, plus a rebate equal to 75% of the amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans will be required to use the rebate to provide beneficiaries with extra benefits, reduced cost sharing, or reduced premiums, including premiums for MA-PD and other supplemental benefits. CMS will have the right to audit the use of these proceeds. The remaining 25% of the excess amount will be retained in the statutory Medicare trust fund. If a Medicare Advantage plan s bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid amount and the benchmark, which is expected to make such plans less competitive.

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

Annual Enrollment and Lock-in. Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. As of January 1, 2006, Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, stand-alone PDP, or traditional fee-for-service Medicare. The initial enrollment period for 2006 began November 15, 2005 and ended on May 15, 2006 for a MA-PD or stand-alone PDP. In addition, beneficiaries had an open election period from January 1, 2006 through June 30, 2006 in which they could make or change an equivalent election. In future years, the annual enrollment period for PDPs will be from November 15 through December 31 of each year, and enrollment in Medicare Advantage plans will occur from November 15 through March 31 of the subsequent year. Enrollment on or prior to December 31 will be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period will be effective as of the first day of the month following the date on which the enrollment occurred. After these defined enrollment periods end, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries and others who qualify for special needs plans and employer group retirees will be permitted to enroll in or change health plans during that plan year. Eligible beneficiaries who fail to timely enroll in a Part D plan will be subject to the penalties described above if they later decide to enroll in a Part D plan. The new annual lock-in created by the MMA will change the way we and other managed care companies market our services to and enroll Medicare beneficiaries in ways we cannot yet fully predict. The recently adopted Tax Relief and Health Care Act of 2006 allows Medicare beneficiaries to enroll throughout the year only in Medicare Advantage plans that do not offer Part D prescription drug coverage. In one of our products we do offer such coverage, thus in that particular product we can only enroll new Medicare Advantage members between November 15 and December 31 each year. We offer another product which does not offer the Part D prescription drug coverage and that is open for enrollment during the entire year. New eligibles can enroll at any time during the year at the date of eligibility. In addition, we can enroll MA members from other carriers through March 31st of the next calendar year. Dual-eligibles are allowed to enroll throughout the year.

Fiscal Intermediary. As set forth in the MMA, the Federal government, through the Centers for Medicare and Medicaid Services (CMS), will replace the current Title 18 fiscal intermediary (Fl) and carrier contracts with competitively procured contracts that conform to the Federal Acquisition Regulation under the new Medicare Administrative Contractor (MAC) contracting authority. CMS has six years, between 2006 and 2011, to complete the transition of Medicare fee-for-service claims processing activities from the FI s and carriers to the MAC s. We are currently engaged in the analysis and evaluation of this transition process and the effect that it may have on our existing organizational structure as a Medicare carrier.

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

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

HIPAA and Gramm-Leach-Bliley Act

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

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HHS has released rules mandating the use of new standard formats with respect to certain health care transactions (e.g. health care claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules requiring the use of standardized code sets and unique identifiers by employers and providers. Our managed care subsidiary was required to comply with the transactions and code set standards by October 16, 2003 and with the employer identifier rules by July 2004 and believes that it is in material compliance with all relevant requirements. Our managed care subsidiary is required to comply with provider identifier rules by May 2007 and currently expects to meet such deadline.

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

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

Employee Retirement Income Security Act of 1974

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

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 26 to the audited consolidated financial statements for the years ended December 31, 2006, 2005 and 2004.

Trademarks

We consider our trademarks of Triple-S and SSS very important and material to all segments in which it is 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 its important and material trademarks in order to protect its rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the Blue Shield mark in Puerto Rico. See Blue Shield License .

Employees

As of February 28, 2007, we had 2,252 full-time employees and 266 temporary employees. Our managed care subsidiary has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 45% of our managed care subsidiary s 794 regular employees. The collective bargaining agreement expires on July 31, 2012. The Corporation considers its relations with employees to be good.

Available Information

We file annual, quarterly and current reports and other information with the Securities and Exchange Commission (the SEC). The SEC maintains a website that contains annual, quarterly and current reports and other information that issuers and filers (including ourselves) file electronically with the SEC. The SEC s website is www.sec.gov. We

currently do not have an Internet website through which we can make available our SEC filings. The website address listed above is provided for the information of the reader and is not intended to be an active link. We will provide free of charge copies of our filings to any shareholder that requests them at the following address: Triple-S Management Corporation; Office of the Secretary of the Board; PO Box 363628; San Juan, P.R. 00936-3628.

Cautionary Statement Regarding Forward-Looking Information

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 sections of this Annual Report on Form 10-K entitled Business , Risk Factors , Management s Discussion and Analysis of Financial Condition and Results of Operations and elsewhere in this Annual Report on Form 10-K. Statements that use the terms believe , expect , plan , intend , estimate , anticipate , project , may 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 Risk Factors and elsewhere in this Annual Report on Form 10-K. 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. The following risk factors and other information included in this Annual Report on Form 10-K should be carefully considered. 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 also may impair our business operations. If any of the following risks occur our business, financial condition, operating results, and cash flows could be materially affected.

Risks Relating to our Capital Stock

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

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 the Corporation s provider network to sell the provider shares of SSS at a future date (each a Share Acquisition Agreement). These 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 Corporation s reorganization, TSM s shareholders did not approve attempts to increase TSM s share capital in 2002 and 2003.

Notwithstanding the fact that TSI and its predecessors were never in a position to issue new shares to providers as contemplated by the Share Acquisition Agreements because shareholder approval for such issuance was never obtained, and the fact that SSS on several occasions in the 1990s offered providers the opportunity to purchase shares of its treasury stock and such offers were accepted by very few providers, providers who entered into Share

Acquisition Agreements may claim that the Share Acquisition Agreements entitled them to acquire shares of TSI or TSM 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. Were TSI or TSM required to issue a significant number of shares in respect of these Agreements, the interest

of existing shareholders in the Corporation would be substantially diluted. As of the date of this annual report, although no judicial claims of this nature have been commenced, our records indicate that the Corporation has received inquiries with respect to at least approximately 500 shares under Share Acquisition Agreements.
Management has been advised by Puerto Rico counsel that, on the basis of a reasoned analysis, while the matter is not free from doubt and there are no applicable controlling precedents, the Corporation should prevail if litigation of these claims were to be commenced by providers because, among other defenses, the condition precedent to SSS s obligations under the Share Acquisition Agreements never occurred, and any obligation it or its subsidiaries or predecessors may 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.

Management believes the Corporation should prevail in litigation if any judicial claims are commenced with respect to these matters; however, the Corporation 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 the Corporation s 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 its history, the Corporation and its predecessor entities have restricted the ownership or transferability of their shares, including by reserving to TSM or its predecessors a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, TSM and its predecessors, consistent with the requirements of their by-laws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, the Corporation anticipates that some 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 TSM shares or to damages in respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 Non-medical Heirs who may claim to have inherited up to 3,500 shares, although no judicial claims in this regard have ever been initiated. Our records indicate that, as of the date of this Annual Report on Form 10-K, we have received inquiries from Non-medical Heirs with respect to approximately 420 shares.

Management believes that the Corporation should generally prevail against any such claims if brought; however, management cannot predict the outcome of any eventual litigation regarding these Non-medical Heirs. The interests of the Corporation s existing shareholders could be materially diluted to the extent that any such claims are successful.

Risks Related to Our Business

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

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

environment including the implementation of Health Insurance Portability and Accountability Act of 1996 (HIPAA), as well as others, may adversely affect our ability to predict and manage managed care costs, as well as our business, financial condition and results of operations.

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

In addition to the challenge of managing managed care costs, we face pressure to contain premium rates. Our customers may move to a competitor at policy renewal to obtain more favorable premiums. Future Medicare and Reform

premium rate levels may be affected by continuing government efforts to contain medical expense or other federal budgetary constraints. In particular, in the past the government of Puerto Rico has adopted several measures to control Reform expenditures, such as closer and continuous scrutiny of participants eligibility, redesign of benefits, co-payments, deductibles, and requiring the establishment of disease management programs. Changes in the Medicare and Reform 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 and the Reform. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

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

Our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other managed care providers. We face heavy competition from other managed care plans to enter into contracts with hospitals, physicians and other providers in our provider networks. Consolidation in our industry, both on the provider side and on the managed care side, only exacerbates this competition. Currently certain providers are pressing for legislation that would allow them to negotiate service fees by provider groups. 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 BCBS license; and any general economic downturn that results in business failures.

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

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

Reform Program. We participate in the government of Puerto Rico Health Reform to provide health coverage to medically indigent citizens in Puerto Rico. Our results of operations have depended to a significant extent on our participation in the Reform program. During each of the years ended December 31, 2006, 2005 and 2004, the Reform program has accounted for 30.2%, 37.0% and 37.3%, respectively , of our consolidated premiums earned, net. During these periods, we were the sole Reform provider in three of the eight Reform regions in Puerto Rico. Since we obtained our first Reform contract in 1995, we have been the sole provider for two to three regions each year. The contract for each geographical area is subject to termination in the event of any non-compliance by the insurance company which is not corrected or cured to the satisfaction of the government entity overseeing the Reform, or on ninety days prior written notice in the event that the government determines that there is an insufficiency of funds to finance the Reform. These contracts have one-year terms and expire on September 30 of each year. Upon the expiration of the contract for a geographical area, the government of the Commonwealth of Puerto Rico usually commences an open bidding process for such area. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company effective November 1, 2006. During each of the years ended December 31, 2006, 2005 and 2004, this region accounted for 10.7%, 14.6% and 14.2%, respectively, of our consolidated premiums earned, net and 7.3%, 10.3% and 9.3%, respectively, of our consolidated operating income. We intend to continue to participate in the Reform program, but we may not be able to retain the right to service a particular geographical area in which we currently operate after the expiration of our current or any future contracts.

Medicare Advantage: We provide services through our Medicare Advantage health plans pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if any of these contracts are terminated, our business would be materially impaired. Contracts with CMS represented 11.3% of our consolidated premiums earned, net and 45.9% of our consolidated operating income during the year ended December 31, 2006 and may in the future represent a greater percentage of our results.

