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

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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, 2010**

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

**COMMISSION FILE NUMBER 001-33865**
**Triple-S Management Corporation**

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

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

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

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

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

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

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

Indicate by checkmark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). o Yes o No

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

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

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

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all directors and executive officers of the registrant are affiliates ) as of June 30, 2010 was approximately $373,047,753 for the Class B common stock (the only stock of the registrant that trades in a public market) and $9,042,809 for the Class A common stock (valued at its par value of $1.00 since it is not publicly traded).

**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the definitive Proxy Statement to be delivered to shareholders in connection with the Annual Meeting of Shareholders to be held on April 29, 2011 are incorporated by reference into Parts II and III of this Annual Report on Form 10-K.

**Triple-S Management Corporation**
**FORM 10-K**
For The Fiscal Year Ended December 31, 2010
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**Part I**

***Item 1. Business***

***General Description of Business and Recent Developments***

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

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

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

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

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

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

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

***Industry Overview***

***Managed Care***

In response to an increasing focus on health care costs by employers, the government and consumers, there has been a growth in alternatives to traditional indemnity health insurance, such as Health Maintenance Organizations ( HMOs ) and Preferred Provider Organizations ( PPOs ). Through the introduction of these alternatives the managed care industry has attempted to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver health care to plan members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of certain outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and

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various levels of care management programs to help members better understand and navigate the medical system. In addition, providers may have incentives to achieve certain quality measures or may share medical cost risk. Members generally pay co-payments, coinsurance and deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization. An HMO plan may also require members to select one of the network primary care physicians to coordinate their care and approve any specialist or other services.

The government of the United States of America (the U.S. government or federal government ) provides hospital and medical insurance benefits to eligible people aged 65 and over as well as certain other qualified persons through the Medicare program, including the Medicare Advantage program. The federal government also offers prescription drug benefits to Medicare eligibles, both as part of the Medicare Advantage program and on a stand-alone basis, pursuant to Medicare Part D (also referred to as PDP stand-alone product or PDP ). In addition, the government of the Commonwealth of Puerto Rico (the government of Puerto Rico ) provides managed care coverage to the medically indigent population of Puerto Rico.

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

We are licensed by Blue Cross and Blue Shield Association ( BCBSA ) to use the Blue Cross Blue Shield name and mark in Puerto Rico and the U.S. Virgin Islands. The BCBSA had 39 independent licensees as of December 31, 2010. BCBS membership stood at 97.6 million members at September 30, 2010, which represents 31.4% of the U.S. population. The BCBS plans work cooperatively in a number of ways that create significant market advantages, especially when competing for very large, multi-state employer groups. For example, all BCBS plans participate in the BlueCard program, which effectively creates a national Blue network. Each plan is able to take advantage of other BCBS plans broad provider networks and negotiated provider reimbursement rates where a member covered by a policy in one state or territory lives or travels outside such state or territory. The BlueCard program is a source of revenue for TSS from services provided in Puerto Rico to individuals who are customers of other BCBS plans and also provides us a significant network in the U.S, creating a significant competitive advantage for us because Puerto Ricans frequently travel to the continental United States.

***Life Insurance***

Total annual premiums in Puerto Rico for the nine months ended September 30, 2010 for the life insurance market approximated $1.1 billion. The main products in this market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are independent agents. In recent years banks have established general agencies to cross sell many life insurance products, such as term life and credit life.

***Property and Casualty Insurance Segment***

The total property and casualty market in Puerto Rico in terms of gross premiums written as of September 30, 2010 was approximately $1.4 billion. Property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi peril, fire and allied lines and other general liabilities. Approximately 69% of the market is written by the top six companies in terms of market share, and approximately 88% of the market is written by companies incorporated under the laws of, and which operate principally in Puerto Rico.

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

***Puerto Rico s Economy***

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

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

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

The economy of Puerto Rico is closely linked to that of the continental United States, as most of the external factors that affect the Puerto Rico economy (other than the price of oil) are determined by the policies and results of the U.S. These external factors include exports, direct investment, the amount of federal transfer payments, the level of interest rates, the rate of inflation, and tourist expenditures. In the past, the economy of Puerto Rico has generally followed economic trends in the overall United States economy. However, in recent years economic growth in Puerto Rico has lagged behind growth in the United States.