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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 U.S. Office of Personnel Management, or OPM, that is subject to termination in the event of noncompliance not corrected to the satisfaction of the OPM. Premiums generated under this contract represented 7.5%, 8.2% and 8.3% of our consolidated premiums earned, net during the years ended December 31, 2006, 2005 and 2004, 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 premiums would be materially adversely affected. The further loss or non-renewal of either of our Reform contracts could have a material adverse effect on our operating results and could result in the downsizing of certain personnel, the cancellation of lease agreements of certain premises and of certain contracts, and severance payments, among others.

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

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than administrative services 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 self-funded, or ASO, arrangements. In addition, the government of the Commonwealth of Puerto Rico began a pilot project in 2003 in one of the eight geographical areas under which it contracted services on an ASO basis for certain members instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us until October 31, 2006. There can be no assurance that the government will not implement such a program in areas served by us. As of December 31, 2006, 83.9% of our managed care customers had fully insured arrangements and 16.1% had ASO arrangements, as compared to approximately 87.8% and 12.2%, respectively, as of December 31, 2005. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

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

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

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

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

Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the Blue Shield name and mark. Failure to comply with any of these requirements and restrictions could result in a termination of the license agreements. The standards under the license agreements may be modified in certain instances by the BCBSA. Additional information about BCBSA requirements is included under Item 1

Products and Services Blue Shield License . To the extent that such amendments to the license agreements 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 Blue Shield name and mark in Puerto Rico. Furthermore, the BCBSA would be free to issue a license to use the Blue Shield name and mark in Puerto Rico to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the

appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Accordingly, termination of the license agreements 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 RBC. RBC is designed to identify weakly capitalized companies by comparing each company s adjusted surplus to its required surplus (the RBC ratio). Although we are currently in compliance with these requirements, we may be unable to continue to comply in the future. Failure to comply with these requirements could result in the revocation or loss of our BCBS license.

Upon termination of a license agreement, the BCBSA would impose a Re-establishment Fee upon us, which would allow the BCBSA to re-establish a Blue Shield presence in the vacated service area with another managed care company. Through December 31, 2006 the fee is set at $83.41 per licensed enrollee. If the re-establishment fee was applied to our total Blue Shield enrollees, we would be assessed approximately $81.7 million by the BCBSA.

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, 2006, 41.3%, or $65.7 million, of the premiums written in the property and casualty insurance segment and 10.6%, or $9.7 million, of the premiums written in the life insurance segment were ceded to reinsurers. The availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or to obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

It is also possible that the losses we experience on insured risks for which we have obtained reinsurance will exceed the coverage limits of the reinsurance. 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 because buying reinsurance does not relieve us of our liability to policyholders. In accordance with general industry practices, our property and casualty and life insurance subsidiaries annually purchase reinsurance to protect them from the impact of large unforeseen losses and prevent sudden and unpredictable changes in our net income and stockholders equity. Reinsurance contracts do not relieve us from our obligations to policyholders. In the event that all or any of the reinsurance companies are unable to meet their obligations under existing reinsurance agreements or pay on a timely basis, we will continue to be liable to our policyholders notwithstanding such defaults or delays. If our reinsurers are not capable of fulfilling their 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 the property and casualty of insurance companies in Puerto Rico. In July 2006, as a result of the additional indebtedness we incurred in connection with the acquisition of GA Life, A.M. Best although maintaining our property and casualty insurance subsidiary s rating of A-; changed the outlook to negative. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary s rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best

financial strength ratings.

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

Managed Care

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed

of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of managed care companies. In addition, the managed care market in Puerto Rico, other than the Medicare Advantage market, is mature. According to the U.S. Census Bureau, Puerto Rico s population grew by 0.4% between July 2004 and 2005, less than half the national population rate growth of 0.9% during the same period. As a result, in order to increase our profitability we must increase our membership in the new Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically. In Puerto Rico, several new managed care plans and other entities have been awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans and entered that market in 2006. We anticipate that these other plans will aggressively market their benefits to our current and our prospective members. Although we believe that we market an attractive offering, there are no assurances that we will be able to compete successfully with these other plans for new members, or that our current members will not choose to terminate their relationship with us and enroll in these other plans.

Concentration in our industry also has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. 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 the relatively low level of economic growth in Puerto Rico, there are few new sources of business in this segment. As a result, property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. We also face heavy competition in the life and disability insurance market.

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

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

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

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. These regulations, among other things, require insurance companies to maintain certain levels of capital which range by type of insurance from $1.0 million to $3.0 million, thereby restricting the amount of earnings that can be distributed. Our subsidiaries ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, if any, business and other legal restrictions. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries have a superior claim to such subsidiaries assets. Our subsidiaries may not be able to pay dividends or otherwise contribute or distribute funds to us in an amount sufficient for us to meet our financial obligations. In addition, from time to time, we could be required to provide financial assistance, either through subordinated loans or capital infusions to our subsidiaries.

In addition, we are subject to RBC requirements by the BCBSA. See The termination or modification of our license agreements to use the Blue Shield name and mark could have an 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.

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

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

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

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

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

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

Furthermore, the Deficit Reduction Act of 2005, or the DRA, signed by the President on February 8, 2006, directs CMS to conduct an analysis of fee-for-service provider (a provider who receives payment for services based on actual

services provided to Medicare beneficiaries and a contractually mandated or CMS-mandated fee schedule) and Medicare Advantage plan treatment and coding practices (methods of documenting medical services provided to and diagnoses of members) and to incorporate any identified differences into benchmark calculations no later than 2008. This revised rate calculation system established by the MMA and amended by the DRA is likely to eventually result in reduced Medicare Advantage payment rates, which could reduce our revenues and cause our profitability to decline. We may also face the risk of reduced or insufficient government funding and we may need to terminate our Medicare Advantage 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, 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 health plans to improve the accuracy of payments and establish incentives for Medicare plans to enroll and treat less healthy Medicare beneficiaries. CMS is phasing 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 including hospital inpatient diagnoses, diagnosis data from ambulatory treatment settings, including hospital outpatient facilities and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS s internal database. As part of the phase-in, during 2003, risk adjusted payments accounted for 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional CMS demographic rate books. The portion of risk adjusted payments was increased to 30% in 2004, 50% in 2005 and 75% in 2006, and will increase to 100% in 2007. 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 premium revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of recording diagnosis code information, which has an impact on our risk scores.

Payments to Medicare Advantage plans are also adjusted by a budget neutrality factor that was implemented in 2003 by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. The President s budget for 2005 assumed the phasing out of the budget neutrality adjustments over a five year period from 2007 through 2011.

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

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

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 and disability insurance subsidiary, GA Life, 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.

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

We have exposure to market risk in our investment activities. The market values of our investments vary from time to time depending on economic and market conditions. Fixed maturity securities expose us to interest rate risk. Equity securities expose us to equity price risk. Interest rates are highly sensitive to many factors, including governmental monetary policies and domestic and international economic and political conditions. These and other factors also affect the equity securities owned by us. The outlook of our investment portfolio depends on the future direction of interest rates, fluctuations in the equity securities market and in the amount of cash flows available for investment. For additional information, see Item 7A Quantitative and Qualitative Disclosures About Market Risk for a detailed 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.

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. If economic conditions in Puerto Rico deteriorate, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, financial condition and results of operations.

A number of key economic indicators suggest that the Puerto Rican economy is suffering a slowdown, as a result of, among other things, the persistent high levels of oil prices, the current trend in short-term interest rates, the depreciation of the dollar and the deceleration of public investment due to the current fiscal situation in Puerto Rico. If economic conditions in Puerto Rico deteriorate, we may experience a reduction in existing and new business, which could have a material adverse effect on our business, financial condition and results of operations.

We may not be able to retain our executive officers and significant employees, and the loss of any one or more of these officers and their expertise could adversely affect our business.

Our operations are highly dependent on the efforts of our senior executives, each of whom has been instrumental in developing our business strategy and forging our business relationships. While we believe that we could find replacements, the loss of the leadership, knowledge and experience of our executive officers could adversely affect our business. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the industries in which we operate have the breadth and depth of skills and experience necessary to operate and expand successfully a business such as ours. We do not currently maintain key-man life insurance on any of our executive officers.

The success of our business depends on developing and maintaining effective information systems.

Our business and operations may be harmed if we do not maintain our information systems and the integrity of our proprietary information. We are materially dependent on our information systems for all aspects of our business operations, including monitoring utilization and other factors, supporting our managed care management techniques, processing provider claims and providing data to our regulators, and our ability to compete depends on our ability to continue to adapt technology on a timely and cost-effective basis. Malfunctions in our information systems, communication and energy disruptions, security breaches or the failure to maintain effective and up-to-date information systems could disrupt our business operations, alienate customers, contribute to customer and provider disputes, result in regulatory violations and possible liability, increase administrative expenses or lead to other adverse consequences. The use of patient data by all of our businesses is regulated at federal and local levels. These laws and rules change frequently and developments require adjustments or modifications to our technology infrastructure.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. If we are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments on a timely basis, loss of members, difficulty in attracting new members, regulatory problems and increases in administrative expenses. We recently completed a system conversion process related to our property and casualty insurance business. We started the implementation of this system in April 2005 and completed it on October 1, 2006 at an estimated cost of $4 million. In addition, we recently selected QCSI to assess and implement new core business applications for our managed care segment. We expect the assessment to be completed in 2007, at which point we plan to convert our managed care systems over time by line of business, with the first line of business expected to be converted in the first half of 2009. We expect the managed care conversion process to be completed by 2012 at a total cost of approximately $40 million. If we are unsuccessful in implementing these improvements in a timely manner or if these improvements do not meet our customers requirements, we may not be able to recoup these costs and expenses and effectively compete in our industry.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other event or developments could result in compromises or breaches of our security system and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network and data is sent over this network from many sources. In the past, computer viruses or

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

We are required to evaluate our internal control over financial reporting under Section 404 of Sarbanes Oxley, and any adverse results from such evaluation could result in a loss of investor confidence in our financial reports and have an adverse effect on our stock price.

Pursuant to Section 404 of Sarbanes-Oxley Act, beginning with our Annual Report on Form 10-K for the fiscal year ending December 31, 2007, we will be required to furnish a report by our management on our internal control over financial reporting. Such a report will contain, among other matters, an assessment of the effectiveness of our internal control over financial reporting as of the end of our fiscal year, including a statement as to whether or not our internal control over financial reporting is effective. This assessment must include disclosure of any material weaknesses in our internal control over financial reporting identified by management.

The Committee of Sponsoring Organizations of the Treadway Commission (COSO) provides a framework for companies to assess and improve their internal control systems. The Public Company Accounting Oversight Board s Auditing Standard No. 2 provides the professional standards and related performance guidance for auditors to attest to, and report on, management s assessment of the effectiveness of internal control over financial reporting under Section 404. Management s assessment of internal control over financial reporting requires management to make subjective judgments and some of the judgments will be in areas that may be open to interpretation and therefore the report may be uniquely difficult to prepare. We are still performing the system and process documentation and evaluation needed to comply with Section 404, which is both costly and challenging.

During this process, if our management identifies one or more material weaknesses in our internal control over financial reporting, we will be unable to assert such internal control is effective. If we are unable to assert that our internal control over financial reporting is effective as of December 31, 2007, or if our auditors are unable to attest that our management s report is fairly stated or they are unable to express an opinion on the effectiveness of our internal controls as of December 31, 2008, we could lose investor confidence in the accuracy and completeness of our financial reports.

We cannot be certain as to the timing of completion of our evaluation, testing and any required remediation. If we are not able to complete our assessment under Section 404 in a timely manner, we would be unable to conclude that our internal control over financial reporting is effective as of December 31, 2007.

We face risks related to litigation.

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.

We are a defendant in various lawsuits, including two class action 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 such damage awards could have an adverse effect on our cash flows, results of operations and financial condition. See Item 3 Legal Proceedings .

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

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

Covenants in our credit agreements and note purchase agreements may restrict our operations.

We are a party to two secured loans with a commercial bank in an aggregate amount of $61.0 million, of which we had a total outstanding balance of $27.6 million and $10.5 million, respectively, as of December 31, 2006. Also, we have an aggregate of $145.0 million of senior unsecured notes, consisting of $50.0 million aggregate principal amount of 6.30% notes due 2019, $60.0 million aggregate principal amount of 6.60% notes due 2020 and $35.0 million

aggregate principal amount of 6.70% notes due 2021 (collectively, the notes). The credit agreements and the note purchase agreements governing the notes contain covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These covenants could restrict our operations. In addition, if we fail to make any required payment under our credit agreements or note purchase agreements governing the notes or to comply with any of the covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our credit agreements or note

purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the credit agreements, cease to make further extensions of credit. If the indebtedness under our credit agreements or note purchase agreements is accelerated, it could have a material adverse effect in our business for we may be unable to repay or finance the amounts due.

We expect to pursue acquisitions in the future.

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

- disruption of on-going business operations, distraction of management, diversion of resources and difficulty in maintaining current business standards, controls and procedures;
- difficulty in integrating information technology of acquired entity and unanticipated expenses related to such integration;
- difficulty in the integration of the new company s accounting, financial reporting, management, information, human resources and other administrative systems and the lack of control if such integration is delayed or not implemented;
- difficulty in the implementation of controls, procedures and policies appropriate for filers with the Securities and Exchange Commission 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 the Regulation of Our Industry

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

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

- initiatives to increase healthcare regulation, including efforts to expand the tort liability of health plans;
- local government plans and initiatives, and
- Medicare and Reform reform legislation.

The U.S. Congress is developing legislation aimed at patient protection, including proposed laws that could expose insurance companies to damages, and in some cases punitive damages, for certain coverage determinations including the denial of benefits or delay in providing benefits to members. Similar legislation has been proposed in Puerto Rico.

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 stockholders. While we cannot predict the terms of future regulation, the enactment of new legislation could affect the cost or demand of insurance policies, limit our ability to obtain rate increases in those cases where rates are regulated, otherwise restrict our operations, limit the expansion of our business,

expose us to expanded liability or impose additional compliance requirements. In addition, we may incur additional operating expenses in order to comply with new legislation and may be required to revise the ways in which we conduct our business.

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

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 voting stock of an insurance company, or of the total stock issued and outstanding of a holding company of an insurance company, 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; in some instances, subject to the discretion of the Commissioner of Insurance, operating licenses could be revoked.

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

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

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

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

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

Certain implementing regulations of the Health Insurance Portability and Accountability Act of 1996 (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. These rules 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 the Department of Health and Human Service s Office for Civil Rights for privacy, CMS for security and electronic transactions, and by the Department of Justice for criminal violations. Further, Gramm-Leach Bliley, or GLB, 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. Furthermore, Puerto Rico s ability to promulgate its own laws and regulations (including those issued in response to GLB), 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.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

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

In addition to the properties described above, we or our subsidiaries are parties to operating leases that are entered into in the ordinary course of business.

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.

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

Management believes, based on the opinion of legal counsel, that the aggregate liabilities, if any, arising from such claims, assessments, audits and lawsuits would not have a material adverse effect on our consolidated financial position or results of operations. 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 operating results and/or cash flows. 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 .

Sánchez Litigation

On September 4, 2003, José Sánchez and others filed a putative class action complaint against us, present and former directors of the Board and our managed care subsidiary, and others, in the United States District Court for the District of Puerto Rico, alleging violations under the Racketeer Influenced and Corrupt Organizations Act, better known as the RICO Act. On May 4, 2006, the Court issued an Opinion and Order, which entered a summary judgment in favor of all the defendants, and dismissing the case. Plaintiffs filed a notice of appeal before the United States Court of Appeals for the First Circuit. The Appeals Court notified the briefing schedule, and plaintiffs filed their brief on August 21, 2006. Respondent filed theirs on September 30, 2006. The parties argued the case before the First Circuit on February 6, 2007, who took the case under advice. Judgment is expected within the next 90 days.

Jordán el al Litigation

On April 24, 2002, Octavio Jordán, Agripino Lugo, Ramón Vidal, and others filed a suit against TSM, TSI and others in the Court of First Instance for San Juan, Superior Section, alleging, among other things, violations by the defendants of provisions of the Puerto Rico Insurance Code, anti-monopolistic practices, unfair business practices and damages in the amount of $12.0 million. They also requested that we sell shares to them. It appears that many of the allegations brought by the plaintiffs in this complaint have been resolved in favor of us and our managed care subsidiary in previous cases brought by the same plaintiffs in the United States District Court for the District of Puerto Rico and in the local courts. The defendants, including us and our managed care subsidiary, answered the complaint, filed a counterclaim and filed several motions to dismiss this claim.

On May 9, 2005 the plaintiffs amended the complaint and the defendants are preparing the corresponding motions to dismiss this amended complaint. The plaintiffs amended the complaint to allege causes of action similar to those dismissed in the Sánchez case, in which summary judgment has been granted to us. Defendants moved to dismiss the

amended complaint. Plaintiffs have notified their opposition to some of the defendants motion to dismiss, and the defendants filed the corresponding replies. In 2006 the Court held several hearings to argue dispositive motions. The Court stayed all discovery until the motions are resolved. On January 19, 2007, the Court denied a motion by the plaintiffs to dismiss the defendants counterclaim for malicious prosecution and abuse of process. The Court ordered Plaintiffs to answer the counterclaim by February 20, 2007. Although done after the required date, plaintiffs filed the answer to the counterclaim. Also, on February 7, 2007 the Court decided the motions to dismiss that have been filed. In summary, the Court dismissed the following counts: charitable trust, RICO and violation of due process. The dismissal of these counts affects all the plaintiffs. Other counts of the complaint, torts, breach of contract and violation of the Puerto Rico corporations law, were dismissed only against certain of the physician plaintiffs. The Court allowed the count based on antitrust. We will appeal the denial of the motion to dismiss the antitrust allegations.

Thomas Litigation

On May 22, 2003 a putative class action suit was filed by Kenneth A. Thomas, M.D. and Michael Kutell, M.D., on behalf of themselves and all others similarly situated and the Connecticut State Medical Society against the Blue Cross and Blue Shield Association (BCBSA) and substantially all of the other Blue plans in the United States, including our managed care subsidiary. The case is pending before the U.S. District Court for the Southern District of Florida, Miami District.

The individual plaintiffs bring this action on behalf of themselves and a class of similarly situated physicians seeking redress for alleged illegal acts of the defendants, which they allege have resulted in a loss of their property and a detriment to their business, and for declaratory and injunctive relief to end those practices and prevent further losses. Plaintiffs alleged that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to doctors so that they are not paid in a timely manner for the covered, medically necessary services they render.

The class action complaint alleges that the health care plans are the agents of BCBSA licensed entities, and as such have committed the acts alleged above and acted within the scope of their agency, with the consent, permission, authorization and knowledge of the others, and in furtherance of both their interest and the interests of other defendants.

Management believes that our managed care subsidiary was brought to this litigation for the sole reason of being associated with the BCBSA. However, on June 18, 2004 the plaintiffs moved to amend the complaint to include the Colegio de Médicos y Cirujanos de Puerto Rico (a compulsory association grouping all physicians in Puerto Rico), Marissel Velázquez, MD, President of the Colegio de Médicos y Cirujanos de Puerto Rico, and Andrés Meléndez, MD, as plaintiffs against our managed care subsidiary. Later Marissel Velázquez, MD voluntarily dismissed her complaint against our managed care subsidiary.

Our managed care subsidiary, along with the other defendants, moved to dismiss the complaint on multiple grounds, including but not limited to arbitration and applicability of the McCarran Ferguson Act.

The parties are currently engaged in mediation. Twenty four (24) plans have been actively participating in the mediation efforts. The mediation resulted in the creation of a Settlement Agreement, presently under discussion with the plaintiffs lawyers.

Solomon Litigation

On December 8, 2003 a putative class action was filed by Jeffrey Solomon, MD and Orlando Armstrong, MD, on behalf of themselves and all other similarly situated and the American Podiatric Medical Association, Florida Chiropractic Association, California Podiatric Medical Association, Florida Podiatric Medical Association, Texas Podiatric Medical Association, and Independent Chiropractic Physicians, against the BCBSA and multiple other insurance companies, including TSI and all members of the BCBSA. The case is still pending before the United States District Court for the Southern District of Florida, Miami District.

This lawsuit challenges many of the same practices previously described for the Thomas litigation. Management believes that TSI was brought to this litigation for the sole reason of being associated with the BCBSA

On June 25, 2004, plaintiffs amended the complaint but the allegations against TSI did not vary. TSI along with the other defendants, moved to dismiss the complaint on multiple grounds, including but not limited to arbitration and

applicability of the McCarran Ferguson Act. During September 2006, the Court, *sua sponte*, ordered the parties to engage in Mediation. However, the defendants presented a joint position that they do not which to mediate but to have the class certification issue decided by the Court. On March 6, 2007, the plaintiffs filed a notice of voluntary dismissal to dismiss the complaint without prejudice, against 52 of the 74 defendants, including us. Case was dismissed without prejudice by the Court on March 14, 2007.