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

On March 12, 2009, the government of Puerto Rico approved various temporary revenue raising measures, including a modification to the alternative minimum tax on corporations that limits deductions for expenses incurred outside Puerto Rico and a 5% surcharge on corporations, including insurance companies. The government of Puerto Rico has developed a comprehensive long-term economic development plan aimed at improving overall competitiveness and business environment and increasing private-sector participation in the economy. As part of this plan, the permitting and licensing process was modernize to provide for a leaner and more efficient process that fosters economic development. Furthermore, the government proposes to (i) strengthen the labor market and encourage greater labor-force participation by bringing out-of-date labor laws and regulations in line with U.S. and international standards, (ii) adopt a new energy policy that seeks to lower energy costs and reduce energy-price volatility by reducing Puerto Rico s dependence on fuel oil and the promotion of diverse, renewable-energy technologies, and (iii) adopt a comprehensive tax reform in two phases. The first phase of the tax reform was enacted in the last quarter of 2010 and was mostly related to reducing the income tax burden to individuals. For 2010 only, corporations received an income tax credit amounting to 7% of the tax determined, defined as the tax liability less certain credits. The second phase of the reform, which was approved on January 31, 2011, provides for the reduction of the maximum corporate income tax rate from 40.95% to approximately 30% including the elimination of the above mentioned 5% surcharge on corporations, as well as adding several tax credits and deductions, among other tax reliefs and changes.

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

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***Products and Services***

***Managed Care***

Through our subsidiary TSS, we offer a broad range of managed care products, including HMOs, PPOs, Medicare Supplement, Medicare Advantage and Medicare Part D. Managed care products represented approximately 89% of our consolidated premiums earned, net for the years ended December 31, 2010, 2009 and 2008. We design our products to meet the needs and objectives of a wide range of customers, including employers, individuals and government entities. Our customers either contract with us to assume underwriting risk or they self-fund underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members access to providers is subject to referral or preauthorization requirements.

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

We currently offer the following managed care plans:

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

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

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

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

*Prescription Drug Benefit Plans.* Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D in our Medicare Advantage plans as well as on a stand-alone basis. We also offer a Drug Discount Card for local government employees and individuals. The Drug Discount Card program is not insurance, but rather provides access to discounts from contracted pharmacies. As of December 31, 2010, we had enrolled approximately 26,000 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2011.

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

***Life Insurance***

We offer a wide variety of life, accident, disability and health and annuity products in Puerto Rico through our subsidiary Triple-S Vida, Inc. ( TSV ). Life insurance premiums represented approximately 6% of our consolidated premiums earned, net for the years ended December 31, 2010, 2009 and 2008. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases ( Cancer line of business), and pre-need life products are marketed through independent agents. TSV is the leading distributor of life products in Puerto Rico. We are the principal home service company in Puerto Rico and offer guaranteed issue, funeral and cancer policies to the lower and middle income market segments directly to people in their homes. We also market our group life and disability coverages through our managed care subsidiary s network of exclusive agents.

***Property and Casualty Insurance***

We offer a wide range of property and casualty insurance products through our subsidiary Triple-S Propiedad, Inc. ( TSP ). Property and casualty insurance premiums represented approximately 5% of our consolidated premiums earned, net for the years ended December 31, 2010, 2009 and 2008. Our predominant lines of business are commercial multi-peril, commercial property mono-line, auto physical damage, auto liability and dwelling policies. This segment s commercial lines target small to medium size accounts. We generate a majority of our dwelling business through our strong relationships with financial institutions.

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

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Our policy is to enter into reinsurance agreements with reinsurers considered to be financially sound. Practically all our reinsurers have an A.M. Best rating of "A- or better, or an equivalent rating from other rating agencies. During the year ended December 31, 2010, 40.0% of the premiums written in the property and casualty insurance segment were ceded to reinsurers. Although these reinsurance arrangements do not relieve us of our direct obligations to our insureds, we believe that the risk of our reinsurers not paying balances due to us is low.

***Marketing and Distribution***

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

***Branding and Marketing***

Our branding and marketing efforts include brand advertising , which focuses on the Triple-S name and the Blue Cross Blue Shield mark, acquisition marketing , which focuses on attracting new customers, and institutional advertising , which focuses on our overall corporate image. We believe that the strongest element of our brand identity is the Triple-S name. We seek to leverage what we believe to be the high name recognition and comfort level that many existing and potential customers associate with this brand. Acquisition marketing consists of business-to-business marketing efforts which are used to generate leads for brokers and our sales force as well as

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direct-to-consumer marketing efforts which are used to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall company image. We believe these efforts support and further our competitive brand advantage. We will continue to utilize the Triple-S name and the Blue Cross Blue Shield mark for all managed care products and services in Puerto Rico and the U.S. Virgin Islands, except for Medicare Advantage products and services offered through our recently acquired subsidiary, AHI, which will continue using its own name and will not carry the BCBS mark.