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

None.

Part II

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

Market Information

There is no established public trading market for our common stock. Sporadic transfers of our common stock have been limited to redemptions at the greater of the shares $40.00 par value or at the amount originally paid for the stock, since our common stock was not transferable to the general public. In March 2007 we filed amended and restated Articles of Incorporation which eliminated previous ownership and transferability restrictions.

In determining the market value of common stock disclosed in the facing page of this Annual Report on Form 10-K, we used the shares par value of $40.00 as of December 31, 2006.

Holders

Our only outstanding voting securities are shares of common stock, par value $40.00 per share. As of March 15, 2007, there were 8,913 shares of Common Stock outstanding. The number of our holders of common stock as of March 15, 2007 was 1,779.

Dividends

On January 13, 2006, our board of directors (the Board) declared a cash dividend of $6.2 million distributed pro rata among all of the issued and outstanding common shares, excluding those shares issued to the representatives of the community that are members of the Board (the qualifying shares). All shareholders of record as of the close of business on January 16, 2006, except those who only hold qualifying shares, received a dividend per share of $700 for each share held on that date. We did not declare any dividends during the year 2005.

Recent Sales of Unregistered Securities

Not applicable.

Purchases of Equity Securities by the Issuer

Not applicable.

Item 6. Selected Financial Data.

(Dollar amounts in millions, except per share data)	**2006 (1)**	**2005**	**2004**	**2003**	**2002**
Statement of Earnings Data					
Years ended December 31,					
Premiums earned, net	$1,511.6	1,380.2	1,299.0	1,264.4	1,236.6
Administrative service fees	14.1	14.4	9.2	8.3	9.5
Net investment income	42.7	29.1	26.8	24.7	24.8
Total operating revenues	1,568.4	1,423.7	1,335.0	1,297.4	1,270.9
Net realized investments gains	0.8	7.2	11.0	8.4	0.2
Net unrealized investment gain (loss) on trading securities	7.7	(4.7)	3.0	14.9	(8.3)
Other income, net	2.3	3.7	3.4	4.7	2.1
Total revenues	$1,579.2	1,429.9	1,352.4	1,325.4	1,264.9
Net income	$ 54.5	28.4	45.8	26.2	48.2
Basic net income per share (2):	$ 6,120	3,193	5,135	2,857	1,085
Dividend declared per common share (3):	$ 700				
Balance Sheet Data					
December 31,					
Total assets	$1,345.5	1,137.5	919.7	834.6	721.9
Long-term borrowings	$ 183.1	150.6	95.7	48.4	50.0
Total stockholders equity	$ 342.6	308.7	301.4	254.3	231.7

(1) On January 31, 2006 we completed the acquisition of GA Life. The results of operations and financial

condition of GA Life are included in this table for the period following the effective date of the acquisition. See note 3 to the audited consolidated financial statements for the years ended December 31, 2006, 2005 and 2004.

(2) Further details of the calculation of basic earnings per share are set forth in notes 2 and 22 of the audited financial consolidated financial statements for the years ended December 31, 2006, 2005 and 2004.

(3) Shareowners holding qualifying shares were excluded from dividend payment. See note 23 of the audited financial consolidated financial statements for the years ended December 31, 2006, 2005 and 2004.

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, 2006 and 2005, and consolidated results of operations for 2006, 2005 and 2004. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

Overview

We are the largest managed care company in Puerto Rico in terms of membership, with over 45 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial, Reform, Medicare Advantage and Part D stand-alone prescription drug plan (PDP) markets. The Reform is a Puerto Rico government-funded managed care program for the medically indigent, similar to Medicaid. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico, serve approximately one million members across all regions of Puerto Rico and hold a leading market position covering approximately 25% of the population. We also have significant positions in the life insurance and property and casualty insurance markets. Our life insurance segment has a market share of approximately 25% (in terms of premiums written giving pro forma effect

to the acquisition of GA Life) as of December 31, 2005. Our property and casualty segment has a market share of 8.5% (in terms of direct premiums) as of December 31, 2006. For the year ended December 31, 2006, our managed care segment represented 88.6% of our total consolidated premiums earned, net and 62.0% of our operating income. We participate in the managed care market through our subsidiary, TSI. Our managed care subsidiary is a BCBSA licensee, which provides us with exclusive use of the Blue Shield brand in Puerto Rico. We offer products to the commercial, Reform, Medicare Advantage and PDP market sectors, including corporate accounts, federal government employees, local government employees, individual accounts and Medicare Supplement.

We participate in the life insurance market through our subsidiary, GA Life (formerly Seguros de Vida Triple-S, Inc.) and in the property and casualty insurance market through our subsidiary, STS, which represented approximately 5.7% and 5.9%, respectively, of our consolidated premiums earned, net for the year ended December 31, 2006 and 15.3% and 15.3%, 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. GAAP in making such determinations. See note 24 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 inter-company 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)	**2006**	**2005**	**2004**
Premiums earned, net			
Managed care	$1,339.8	1,279.5	1,199.2
Life insurance	86.9	17.1	16.4
Property and casualty insurance	88.5	86.8	86.2
Intersegment premiums earned	(3.6)	(3.2)	(2.8)
Consolidated premiums earned, net	$1,511.6	1,380.2	1,299.0

	Years ended December 31,		
(Dollar amounts in millions)	**2006**	**2005**	**2004**
Administrative service fees			
Managed care	$16.9	15.5	10.3
Intersegment administrative service fees	(2.8)	(1.1)	(1.1)

Consolidated administrative service fees	$14.1	14.4	9.2

	Years ended December 31,		
(Dollar amounts in millions)	**2006**	**2005**	**2004**
Operating income			
Managed care	$45.5	16.1	36.2
Life insurance	11.2	3.0	0.6
Property and casualty insurance	11.2	12.3	7.7
Other segments and intersegment eliminations	5.4	2.3	2.8
Consolidated operating income	$73.3	33.7	47.3

During the reported periods, we had one-year contracts with the government of Puerto Rico to be the Reform insurance carrier for three of the eight geographical areas into which Puerto Rico is divided for purposes of the Reform. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company, effective November 1, 2006. The contracts for the other two regions were renewed for an additional one-year period. The premiums earned, net and operating income related to the operations of the Metro-

North region during the years ended December 31, 2006 amounted to $161.6 million and $5.4 million, respectively, and during the year ended December 31, 2005 amounted to $200.9 million and $3.5 million, respectively.

Results of Operations

Revenue

General. Our revenue consists primarily of (i) premium revenue we generate from our managed care business, (ii) administrative service fees we receive for administrative services provided to self-insured (ASO) employers, (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, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement, as well as to the Medicare Advantage, Reform and PDP sectors. We receive a monthly payment from or on behalf of each member enrolled in our commercial managed care plans (excluding ASO). We recognize all premium revenue in our managed care business during the month in which we are obligated to provide services to an enrolled member. Premiums we receive in advance of that date are recorded as unearned premiums.

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

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

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

Other Premium Revenue. Other premium revenue includes premiums generated from the sale of life insurance and property and casualty insurance products. Premiums on life insurance policies are billed in the month prior to the effective date of the policy, with a one-month grace period, and the related revenue is recorded as earned during the coverage period. If the insured fails to pay within the one-month grace period, we may cancel the policy. We recognize premiums on property and casualty contracts as earned on a pro rata basis over the policy term. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheet as unearned premiums and is transferred to premium revenue as earned.

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

Expenses

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

and actuarial estimate of claims incurred but not reported during the period.

The medical loss ratio (MLR), which is calculated by dividing managed care claims incurred by managed care premiums earned, net is one of our primary management tools for measuring these costs and their impact on our profitability. The medical loss ratio is affected by the cost and utilization of services. The cost of services is affected by many factors, in particular our ability to negotiate competitive rates with our providers. The cost of services is also

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

Operating Expenses. Operating expenses include commissions to external brokers, general and administrative expenses, cost containment expenses such as case and disease management programs, and depreciation and amortization. The operating expense ratio is calculated by dividing operating expenses by premiums earned, net and administrative service fees. A significant portion of our operating expenses are fixed costs. Accordingly, it is important that we maintain or increase our volume of business in order to distribute our fixed costs over a larger membership base. Significant changes in our volume of business will affect our operating expense ratio and results of operations. We also have variable costs, which vary in proportion to changes in volume of business. Our operating expense ratio has remained broadly constant over the past three years, notwithstanding membership growth, because of certain significant expenses incurred in recent years, including the costs associated with Sarbanes-Oxley Section 404 compliance, HIPAA compliance, additional legal expenses and related reserves in connection with certain litigation, costs associated with the acquisition of GA Life and consulting costs incurred in connection with IT systems upgrades.

Membership

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

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

We believe that the Medicare Advantage and PDP programs provide a significant opportunity for growth in membership. We commenced offering Medicare Advantage products in 2005, with the introduction of our *Medicare Selecto* and *Medicare Optimo* plans. Membership enrolled in our Medicare Advantage programs increased by 126% in 2006; from 11,993 as of December 31, 2005 to 27,078 members as of December 31, 2006. In January 2006, we launched our stand-alone PDP plan, *FarmaMed*, which as of December 31, 2006, had 14,063 members. We expect that Medicare Advantage enrollment will continue to experience significant growth, but not at the same pace as in this initial period.

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

	As of December 31,		
	2006	**2005**	**2004**
Commercial (1)	580,850	612,218	621,665
Reform (2)	357,515	628,438	614,443
Medicare Advantage	27,078	11,993	
Part D Stand-Alone Prescription Drug Plan	14,063		
Total	979,506	1,252,649	1,236,108

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

(2) Enrollment for 2005 and 2004 includes the Metro-North region. The contract for this region was not renewed effective November 1, 2006.