***Sales and Marketing***

We employ a wide variety of sales and marketing activities. Such activities are closely regulated by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services ( HHS ) and other government of Puerto Rico agencies. For example, our sales and marketing materials must be approved in advance by the applicable regulatory authorities, and they often impose other regulatory restrictions on our marketing activities.

***Distribution***

*Managed Care Segment.* We rely principally on our internal sales force and a network of independent brokers and agents to market our products. Individual policies and Medicare Advantage products are sold entirely through independent agents who exclusively sell our individual products, and group products are sold through our 65 person internal sales force as well as our approximately 168 independent brokers and agents. We believe that each of these marketing methods is optimally suited to address the specific needs of the customer base to which it is assigned.

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

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

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

***Customers***

***Managed Care***

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

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

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*Commercial Sector*

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

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

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

*Individual Accounts.* We provide managed care services to individuals and their dependent family members who contract these services directly with us though our network of independent brokers. We provide individual and family contracts.

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

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

*Medicare Advantage Sector*

Medicare is a federal program administered by CMS that provides a variety of hospital and medical insurance benefits to eligible persons aged 65 and over as well as to certain other qualified persons. Medicare, with the approval of the Medicare Modernization Act, started promoting a managed care organizations ( MCO ) sponsored Medicare product that offers benefits similar to or better than the traditional Medicare product, but where the risk is assumed by the MCOs. This program is called Medicare Advantage. We entered into the Medicare Advantage market in 2005 and have contracts with CMS to provide extended Medicare coverage to Medicare beneficiaries under our *Medicare Optimo*, *Medicare Selecto* and *Medicare Platino* policies. Under these annual contracts, CMS pays us a set premium rate based on membership that is risk adjusted for health status. Depending on the total benefits offered, for certain of our Medicare Advantage products the member will also be required to pay a premium.

Our *Medicare Selecto* and *Medicare Platino* policies target the sector of the population eligible for both Medicare and Medicaid, or dual-eligible beneficiaries. The government of Puerto Rico has implemented a plan to allow dual-eligibles enrolled in Medicaid to move to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in the Medicare Advantage programs, such as deductibles and co-payments of prescription drug benefits.

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

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***Life Insurance***

Our life and health insurance customers consist primarily of individuals, who hold approximately 465,000 policies, and we insure approximately 1,400 groups.

***Property and Casualty Insurance***

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

***Underwriting and Pricing***

***Managed Care***

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

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

We have been able to maintain relatively high retention rates, which is the percentage of existing business retained in the renewal process, in the corporate accounts sector of our managed care business and since 2003 have maintained our market share in that sector. The retention rate in our corporate accounts has been 95% or above in each of the last five years.

Our managed care rates are set prospectively, meaning that a fixed premium rate is determined at the beginning of each contract year and revised at renewal. We renegotiate the premiums of different groups in the corporate accounts subsector as their existing annual contracts become due. We set rates for individual contracts based on the most recent semi-annual claims data. We consider the actual claims trend of each group when determining the premium rates for the following contract year. Rates in the Medicare sector and for federal and local government employees are generally set on an annual basis through negotiations with the U.S. federal and Puerto Rico governments, as applicable.

***Life Insurance***

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

***Property and Casualty Insurance***

The property and casualty insurance sector is experiencing a soft market in Puerto Rico, principally as a result of economic conditions. Lower reinsurance costs have also contributed to soft market conditions. Notwithstanding these conditions, our property and casualty segment has maintained its leadership position in the property insurance sector by following prudent underwriting and pricing practices.

Our core business is comprised of small and medium-sized accounts. We have been able to maintain a stable volume of business as the result of attentive risk assessment and strict adherence to underwriting guidelines,

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combined with maintenance of competitive rates on above-par risks designed to maintain a relatively high retention ratio. Underwriting strategies and practices are closely monitored by senior management and constantly updated based on market trends, risk assessment results and loss experience. Commercial risks in particular are fully reviewed by our underwriters.

***Quality Initiatives and Medical Management***

We utilize a broad range of focused traditional cost containment and advanced care management processes across various product lines. We continue to enhance our management strategies, which seek to control claims costs while striving to fulfill the needs of highly informed and demanding managed care consumers. One of these strategies is the reinforcement of population and case management programs, which empower consumers by educating them and engaging them in actively maintaining or improving their own health. Early identification of patients and inter-program referrals are the focus of these programs, which allow us to provide integrated service to our customers based on their specific conditions. The population management programs include programs that target asthma, congestive heart failure, hypertension, diabetes, and a prenatal program that focuses on preventing prenatal complications and promoting adequate nutrition. We developed a medication therapy management program aimed at plan members who are identified as having high drug utilization and unrelated diagnostics. We commenced this program in 2010 and expect to fully deploy the program to all our groups during 2011. In addition, we have a contract with McKesson Health Solutions ( McKesson ) pursuant to which they provide to our members a 24-hour telephone-based triage program and health information services. McKesson also provides utilization management services for our Medicare sector. We intend to maximize utilization of population and case management programs among our insured populations and expand the medication therapy management program to the Commercial sector. Other strategies include innovative partnerships and business alliances with other entities to provide new products and services such as an employee assistance program and the promotion of evidence-based protocols and patient safety programs among our providers. We also employ registered nurses and social workers to manage individual cases and coordinate healthcare services. We reviewed our hospital concurrent review program, the goal of which is to monitor the appropriateness of high admission rate diagnoses and unnecessary stays. To expand the scope of the revision, we established a phone based review for low admissions hospitals, which freed resources to cover the biggest hospitals and allowed the onsite nurses to participate in the patient discharge planning, referral to programs, the quality of the services, including the occurrence of never events. As part of the cost containment measures we have preauthorization services for certain procedures and the mandatory validation of member eligibility prior to accessing services. In addition, we provide a variety of services and programs for the acute, chronic and complex populations. These services and programs seek to enhance quality at physicians premises, thus reducing emergency care and hospitalizations. We promote the use of a formulary for accessing medications, encouraging the use of generic drugs in the three-tier formulary, which offers three co-payment levels.

We have also established an exclusive pharmacy network with higher discounted rates than our broader network. In addition, through arrangements with our pharmacy benefits manager, we are able to obtain discounts and rebates on certain medications based on formulary listing and market share.

We have designed a comprehensive Quality Improvement Program ( QIP ). This program is designed with a strong emphasis on continuous improvement of clinical and service indicators, such as Health Employment Data Information Set ( HEDIS ) and Consumer Assessment of Healthcare Providers and Systems ( CAHPS ) measures. Our QIP also includes a Physician Incentive Program ( PIP ) and a Hospital Quality Incentive Program ( HQIP ), which are directed to support corporate quality initiatives, utilizing clinical and benchmark criteria developed by governmental agencies and professional organizations. The PIP encourages the participation of members in chronic care improvement programs and the achievement of specific clinical outcomes. The HQIP encourages participating hospitals to achieve the national benchmarks related to the five core measures established by CMS and the Joint Commission.

***Information Systems***

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

status inquiries, and referrals and authorizations.

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

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

***Provider Arrangements***

Approximately 98% of member services are provided through one of our contracted provider networks and the remainder are provided by out-of-network providers. Our relationships with managed care providers, physicians, hospitals, other facilities and ancillary managed care providers are guided by standards established by applicable regulatory authorities for network development, reimbursement and contract methodologies. As of December 31, 2010, we had provider contracts with approximately 5,400 primary care physicians, 3,700 specialists and 60 hospitals.

We contract with our managed care providers in different forms, including capitation-based reimbursement. For certain ancillary services, such as behavioral health services and primary care services in our *Medicare Optimo* product, we generally enter into capitation arrangements with entities that offer broad based services through their own contracts with providers. We attempt to provide market-based reimbursement along industry standards. We seek to ensure that providers in our networks are paid in a timely manner, and we provide means and procedures for claims adjustments and dispute resolution. We also provide a dedicated service center for our providers. We seek to maintain broad provider networks to ensure member choice while implementing effective management programs designed to improve the quality of care received by our members.

We promote the use of electronic claims billing by our providers. Approximately 93% of claims are submitted electronically through our fully automated claims processing system, and our first-pass rate , or rate at which a claim is approved for payment when first processed by our system without human intervention, for provider claims has averaged 86% and 85% in 2010 and 2009, respectively.

We believe that physicians and other providers primarily consider member volume, reimbursement rates, timeliness of reimbursement and administrative service capabilities along with the non-hassle factor, or reduction of non-value adding administrative tasks, when deciding whether to contract with a managed care plan. As a result of our established position in the Puerto Rican market, the strength of the Triple-S name and our association with the BCBSA, we believe we have strong relationships with hospital and provider networks leading to a strong competitive position in terms of hospital count, number of providers and number of in-network specialists.