Significant Transactions

Effective January 31, 2006, we completed the acquisition of 100% of the common stock of GA Life for $37.5 million, and effective June 30, 2006 we merged the operations of our former life insurance subsidiary, SVTS, into GA Life. GA Life s results of operations and financial condition are included in our consolidated financial statements for the period following January 31, 2006. Our historical results of operations and comparable basis information for 2005 are included in the following tables. Comparable basis information was determined by adding the historical statements

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of earnings of GA Life from February 1, 2005 to December 31, 2005 to our statement of earnings for the year 2005. Comparable basis information is presented in order to provide a more meaningful comparison of the 2006 and 2005 periods. Comparable basis is not calculated in accordance with U.S. generally accepted accounting principles and is not intended to represent or be indicative of the results of operations that would have been reported by us had the acquisition been completed as of January 31, 2005. Comparable basis information, unlike the pro forma financial information included in note 3 of the audited financial consolidated financial statements for the years ended December 31, 2006, 2005 and 2004, does not reflect adjustments, such as interest expense associated with indebtedness incurred in connection with the acquisition.

Consolidated

	Year ended December 31, 2005		
(Dollar amounts in millions, except per share data)	**TSM**	**GA Life**	**Comparable Basis**
Revenues:			
Premiums earned, net	$1,380.2	61.6	1,441.8
Administrative service fees	14.4		14.4
Net investment income	29.1	10.6	39.7
Total operating revenues	1,423.7	72.2	1,495.9
Net realized investment gains	7.2	4.4	11.6
Net unrealized investment loss in trading securities	(4.7)		(4.7)
Other income, net	3.7		3.7
Total revenues	1,429.9	76.6	1,506.5
Benefits and expenses:			
Claims incurred	1,208.3	29.0	1,237.3
Operating expenses	181.7	31.5	213.2
Total operating costs	1,390.0	60.5	1,450.5
Interest expense	7.6	1.4	9.0
Total benefits and expenses	1,397.6	61.9	1,459.5
Income before taxes	32.3	14.7	47.0
Income tax expense (benefit):			
Current	4.0	0.6	4.6
Deferred	(0.1)	(1.4)	(1.5)
Total income taxes	3.9	(0.8)	3.1
Net income	$ 28.4	15.5	43.9

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Life and Disability Insurance Segment

	Year ended December 31, 2005		
(Dollar amounts in thousands)	**SVTS**	**GA Life**	**Comparable Basis**
Operating revenues:			
Net earned premiums:			
Earned premiums	$ 24.2	63.7	87.9
Earned premiums ceded	(8.0)	(2.1)	(10.1)
Assumed earned premiums	0.4		0.4
Net earned premiums	16.6	61.6	78.2
Commission income on reinsurance	0.5		0.5
Premiums earned, net	17.1	61.6	78.7
Net investment income	3.0	10.6	13.6
Total operating revenues	20.1	72.2	92.3
Operating costs:			
Policy benefits and claims incurred	8.9	29.0	37.9
Underwriting and other expenses	8.2	31.5	39.7
Total operating costs	17.1	60.5	77.6
Operating income	$ 3.0	11.7	14.7

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2006, 2005 and 2004. The 2005 comparable basis information is presented to provide a more meaningful comparison of the 2006 and 2005 periods, see Significant Transactions Consolidated included in this Item.

(Dollar amounts in millions)	**2006**	**Comparable Basis 2005**	**2005**	**2004**

Year ended December 31, 2006 compared with the year ended December 31, 2005

<u>*Operating Revenues*</u>

Consolidated premiums earned, net and administrative service fees presented a combined increase during 2006 of $131.1 million, or 9.4%, to $1.5 billion in the 2006 period as compared to the 2005 period. On a comparable basis,

including GA Life s results from both periods, consolidated earned premiums, net and administrative service fees increased by $69.5 million, or 4.8%. These increases were primarily due to an increase in our managed care segment, principally due to strong growth from our Medicare Advantage and PDP products, net of a decrease in the Reform sector due to the loss of the Metro-North region.

Consolidated net investment income presented an increase of $13.6 million, or 46.7%, to $42.7 million during the year 2006. On a comparable basis, the consolidated net investment income increased by $3.0 million, or 7.6%, during the 2006 period. This increase is primarily the result of a higher balance of invested assets and an increase in yield during 2006.

Net realized investment gains

Consolidated net realized investment gains presented a decrease of $6.4 million, or 88.9%, to $0.8 million during 2006. On a comparable basis, the consolidated net realized investment gains decreased by $10.8 million, or 93.1%, during the 2006 period. This decrease is primarily the a result of high levels of sales of investments in 2005 in order to take advantage of a temporary reduction in the capital gains tax rate for sales of long-term capital assets, thus causing relatively significant gains to be realized in the 2005 period.

Net unrealized gain (loss) on trading securities and other income, net

The combined balance of our consolidated net unrealized gain on trading securities and other income, net was $10.0 million during the 2006 period, an increase of $11.0 million on both an actual and comparable basis. This increase is attributable to unrealized gains in the trading portfolios held by the segments in equity securities. The loss in 2005 period is attributable to the realization of gains in that period, as discussed above.

Claims Incurred

Consolidated claims incurred during 2006 increased by $50.7 million, or 4.2%, to $1.3 billion in 2006 when compared to the claims incurred during 2005. On a comparable basis, the consolidated claims incurred increased by $21.7 million, or 1.8%, principally due to increased claims in the managed care segment as a result of increased enrollment in the Medicare Advantage and PDP sectors, net of a decrease in the Reform sector. In addition, the loss ratio on a comparable basis decreased by 2.5 percentage points.

Operating Expenses

Consolidated operating expenses during 2006 increased by $54.4 million, or 29.9%, to $236.1 million in the 2006 period as compared to the operating expenses during the 2005 period. On a comparable basis, consolidated operating expenses increased by $22.9 million, or 10.7%, which is attributed primarily to increased volume of business across all of our businesses during the 2006 period. In addition, we experienced normal increases in payroll and related expenses, commission expenses and information technology related costs.

Interest expense

Consolidated interest expense for 2006 period increased by $9.0 million, to $16.6 million in 2006. On a comparable basis, consolidated interest expense increased by $7.6 million, primarily due to the interest expense corresponding to new debt incurred during the fourth quarter of 2005 and during the first quarter of 2006 in connection with the GA Life acquisition.

Income tax expense

The consolidated effective tax rate increased by 7.2 percentage points, from 12.1% in 2005 to 19.3% in 2006, primarily due to an increase in non-exempt income, offset in part by an increase in net income relating to the life insurance segment, which has a lower effective tax rate than the other lines of business.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Operating Revenues

Consolidated premiums earned, net and administrative service fees presented a combined increase of $86.4 million, or 6.6%, to $1.4 billion during 2005, $85.5 million of which was from the managed care segment across many of our products.

Consolidated net investment income presented an increase of $2.3 million, or 8.6%, to $29.1 million during the year 2005, principally due a higher balance of invested assets as well as to a higher yield during 2005.

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Net realized investment gains

Consolidated net realized investment gains presented a decrease of $3.8 million, or 34.5%, to $7.2 million during 2005, principally due to higher sales of investments in common stocks during 2004.

Net unrealized gain (loss) 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 $7.4 million, or 115.6%, to a loss of $1.0 million in 2005, primarily reflecting unrealized losses in equity securities. We experienced an unrealized loss in 2005 because, during the second quarter of 2005, we sold certain equity investments with unrealized gains in order to take advantage of a temporary reduction in the capital gains tax rate, thus eliminating the unrealized gains that would have offset the unrealized losses in our portfolios during this period.

Claims Incurred

Consolidated claims incurred increased by $92.5 million, or 8.3%, to $1.2 billion during 2005. This increase was principally driven by fluctuations in the claims incurred by the managed care segment, primarily due to increased utilization, costs of services and enrollment.

Operating Expenses

Consolidated operating expenses increased by $9.8 million, or 5.7%, to $181.7 million in 2005, primarily due to increased business volume and startup costs associated with the launching of our new Medicare Advantage products.

Interest expense

Consolidated interest expense in 2005 period increased by $3.0 million, to $7.6 million, primarily due to the interest expense corresponding to new debt incurred by our managed care subsidiary in September 2004.

Income tax expense

The consolidated effective tax rate decreased from 23.8% in 2004 to 12.1% in 2005 due to the net effect of an increase in exempt interest income during 2005, which decreased the effective rate, and an increase in the property and casualty insurance segment s deferred tax expense.

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Managed Care Operating Results

We offer our products in the managed care segment to four distinct market sectors in Puerto Rico: commercial, Reform, Medicare Advantage and stand-alone prescription drug plans. The commercial sector represented 47.2%, and the Reform sector represented 30.2%, of our consolidated premiums earned, net during the year 2006 and 2.4% and 13.8%, respectively, of our operating income for this period. Earned premiums, net and operating income generated from our Medicare Advantage contracts during the year 2006 represented 11.3% and 45.9% of the consolidated earned premiums, net and operating income, respectively.

(Dollar amounts in millions, except enrollment data)	**2006**	**2005**	**2004**
Years ended December 31,			
Medical operating revenues:			
Medical premiums earned, net:			
Commercial	$ 713.2	734.5	714.5
Reform	455.8	510.8	484.7
Medicare Advantage	155.7	34.2	
PDP	15.1		
Medical premiums earned	1,339.8	1,279.5	1,199.2
Administrative service fees	16.9	15.5	10.3
Net investment income	18.8	17.0	16.0
Total medical operating revenues	1,375.5	1,312.0	1,225.5
Medical operating costs:			
Medical claims incurred	1,173.6	1,155.9	1,058.6
Medical operating expenses	156.4	140.0	130.7
Total medical operating costs	1,330.0	1,295.9	1,189.3
Medical operating income	$ 45.5	16.1	36.2
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	5,272,987	5,632,249	5,755,380
Self funded	1,861,833	1,840,716	1,692,108
Total commercial	7,134,820	7,472,965	7,447,488
Reform	6,484,270	7,465,777	7,377,048
Medicare Advantage	281,274	71,947	
PDP	180,444		
Total member months	14,080,808	15,010,689	14,824,536
Medical loss ratio	87.6%	90.3%	88.3%
Medical expense ratio	11.5%	10.8%	10.8%

Year ended December 31, 2006 compared with the year ended December 31, 2005

Medical Operating Revenues

Medical premiums earned during 2006 increased by $60.3 million, or 4.7%, to $1.3 billion when compared to earned premiums during 2005, principally as a result of the following:

Medical premiums generated by the Medicare Advantage business increased during 2006 by $121.5 million, or 355.3%, primarily due to an increase in member months enrollment of 209,327, or 290.9%, reflecting the initial ramp-up of this business, which commenced in 2005, and the introduction of additional Medicare Advantage policies. In January 2006, we expanded our Medicare Advantage business with the introduction of *Medicare Platino* for the dual-eligible population, the medically indigent Medicare-qualified beneficiaries. We expect that Medicare Advantage enrollment will continue to experience significant growth, but not at the same pace as in this initial period.

In January 2006, we introduced a new Part D stand-alone prescription drug plan (PDP), *FarmaMed*, which had member months enrollment of 180,444 and premiums of $15.1 million during the 2006 period. We have noted a trend in this business, where the membership of our PDP business is transferring to one of our Medicare Advantage policies, thus we expect a slight decrease in the enrollment of this business.

During 2006, member months enrollment in the Reform business decreased by 981,507, or 13.1%, and premiums earned during the year decreased by $55.0 million, or 10.8%. This business experienced a decrease in its member months as a result of the loss of the Metro-North region effective November 1, 2006. Monthly premiums earned from the Metro-North region averaged approximately $16.2 million in 2006. In addition, this business also experienced a shift in membership by dual eligibles to Medicare Advantage policies offered by us and our competitors and a tightening of membership restrictions by the Puerto Rico government. The effect of this decrease in membership was mitigated by an increase in premium rates, effective August 1, 2005, of approximately 5.0%.

Medical premiums generated by the commercial sector decreased by $21.3 million, or 2.9%. This decrease is due to a decrease in member months of 359,262, or 6.4%, primarily as a result of the loss of several fully-insured accounts due to aggressive marketing and pricing by our competitors as well as qualified enrollees transferring to our or our competitors Medicare Advantage policies and fully-insured groups changing to ASO arrangements, offset in part by an average increase in premium rates of approximately 3.7%.

Administrative service fees increased by $1.4 million, or 9.0%, to $16.9 million during the 2006 period due to an increase in member months enrollment of ASO arrangements of 21,117, or 1.1%, and increases in fee rates.

Medical Claims Incurred

Medical claims incurred during 2006 increased by $17.7 million, or 1.5%, to $1.2 billion when compared to 2005. The increase in medical claims incurred is mostly related to the medical claims incurred of the Medicare Advantage and PDP businesses, which increased by $92.7 million during the 2006 period due to an increase in members, mitigated by a decrease of $66.7 million in medical claims incurred related to the decreased enrollment of the Reform business. The medical loss ratio decreased by 2.7 percentage points during the 2006 period, to 87.6%, primarily driven by lower utilization trends in the Reform business and the increased relative contribution in the 2006 period of our Medicare Advantage business, which has had a lower medical loss ratio than our other businesses.

Medical Operating Expenses

Medical operating expenses for 2006 increased by $16.4 million, or 11.7%, to $156.4 million when compared to 2005. This increase is primarily attributed to additional administrative costs related to the growth of our Medicare Advantage business of approximately $9.8 million and an increase of $4.4 million in technology-related costs and ordinary course payroll and payroll related increases. The segment s operating expense ratio increased by 0.7 percentage points during the 2006 period.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Medical Operating Revenues

Medical premiums earned, net increased by $80.3 million, or 6.7%, to $1.3 billion during 2005, primarily as a result of the following:

Medical premiums earned of the Medicare Advantage business, which began operating in 2005, amounted to $34.2 million. During 2005 the Medicare Advantage sector had a member months enrollment of 71,947.

Medical premiums earned of the Reform sector increased by $26.1 million, or 5.4%, during 2005. The increase in the medical premiums earned of this business is the result of an increase in average premium rates of 4.5% and an increase in member months enrollment of 88,729, or 1.2%, due to an increase in the number of Reform eligibles.

Medical premiums earned of the commercial sector increased by $20.0 million, or 2.8%, during 2005 due to the net effect of a 6.0% increase in average premium rates and a decrease in member months enrollment of 123,131, or 2.1%. The decrease in enrollment is primarily due to a continuation of the trend of employers shifting their groups from fully-insured to ASO arrangements and a decrease in the member months enrollment of local government employees and individual accounts as retirees change to Medicare Advantage policies.

Administrative service fees increased by $5.2 million, or 50.5%, to $15.5 million during the 2005 period due to an increase in member months enrollment of ASO arrangements of 148,608, or 8.8%, and an increase in the rates charged to certain of these groups.

Medical Claims Incurred

Medical claims incurred during 2005 increased by $97.3 million, or 9.2%, to $1.2 billion in 2005 due to increased enrollment and an increase in claims experience trends. The medical loss ratio increased by 2.0 percentage points

during the same period, from 88.3% in 2004 to 90.3% in 2005, principally driven by higher utilization levels and costs per service in the Reform business, particularly with respect to cardiovascular services, dialysis, obstetrics, office visits, prescription drugs, laboratory services and specialized procedures, such as MRIs and CT scans. The medical claims incurred of the Reform and commercial businesses increased by $40.2 million and $57.1 million, respectively, in 2005. Medical claims experience trends in the commercial sector increased from 5.7% in 2004 to 6.7% in 2005.

Medical Operating Expenses

Medical operating expenses increased by $9.3 million, or 7.1%, to $140.0 million in 2005 principally due to expenses amounting to $9.4 million related to the launch of the new Medicare Advantage product, new business generated during the year and the commencement of preparations to comply with SOX 404, offset in part by a reduction of approximately $2.8 million in expenses related to several operating projects that were completed during 2005 but had been ongoing during most of 2004, such as changes due to the requirements of HIPAA. The medical operating expense ratio was unchanged at 10.8% in 2004 and 2005.

Life Insurance Operating Results

The 2005 comparable basis information included in the following table is presented to provide a more meaningful comparison of the 2006 and 2005 periods, see Significant Transactions Consolidated included in this Item.

(Dollar amounts in millions)	**2006**	**Comparable Basis 2005**	**2005**	**2004**
Years ended December 31,				
Operating revenues:				
Premiums earned, net				
Premiums earned, net	$ 91.9	87.9	24.2	23.7
Premiums earned ceded	(9.7)	(10.1)	(8.0)	(7.8)
Assumed premiums earned	4.4	0.4	0.4	
Net premiums earned	86.6	78.2	16.6	15.9
Commission income on reinsurance	0.3	0.5	0.5	0.5
Premiums earned, net	86.9	78.7	17.1	16.4
Net investment income	13.7	13.6	3.0	2.8
Total operating revenues	100.6	92.3	20.1	19.2
Operating costs:				
Policy benefits and claims incurred	43.6	37.9	8.9	11.2
Underwriting and other expenses	45.8	39.7	8.2	7.4
Total operating costs	89.4	77.6	17.1	18.6
Operating income	$ 11.2	14.7	3.0	0.6
Additional data:				
Loss ratio	50.2%	48.2%	52.0%	68.3%
Expense ratio	52.7%	50.4%	48.0%	45.1%

Year ended December 31, 2006 compared with the year ended December 31, 2005

Operating Revenues

Premiums earned for the segment increased by $67.7 million, or 279.8%, to $91.9 million in 2006 as compared to the 2005 period, reflecting the acquisition of GA Life in 2006. On a comparable basis, premiums earned during 2006 increased by $4.0 million, or 4.6%. This increase is primarily the result of an increase in the life business attributed to new sales of ordinary life and monthly debt ordinary insurance (MDO) policies, as well as an increase in the cancer and other dreaded diseases business.

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

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Policy Benefits and Claims Incurred

Policy benefits and claims incurred in 2006 increased by $34.7 million, or 389.9%, to $43.6 million in the 2006 period when compared to the 2005 period. On a comparable basis, policy benefits and claims incurred increased by $5.7 million, or 15.0%, due in part to our share of claims and actuarial reserves for the month of January 2006 under the coinsurance agreement with GA Life amounting to $2.3 million. In addition, this segment also experienced increases in death benefits, policy surrenders and in policy reserves of approximately $3.6 million, primarily as the result of new sales in the ordinary life and MDO business and to the natural growth of actuarial reserves, which contributed to the increase in the loss ratio on a comparable basis by 2.0 percentage points, from 48.2% in 2005 to 50.2% in the 2006 period.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased from $8.2 million to $45.8 million in 2006 period. On a comparable basis, underwriting and other expenses increased by $6.1 million, or 15.4%. The segment s operating expense ratio on a comparable basis increased by 2.3 percentage points during the year 2006, from 50.4% in to 52.7% in 2006. The increase in underwriting and other expenses includes $1.8 million relating to our share of commissions and other operating expenses for the month of January 2006 under the coinsurance agreement with GA Life. The remaining increase in operating expenses is mostly related to management fees charged by TSM and an increase in the amortization expense resulting from the deferred policy acquisition costs and value of business acquired arising from the acquisition of GA Life.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Operating Revenues

Premiums earned increased by $0.5 million, or 2.1%, to $24.2 million in 2005 as compared to 2004, primarily as a result of an increase in the cancer and other dreaded diseases line of business, which was introduced in the second half of 2004, offset in part by a decrease in the group life line of business due to the termination of a major group with an adverse history of losses.

On December 22, 2005, we entered into a coinsurance funds withheld reinsurance agreement with GA Life pursuant to which GA Life assumed 69% of all business written as of and after the effective date of the agreement. During December 2005, we recorded assumed premiums related to this agreement amounting to $0.4 million.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred decreased by $2.3 million, or 20.5%, to $8.9 million in 2005, primarily as a result of the termination or non-renewal of unprofitable groups. As a result, the loss ratio decreased by 16.3 percentage points, from 68.3% in 2004 to 52.0% in 2005.

Underwriting and Other Expenses

Underwriting and other expenses increased by $0.8 million, or 10.8%, to $8.2 million in 2005, primarily due to increase in commission and other related expenses in the cancer and other dreaded diseases line of business. The operating expense ratio increased by 2.9 percentage points, from 45.1% in 2004 to 48.0% in 2005.