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

*Physicians.* Fee-for-service is our predominant reimbursement methodology for physicians in our PPO products and services referred by the independent practice associations ( IPAs ) under capitation agreements. Our physician rate schedules applicable to services provided by in-network physicians are pegged to a resource-based relative value system fee schedule and then adjusted for competitive rates in the market. This structure is similar to reimbursement methodologies developed and used by the Medicare program and other major payers. Payments to physicians under the Medicare Advantage program are based on Medicare fees. For certain of our Medicare products we contract with IPAs in the form of capitation-based reimbursement for certain risks. We have a network of IPAs that provide managed care services to our members in exchange for a capitation fee. The IPAs assume the costs of certain primary care services provided and referred by their primary care physicians ( PCPs ), including procedures and in-patient services not related to risks assumed by us.

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

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*Subcontracting.* We subcontract our triage call center, certain utilization management, mental and substance abuse health services, and pharmacy benefits management services through contracts with third parties.

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

***Competition***

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

***Managed Care***

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

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

Competitors in the managed care segment include national and local managed care plans. At December 31, 2010 we have approximately 789,000 members enrolled in our managed care segment, representing approximately 21.2% of the population of Puerto Rico. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 19% for the nine-month period ended September 30, 2010. We offer a variety of managed care products, and are the leader by market share in almost every sector, as measured by the share of premiums written. Our main competitors are Medical Card Systems Inc., Aveta Inc. (or MMM Healthcare), and Humana Inc.

***Life Insurance***

We are one of the leading providers of life insurance products in Puerto Rico. In the nine-month period ended September 30, 2010, we were the largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 8%. We are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines. In the life insurance sector, excluding annuities, we were the largest company with a market share of approximately 19%, and our main competitors are Cooperativa de Seguros de Vida de Puerto Rico, AXA Equitable Life and National Life Insurance Co.. In the cancer sector, we were the second largest company with a market share of approximately 18%, and our main competitors are AFLAC (sector leader) and Trans-Oceanic Life Insurance Company.

***Property & Casualty Insurance***

The property and casualty insurance market in Puerto Rico is extremely competitive. In addition, soft market conditions have prevailed in Puerto Rico. In the local market, such conditions mostly affected commercial risks, precluding rate increases and even provoking lower premiums on both renewals and new business. Property and casualty insurance companies tend to compete for the same accounts through price, policy terms and quality of services. We compete by reasonably pricing our products and providing efficient services to producers, agents and clients.

In the nine-month period ended September 30, 2010, we were the fifth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 8%. Our nearest competitor in the property and casualty insurance market in Puerto Rico was Chartis Insurance Company of Puerto Rico (formerly American International Insurance Company of Puerto Rico). The market leaders in the property and

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

***Blue Cross and Blue Shield License***

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

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

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

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

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

failure to satisfy state-mandated statutory net worth requirements;

impending financial insolvency; and

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

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

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

As required by our BCBS license agreements, our articles of incorporation prohibit any institutional investor from owning 10% or more of our voting power, any person that is not an institutional investor from owning 5% or more of our voting power, and any person from beneficially owning shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest in us. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer,

in order to avoid a violation of the ownership limitation in the articles.

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

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Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the BCBS name and mark. The annual BCBSA fee for the year 2011 is $1,764,143. During the years ended December 31, 2010 and 2009, we paid fees to the BCBSA in the amount of $1,717,677 and $1,345,489, respectively. The BCBSA is a national trade association of 39 Member Plans, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as to provide certain coordination among the Member Plans. Each Member Plan is an independent legal organization and is not responsible for obligations of other BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the BCBS names and marks outside our BCBS licensed territory.

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

***Claim Liabilities***

We are required to estimate the ultimate amount of claims which have not been reported, or which have been received but not yet adjudicated, during any accounting period. These estimates, referred to as claim liabilities, are recorded as liabilities on our balance sheet. We estimate claim reserves in accordance with Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes the professional guidelines and standards for actuaries to follow. A significant degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. For additional information regarding the calculation of claim liabilities, see Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates ¯ Claim Liabilities.

***Investments***

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

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

Investment decisions are centrally managed by investment professionals based on the guidelines established by management and approved by our Investment and Financing Committee of the Board of Directors (the Investment and Financing Committee ). Our internal investment group is comprised of the Chief Financial Officer, a Vice President and Treasurer, an investment analyst, and a treasury operations analyst. The internal investment group uses an external investment consultant and manages our short-term investments, fixed income portfolio and equity securities.

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

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

***Trademarks***

We consider our trademarks of Triple-S and SSS to be very important and material to all segments in which we are engaged. In addition to these, other trademarks used by our subsidiaries that are considered important have been duly registered with the Department of State of Puerto Rico and the United States Patent and Trademark

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Office. It is our policy to register all our important and material trademarks in order to protect our rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the Blue Cross and Blue Shield name and mark in Puerto Rico and the U.S. Virgin Islands. See Blue Cross and Blue Shield License .