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Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	**2006**	**2005**	**2004**
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$ 158.9	151.1	141.8
Premiums ceded	(65.7)	(59.2)	(52.2)
Change in unearned premiums	(4.7)	(5.1)	(3.4)
Premiums earned, net	88.5	86.8	86.2
Net investment income	9.6	8.7	7.7
Total operating revenues	98.1	95.5	93.9
Operating costs:			
Claims incurred	41.7	43.6	46.0
Underwriting and other operating expenses	45.2	39.6	40.2
Total operating costs	86.9	83.2	86.2
Operating income	$ 11.2	12.3	7.7
Additional data:			
Loss ratio	47.1%	50.2%	53.4%
Expense ratio	51.1%	45.6%	46.6%
Combined ratio	98.2%	95.8%	100.0%

Year ended December 31, 2006 compared with the year ended December 31, 2005

Operating Revenues

Total premiums written during 2006 increased by $7.8 million, or 5.2%, to $158.9 million, principally as a result of increases in the dwelling and commercial property mono-line, commercial multi-peril and auto physical damage lines of business.

Premiums ceded to reinsurers increased by $6.5 million, or 11.0%, to $65.7 million as a result of an increase in the portion of risk ceded to reinsurers and to increases in the cost of reinsurance, particularly in non-proportional treaties, including catastrophe coverage. The ratio of premiums ceded to premiums written increased by 2.1 percentage points, from 39.2% in the 2005 period to 41.3% in the 2006 period.

Claims Incurred

Claims incurred in the 2006 period decreased by $1.9 million, or 4.4%, to $41.7 million, mostly as the result of the segment s efforts to improve the quality of underwriting and improvements in the claims handling process. The loss ratio decreased by 3.1 percentage points during this period, to 47.1%.

Underwriting and Other Operating Expenses

Underwriting and other operating expenses in 2006 increased by $5.6 million, or 14.1%, to $45.2 million. The operating expense ratio increased by 5.5 percentage points during the same period, to 51.1% in 2006. These increases are primarily due to increases in commission expenses due to increased volume and commission rate increases

reflecting market conditions and salaries and benefits expenses, as well as costs associated with the implementation of new IT systems.

Year ended December 31, 2005 compared with the year ended December 31, 2004

Operating Revenues

Total premiums written increased by $9.3 million, or 6.6%, to $151.1 million in 2005, primarily due to increases in the commercial multi-peril package and auto physical damage lines of business.

Premiums ceded to reinsurers increased by $7.0 million, or 13.4%, to $59.2 million in 2005, primarily as a result of an increase in business volume. The ratio of premiums ceded to total premiums written increased by 2.4 percentage points, from 36.8% in 2004 to 39.2% in 2005, as a result of an increase in the portion of risk ceded to reinsurers, particularly in the commercial and personal lines quota share arrangements as well as increases in cost of reinsurance.

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Claims Incurred

Claims incurred decreased by $2.4 million, or 5.2%, to $43.6 million in 2005. The loss ratio decreased by 3.2 percentage points, to 50.2% in 2005. These decreases are primarily due to net losses of $2.1 million incurred in 2004 from the effects of Tropical Storm Jeanne in September 2004.

Underwriting and Other Operating Expenses

Underwriting and other operating expenses decreased by $0.6 million, or 1.5%, to $39.6 million in 2005, and the operating expense ratio decreased by 1.0 percentage points, to 45.6% in 2005.

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)	**2006**	**2005**	**2004**
Years ended December 31,			
Sources of cash:			
Cash provided by operating activities	$ 73.7	49.1	8.8
Proceeds from long-term borrowings	35.0	60.0	50.0
Proceeds from short-term borrowings	117.8	174.1	20.4
Proceeds from annuity contracts	6.0	11.5	11.0
Other		3.9	6.8
Total sources of cash	232.5	298.6	97.0
Uses of cash:			
Net purchases of investment securities	(7.6)	(92.9)	(41.5)
Acquisition of GA Life, net of cash acquired	(27.8)		
Capital expenditures	(11.9)	(7.6)	(3.5)
Dividends	(6.2)		
Payments of long-term borrowings	(2.5)	(5.1)	(2.6)
Payments of short-term borrowings	(119.5)	(174.0)	(57.4)
Surrenders of annuity contracts	(16.0)	(5.1)	(4.6)
Other	(8.7)		
Total uses of cash	(200.2)	(284.7)	(109.6)
Net increase (decrease) in cash and cash equivalents	$ 32.3	13.9	(12.6)

Year ended December 31, 2006 compared to year ended December 31, 2005

Cash provided by operating activities increased by $24.6 million, or 50.1%, to $73.7 million during 2006. It is principally due to a 10% increase in premiums collected, offset in part by a 4% increase in claims losses and benefits paid, reflecting primarily lower utilization trends in the managed care segment during 2006. Also, our operating cash flows during 2006 include the operating cash flows of GA Life, not present in prior years. The effect of these fluctuations was mitigated by a decrease in net proceeds from sales of our trading portfolio following the sale of $71.9 million of our corporate bond trading portfolio during 2005.

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

Net purchases of investment securities decreased by $85.3 million during the 2006 period, primarily as a result of 2005 acquisitions of available-for-sale securities with the proceeds from the sale of our corporate bonds trading portfolio.

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

Capital expenditures increased by $4.3 million as a result of the renovation of a building adjacent to our corporate headquarters as well as costs related to the acquisition by our property and casualty insurance segment of an insurance application and hardware to manage its operations.

On January 13, 2006, we declared and paid dividends to our shareholders amounting to $6.2 million.

The 2006 period reflects net surrenders of annuity contracts of $10 million while the 2005 period presents net proceeds from annuity contracts of $6.4 million. This fluctuation is principally due to an increase in the amount of annuity surrenders and a decrease in the proceeds received from the fixed deferred annuity product in the 2006 period.

Year ended December 31, 2005 compared to year ended December 31, 2004

Cash provided by operating activities increased by $40.3 million during 2005 to $49.1 million, principally due to an increase in 2005 of the net proceeds received from sales of our corporate bonds trading portfolio, offset by an increase in claims, losses and benefits paid at a higher rate than the premiums collected during 2005. During 2005, the amount of claims, losses and benefits paid increased by 9% while the amount of premiums collected increased by 7%. The fluctuation in the increase in the amount of claims, losses and benefits paid over premiums collected is primarily due to the higher utilization and cost trends experienced by the managed care segment during 2005.

Proceeds from long-term borrowings increased by $10.0 million during 2005 due to the net effect of the $60.0 million proceeds received from the issuance and sale of our 6.6% senior unsecured notes in December 2005 and the $50.0 million proceeds received from the issuance and sale of our managed care subsidiary s 6.3% senior unsecured notes in September 2004 to repay, among other things, short term borrowings.

Net purchases of investments increased by $51.4 million during 2005 principally as a result of investments in available-for-sale securities with the net proceeds obtained from the sale of our corporate bonds trading portfolio.

Capital expenditures increased by $4.1 million in 2005 in connection with the renovation of one of our properties and the acquisition of an insurance operations system by our property and casualty insurance segment.

Net payments of short-term debt decreased by $37.1 million as a result of the repayment of short-term borrowings incurred by us in 2003 to pay the tax liability related to the closing agreement with the Puerto Rico Treasury Department (PRTD) upon the termination of our tax exemption. This repayment was made with the proceeds of the long-term debt described above.

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, 2006, we had $53.0 million of available credit under these facilities. There were no outstanding short-term borrowings under these facilities as of December 31, 2006. Outstanding borrowings under these short-term facilities as of December 31, 2005 amounted to $1.7 million, which were paid out of our operating cash flows in 2006.

As of December 31, 2006, 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 initial ceding commission to GA Life on the effective date of the coinsurance funds withheld reinsurance agreement.

On September 30, 2004 our managed care subsidiary issued and sold $50.0 million of its 6.3% senior unsecured notes due September 2019 (the 6.3% notes). The 6.3% notes are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us. The notes were privately placed to various institutional accredited investors. The notes pay interest semiannually until the principal becomes due and payable. These notes can be prepaid after five years at par, in whole or in part, as determined by our managed

care subsidiary. Most of the proceeds obtained from this issuance were used to repay $37.0 million of short-term borrowings. The remaining proceeds were used for general business purposes.

The 6.3% notes, the 6.6% notes and the 6.7% notes contain certain covenants. At December 31, 2006, we and our managed care subsidiary, as applicable, are in compliance with these covenants.

In addition, we are a party to two secured term loans with a commercial bank, FirstBank Puerto Rico. These secured loans bear interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus a margin specified at the time of the agreement. As of December 31, 2006, the two secured loans had outstanding balances of $27.6 million and

$10.5million, respectively, and average annual interest rates of 6.1% and 6.4%, respectively. The first secured loan requires monthly principal repayment of $0.1 million. The second secured loan requires repayment of principal amounts of not less than $0.3 million and integral multiples of $0.1 million in excess thereof and must be repaid by August 1, 2007.

These secured loans are 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. These secured loans contain certain covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2006, we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the secured loans outstanding balances. Principal repayments on these loans are expected to be paid out from our operating and investing cash flows.

We have an interest rate swap agreement, which changes the variable rate of one of our credit agreements and fixes the rate at 4.72%. We continually monitor existing and alternative financing sources to support our capital and liquidity needs.

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 cost approximately $40.0 million and is expected to be completed by 2011. Our managed care business expects to incur costs of approximately $15.6 million during 2007 in this project. We estimate that $11.3 million of the costs incurred in 2007 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:

Liability for future policy benefits This liability was excluded because we do not expect to make payments in the future until the occurrence of an insurable event, such as death or disability, or because the occurrence of a payment triggering event, such as the surrender of a policy or contract, is not under our control. The determination of the timing of payment of this liability is not reasonably fixed and determinable since the insurable event has not yet occurred. As of December 31, 2006, our liability for future policy benefits amounted to $180.4 million.

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, 2006, we had $113.6 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, 2006, our policyholder deposits had a carrying amount of $45.4 million.

Other long-term liabilities   Due to the indeterminate nature of their cash outflows, $56.2 million of other long-term liabilities are not reflected in the following table, including $32.3 million of liability for the pension benefits and $13.6 million in liabilities to the Federal Employees Health Benefit Plan.

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(Dollar amounts in millions)	**Total**	**Contractual obligations by year**					
		2007	**2008**	**2009**	**2010**	**2011**	**Thereafter**
Long-term borrowings (1)	$326.8	23.7	12.7	12.5	12.5	12.4	253.0
Operating leases	16.8	4.6	3.6	3.1	2.6	2.7	0.2
Purchase obligations (2)	135.5	132.0	0.3	0.5	0.4	0.4	1.9
Claim liabilities (3)	282.6	193.0	50.9	11.6	10.2	6.5	10.4
	$761.7	353.3	67.5	27.7	25.7	22.0	265.5

(1) As of December 31, 2006, our long-term borrowings consist of our managed care subsidiary s 6.3% senior unsecured notes payable (which are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us), our 6.6% senior unsecured notes payable, our 6.7% senior unsecured notes payable, and loans payable to a commercial bank. Total contractual obligations for long-term borrowings include the current maturities of long term debt.