***Regulation***

The operations of our managed care business are subject to comprehensive and detailed regulation in Puerto Rico, as well as U.S. federal regulation. Supervisory agencies include the Office of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance ), the Division of Banking and Insurance of the Office of the Lieutenant Governor of the U.S. Virgin Islands, the Health Department of the Commonwealth of Puerto Rico and the Administration for Health Insurance of the government of Puerto Rico ( ASES , for its Spanish acronym), which administers the government of Puerto Rico Health Insurance Plan including the dual-eligible beneficiaries program. Federal regulatory agencies that oversee our operations include CMS, the Office of the Inspector General ( OIG ) of HHS, the Office of Civil Rights of HHS, the U.S. Department of Justice, the U.S. Department of Labor, and OPM. These government agencies have the right to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of the products and services we offer;
- assess fines, penalties and/or sanctions;
- monitor our solvency and adequacy of our financial reserves; and
- regulate our investment activities on the basis of quality, diversification and other quantitative criteria, within the parameters of a list of permitted investments set forth in insurance laws and regulations.

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

- initiatives to provide greater access to coverage for uninsured and under-insured populations without adequate funding to health plans or to be funded through taxes or other negative financial levy on health plans;
- payments to health plans that are tied to achievement of certain quality performance measures;
- other efforts or specific legislative changes to the Medicare program, including changes in the bidding process or other means of materially reducing premiums;
- local government regulatory changes;
- increased government enforcement, or changes in interpretation or application of fraud and abuse laws; and
- regulations that increase the operational burden on health plans or laws that increase a health plan s exposure to liabilities, including efforts to expand the tort liability of health care plans;

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

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

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

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

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

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

- licensure;
- policy forms, including plan design and disclosures;
- premium rates and rating methodologies;
- underwriting rules and procedures;
- benefit mandates;
- eligibility requirements;
- transactions resulting in a change of control;
- member rights and responsibilities;
- fraud and abuse;
- sales and marketing activities;
- quality assurance procedures;
- privacy of medical and other information and permitted disclosures;

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- security of electronically transmitted individually identifiable health information;
- geographic service areas;
- market conduct;
- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- special rules in contracts to administer government programs;
- transactions with affiliated entities;
- limitations on the ability to pay dividends;
- rates of payment to providers of care;
- rates of payment to providers of care;
- surcharges on payments to providers;
- provider contract forms;
- delegation of financial risk and other financial arrangements in rates paid to providers of care;
- agent licensing;
- financial condition (including reserves);
- reinsurance;
- issuance of new shares of capital stock;
- corporate governance; and
- permissible investments.

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

***Puerto Rico Insurance Laws***

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

Puerto Rico insurance laws prohibit any person from offering to purchase or sell voting stock of an insurance company with capital contributed by stockholders (a stock insurer) that constitutes 10% or more of the total issued and outstanding stock of such company or of the total issued and outstanding stock of a company that controls an insurance company, without the prior approval of the Commissioner of Insurance. The proposed purchaser or seller must disclose any changes proposed to be made to the administration of the insurance company and provide the Commissioner of Insurance with any information reasonably requested. The Commissioner of Insurance must make a determination within 30 days of the later of receipt of the petition or of additional information requested. The determination of the Commissioner of Insurance will be based on its evaluation of the transaction s effect on the public, having regard to the experience and moral and financial responsibility of the proposed purchaser, whether such responsibility of the proposed purchaser will affect the effectiveness of the insurance company s operations and whether the change of control could jeopardize the interests of insureds, claimants or the company s other stockholders.

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

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

of the securities would jeopardize the interests of policyholders or security-holders.

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

***Privacy of Financial and Health Information***

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

***Managed Care Provider Services***

Participating managed care providers of the dual-eligible sector of the population, ministered by the Puerto Rico Health Insurance Administration ( PRHIA ), are required to provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialized services. In addition, the Office of the Solicitor for the Beneficiaries of Medicaid is authorized to review and supervise the operations of entities contracted by the government of Puerto Rico to provide services to the dual-eligible sector of the population. The Solicitor may investigate and adjudicate claims filed by Medicaid beneficiaries against the various service providers contracted by the government of Puerto Rico. See Business Customers-Medicare Supplement and Medicare Advantage Sector sections included in this Item for more information.

***Capital and Reserve Requirements***

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

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

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company s risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the company s total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The company action level is triggered if a company s total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital. At the company action level, a company must submit a comprehensive plan to the regulatory

authority which discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250% and 200% of its risk-based capital is subject to a trend test. The trend test

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calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company s adjusted capital exceeds it risk-based capital) between the current year and the prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year. If a similar decrease in margin in the coming year would result in a risk-based capital ratio of less than 190%, then company action level regulatory action will occur.

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

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

In addition to its catastrophic reinsurance coverage, TSP is required by local regulatory authorities to establish and maintain a reserve supported by a trust fund (the Trust ) to protect policyholders against their dual exposure to hurricanes and earthquakes. The funds in the Trust are solely to be used to pay catastrophic losses whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust, and accordingly additions to the reserve, are determined by a rate (1% in 2010, 2009 and 2008), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2010 and 2009, we had $35.9 million and $33.7 million, respectively, invested in securities deposited in the Trust. The income generated by investment securities deposited in the Trust becomes part of the Trust fund balance and are therefore considered an addition to the reserve. For additional details see note 19 of the audited consolidated financial statements.

***Dividend Restrictions***

We are subject to the provisions of the General Corporation Law of Puerto Rico ( PRGCL ), which contains certain restrictions on the declaration and payment of dividends by corporations organized pursuant to the laws of Puerto Rico. These provisions provide that Puerto Rico corporations may only declare dividends charged to their surplus or, in the absence of such surplus, net profits of the fiscal year in which the dividend is declared and/or the preceding fiscal year. The PRGCL also contains provisions regarding the declaration and payment of dividends and directors liability for illegal payments.

Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Our subsidiaries are subject to regulatory surplus requirements and additional regulatory requirements, which may restrict their ability to declare and pay dividends or distributions to us. In addition, our secured term loan restricts our ability to pay dividends if a default thereunder has occurred and is continuing. Please refer to Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations Liquidity and Capital Resources Restrictions on Certain Payments by the Corporation s Subsidiaries .

***Guaranty Fund Assessments***

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

***Federal Regulation***

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

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*The Medicare Advantage and Medicare Part D Programs*

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

The original Medicare program, created in 1965, known as Medicare fee-for-service, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied an annual $162 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often purchase Medicare supplement products, commonly known as Medigap , which is regulated but not funded by CMS, to cover deductibles, co-payments, and coinsurance.

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

As an alternative to the traditional fee-for-service Medicare program, since the 1980 s, Medicare has also offered Medicare managed care benefits provided though contracted private health plans. Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans members. Beginning in 1997, CMS gradually phased in a risk adjustment payment methodology that based the CMS monthly premium payments to plans on various clinical and demographic factors. Beginning in 2003, Congress introduced a new Medicare managed care approach.

*The 2003 Medicare Modernization Act*

In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act ( MMA ). The MMA transformed Medicare s managed care program known as Medicare Part C or Medicare Advantage and also introduced a prescription drug program known as Medicare Part D.

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

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

If the bid is less than the benchmark, CMS will pay the plan its bid amount, risk adjusted based on its risk scores, plus a rebate equal to 75% of the actual amount by which the benchmark exceeds the bid, resulting in an annual adjustment in reimbursement rates. Plans are required to use the rebate to provide beneficiaries with supplemental benefits, reductions in cost sharing, or reductions in premiums for Part D benefits or other supplemental benefits. It is common for Medicare Advantage plans to provide additional benefits to enrollees such as lower deductibles and co-payments than those required by traditional fee-for-service Medicare, and plan members do not need to purchase supplemental Medigap policies because those types of benefits are covered under the Medicare Advantage benefits package. Because Medicare Advantage plans frequently employ a managed care

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

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

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

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

The Medicare Part D benefits are available to Medicare Advantage plan enrollees as well as Medicare fee-for-service enrollees. Medicare Advantage plan enrollees who elect to participate may pay a monthly premium for this Medicare Part D prescription drug benefit ( MA-PD ) while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan ( PDP ) from a list of CMS-approved PDPs available in their area. Any Medicare Advantage member enrolling in a stand-alone PDP, however, will automatically be disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare for Medicare Parts A and B coverage. Under the standard Part D drug coverage for 2011, Medicare beneficiaries enrolled in a stand-alone PDP will pay a $310 deductible, co-insurance payments equal to 25% of the drug costs between $310 and the initial annual coverage limit of $2,840 and all drug costs between the annual coverage limit and $4,550 in out-of-pocket drug expenses, which is commonly referred to as the Part D doughnut hole or coverage gap . However, in 2011 Medicare beneficiaries are entitled to a fifty percent (50%) discount on brand name formulary drugs and a seven percent (7%) discount on generics purchased during the doughnut hole period. After the Medicare beneficiary has incurred $4,550 in out-of-pocket drug expenses, the MMA provides catastrophic stop loss coverage that will cover approximately 95% of the beneficiaries remaining out-of-pocket drug costs for that year. MA-PDs are not required to match these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to this standard drug coverage benefit design. Medicare Part D plans also may offer supplemental drug coverage for additional benefits not subsidized by Medicare programs payments. The deductible, co-pay and coverage amounts are adjusted by CMS on an annual basis. We are required as a Medicare Advantage coordinated care plan to offer qualified Part D prescription