For the 6.3%, 6.6% and 6.7% senior unsecured notes, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity dates of the notes in 2019, 2020, and 2021, respectively. We may redeem the notes starting five years after issuance; however no redemption is considered in this schedule. The interest payments related to our loans payable were estimated using the interest rate applicable as of December 31, 2006 for each of the loans. The actual amount of interest payments of the loans payable will differ from the amount included in this schedule due to the loans variable interest rate structure. See the Financing and Financing

Capacity section for additional information regarding our long-term borrowings.

(2) Purchase obligations represent payments required by us under material agreements to purchase goods or services that are enforceable and legally binding and where all significant terms are specified, including: quantities to be purchased, price provisions and the timing of the transaction. Other purchase orders made in the ordinary course of business for which we are not liable are excluded from the table above. Estimated pension plan contributions amounting to $5.0 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, 2006. The expected claims payments are an estimate and may not necessarily present the actual claims payments to be made by us. Also, the estimated claims payments included in the table above do not include $32.1 million of

reserves ceded under reinsurance contracts. Since reinsurance contracts do not relieve us from our obligations to policyholders, in the event that any of the reinsurance companies is unable to meet its obligations under the existing reinsurance agreements, we would be liable for such defaulted amounts.

Off-Balance Sheet Arrangements

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

Restriction on Certain Payments by the Corporation s Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico. The se regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by the insurance subsidiaries to TSM. Our managed care subsidiary is required to have minimum capital of $1.0 million, our life insurance subsidiary is required to have minimum capital of $2.5 million and our property and casualty insurance subsidiary is required to have minimum capital of $3.0 million. As of December 31, 2006, our insurance subsidiaries were in compliance with such minimum capital requirements.

These regulations are not directly applicable to us, as a holding company, since we are not an insurance company. Our credit agreements restrict the amount of dividends that we and our subsidiaries can declare or pay to stockholders. Under to the credit agreements, 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, 2006, both we and our managed care subsidiary s estimated RBC ratio was 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 .

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 2006, 2005 and 2004, we paid assessments in connection with insurance companies declared insolvent in the amount of $0.8 million, $1.0 million and $1.1 million, respectively. 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 2006, 2005 and 2004, 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 three-year period ended December 31, 2006, the Association distributed good experience refunds. The segment received refunds amounting to $0.8 million, $0.9 million and $0.8 million in 2006, 2005, and 2004, 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 generally accepted accounting principles applied on a consistent basis. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America 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.

Claim Liabilities

Claim liabilities as of December 31, 2006 by segment were as follows:

(Dollar amounts in millions)	**Managed Care**	**Life Insurance**	**Property and Casualty Insurance**	**Consolidated**
Claims processed and incomplete (1)	$ 72.0	26.3	48.9	147.2
Unreported losses (2)	108.0	8.5	34.2	150.7
Unpaid loss-adjustment expenses (3)	5.3	0.3	11.2	16.8
	$185.3	35.1	94.3	314.7

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

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

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

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

We recognize claim liabilities as follows:

Managed Care Segment

At December 31, 2006, claim liabilities for the managed care segment amounted to $185.3 million and represented 58.9% of our total consolidated claim liabilities and 18.5% of our total consolidated liabilities.

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

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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, or trend factors . Using all of the above methodologies, our actuaries determine based on the different circumstances the unpaid claims as of the end of any 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 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 of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 75% of the claims are paid the first quarter following the incurrence date and about 10% are paid during the second quarter, for a total of 85% paid during the first six months following the incurrence date.

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 trend factors can have a significant impact on determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2006 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

(Dollar amounts in millions)

Completion Factor [1] (Decrease) Increase		**Claims Trend Factor [2] (Decrease) Increase**	
In completion factor	**In unpaid claim liabilities**	**In claims trend factor**	**In unpaid claim liabilities**
(0.6)%	$ 7.2	(0.6)%	$ 9.3
(0.4)%	4.8	(0.4)%	6.2
(0.2)%	2.4	(0.2)%	3.1

0.2%	(2.4)	0.2%	(3.1)
0.4%	(4.7)	0.4%	(6.2)
0.6%	(7.1)	0.6%	(9.3)

[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. In 2004, the managed care segment s claim payment patterns were affected by a slowdown in claims submission from providers due to HIPAA coding changes that occurred during the latter half of 2003 and by the effect of tropical storm Jeanne, which limited access to providers during the months of September and October 2004. The first event affects historical completion factors while the second event changed utilization trends. Management has not noted any significant emerging trends in claim frequency and severity, other than those described above, and the normal fluctuation in utilization trends from year to year.

The following table shows the variance between the segment s total incurred claims as reported and the total 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 9 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	**2005**	**2004**	**2003**
Total incurred claims:			
As reported (1)	$1,148.2	1,062.7	1,026.0
On a retrospective basis	1,137.5	1,070.4	1,021.9
Variance	$ 10.7	(7.7)	4.1
Variance to total incurred claims as reported	0.9%	-0.7%	0.4%

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

Management expects that substantially all of the development of the 2006 estimate of medical claims payable will be known during 2007 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, 2006, claim liabilities for the life insurance segment amounted to $35.1 million and represented 11.2% of total consolidated claim liabilities and 3.5% of our total consolidated liabilities.

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

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

The key assumption with regard to claim liabilities for our life insurance segment is related to claims included prior to the end of the year, but not yet reported to our subsidiary. A liability for these claims is estimated based upon

experience with regards to amounts reported subsequent to the close of business in prior years. There are uncertainties attendant to these estimates; however, in recent years our estimates have proved to be slightly conservative.

Property and Casualty Insurance Segment

At December 31, 2006, claim liabilities for the property and casualty insurance segment amounted to $94.3 million and represented 30.0% of the total consolidated claim liabilities and 9.4% 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, and include the participation of the segment s external actuaries. Our actuaries certify reserves for both current and prior accident years using current claims data. These reviews incorporate a variety of actuarial methods, judgments, and analysis. For each line of business, a variety of actuarial methods are used, with the final selections of ultimate losses that are appropriate for each line of business selected based on the current circumstances affecting that line of business. These selections incorporate input from management, particularly from the claims, underwriting and operations divisions, about reported loss cost trends and other factors that could affect the reserve estimates.

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

At December 31, 2006, the actuarial reserve range determined by the actuaries was from $90.4 million to $101.0 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 $4.6 million and $3.6 million, respectively.

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. The segment computes the amounts for actuarial liabilities in conformity with GAAP.

Liabilities for future policy benefits for whole life and term insurance products are computed by the net level premium method, using interest assumptions ranging from 5.0 percent to 5.4 percent and withdrawal, mortality and morbidity assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as

applicable). Accident and health reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.
The liabilities for all products, except for universal life and deferred annuities, are based upon a variety of actuarial assumptions that are uncertain. The most significant of these assumptions are 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 futures policy benefits is sufficient, in combination with anticipated future cash flows, to provide for all contractual obligations. Note that, for all products except for universal life and deferred annuities, according to SFAS No. 60, *Accounting and Reporting by Insurance Enterprises*, the basis for the liability for future policy benefits 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 to provide for future policy benefits. To date, our analysis indicates that this event is not likely.

Based upon the most recent actuarial reviews of all of these assumptions, we do not anticipate material changes to the level of these liabilities in the future.

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, are amortized to income over the premium-paying period of the related whole life and term insurance policies in proportion to the ratio of the expected annual premium revenue to the expected total premium revenue, and over the anticipated lives of universal life policies in proportion to the ratio of the expected annual gross profits to the expected total gross profits. The expected premiums revenue and gross profits are based upon the same mortality and withdrawal assumptions used in determining the liability for future policy benefits. For universal life policies, changes in the amount or timing of expected gross profits result in adjustments to the cumulative amortization of these costs. The effect on the amortization of deferred policy acquisition costs for revisions to estimated gross profits is reported in earnings in the period such estimated gross profits are revised.

The schedules of amortization of the life insurance deferred policy acquisition costs (DPAC) and the 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 are the level of contract persistency and investment yield rates. Note that for these products according to FASB No. 60 the basis for the amortization of DPAC and VOBA are 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 to provide for future policy benefits. To date, our analysis indicates that this event is not likely. 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 acticipate material changes to the level of these amortization schedules in the futures.

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

During the years ended December 31, 2006 and 2005 we recognized other-than-temporary impairments amounting to $2.1 and $1.4 million, respectively, on one of our equity securities classified as available for sale. No other-than-temporary impairment was recognized in 2004. As of December 31, 2006, of the total amount of investments in securities of $869.1 million, $83.4 million, or 10%, are classified as trading securities, and thus are recorded at fair value with changes estimated fair value recognized in the statement of operations. The remaining $785.7 million is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $664.4 million, or 85%, are securities in U.S. Treasury securities, obligations of U.S. government-sponsored enterprises, obligations of the Commonwealth of Puerto Rico, mortgage backed and collateralized mortgage obligations that are U.S. agency-backed, and obligations of U.S. and Puerto Rican government instrumentalities. The remaining

$121.3 million, or 15%, are from corporate fixed and equity securities. Gross unrealized losses as of December 31, 2006 of the available-for-sale and held-to-maturity portfolios amounted to $14.5 million.

The impairment analysis as of December 31, 2006 and 2005 indicated that, other than the equity security for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was other-than-temporarily impaired as of that date; however, several factors are beyond management s control, such as the following: financial condition of the issuer, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management s judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income. Taking into account the quality of the securities in the investment portfolio, the amount of unrealized losses within the available-for-sale and held-to-maturity portfolios, and past experience, management believes that, the amount of likely future impairments in the next year should not be material.

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

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2006 and 2005 is included in note 4 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 $18.2 million and $12.2 million as of December 31, 2006 and 2005, respectively. The amount of the allowance is based on the age of unpaid accounts, information about the customer s creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

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

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

Other Significant Accounting Policies

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

Recently Issued Accounting Standards

Statement of Financial Accounting Standards (SFAS) No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities*, was issued in February 2007. This statement permits entities