drug coverage of our MA plan service areas. We currently offer prescription drug benefits through our Medicare Advantage plans and also offer a stand-alone PDP. Among the options in Medicare Advantage we offer three MA-PD plans, which have generic coverage with a $5 co-payment during the doughnut

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hole period. On the PDP side, we currently offer two plans, one of which has no initial deductible and one of which has generic coverage with a $5 co-payment during the doughnut hole period.

*Dual-Eligible Beneficiaries.* A dual-eligible beneficiary is a person who is eligible for both Medicare and Medicaid, because of age or other qualifying status, and Medicaid, because of economic status. The government of Puerto Rico established a model that wraps-around benefits included in Medicaid that were not included in MA benefits. Dual-eligible beneficiaries in Puerto Rico have the option to participate in this model called *Platino*. Health plans that offer *Platino* products receive premiums from CMS and the government of Puerto Rico. In this plan the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dual-eligible members. The MMA provides subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid program. Companies offering stand-alone PDPs with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within the applicable region.

*Sales and Marketing.* Our sales and marketing activities are closely regulated by CMS, ASES and the Office of the Solicitor for the Beneficiaries of Medicaid. CMS Regulations in this area preempt local law.

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

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

*Federal False Claims Act.* Federal regulations also strictly prohibit the presentation of false claims or the submission of false information to the federal government. Under the federal False Claims Act, any person or entity that has knowingly presented or caused to be presented a false or fraudulent request for payment from the federal government or who has made a false statement or used a false record in the submission of a claim may be subject to treble damages and penalties of up to $11,000 per claim. The federal government has taken the position that claims presented in relationships that violate the anti-kickback statute may also be considered to be violations of the federal False Claims Act. Furthermore, the federal False Claims Act permits private citizen whistleblowers to bring actions on behalf of the federal government for violations of the Act and to share in the settlement or judgment that may result from the lawsuit. In 2010, recoveries from civil health care matters brought under the False Claims Act exceeded $2.5 million.

***HIPAA and Gramm-Leach-Bliley Act***

Health care entities, such as TSS, are subject to laws, including HIPAA and the Gramm-Leach-Bliley Act, that require the protection of certain health and other information. The Health Insurance Portability and Accountability Act of 1996 ( HIPAA ) authorizes HHS to issue standards for administrative simplification, as well as privacy and security of medical records and other individually identifiable health information. The regulations under the HIPAA Administrative Simplification section impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors. HIPAA Administrative Simplification section requirements apply to self-funded group plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically ( covered entities ). Regulations promulgated pursuant to the Stimulus (as defined below) also require that business associates acting for or on behalf of HIPAA-covered entities comply with many of the HIPAA standards regarding the privacy and security of individually identifiable health

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

HHS has released rules mandating the use of standard formats with respect to certain health care transactions (e.g. health care claims information, plan eligibility, referral certification and authorization, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules requiring the use of standardized code sets and unique identifiers by employers and providers. Our managed care subsidiary believes that it is in material compliance with all relevant requirements.

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

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

The American Recovery and Reinvestment Act of 2009 (H.R. 1, S. 1) ( the Stimulus ), signed by President Obama on February 17, 2009, contains several provisions that expand the scope and enforcement of HIPAA. Many of those Stimulus provisions that affect and expand HIPAA became effective on February 17, 2010. The Secretary of HHS has promulgated regulations clarifying certain aspects of the Stimulus pertaining to HIPAA and it is expected that the Secretary of HHS will issue additional regulations pertaining to HIPAA in the near future. We have updated our internal policies and operations to comply with the Stimulus pertaining to HIPAA. We will monitor the further implementation of the Stimulus and the regulations promulgated thereunder, and we will modify our policies and operations as necessary to comply with these future amendments. In the fall of 2010 CMS notified all Medicare Advantage plans, including TSS, that it intends to devote greater attention to HIPAA enforcement under its legal mandate to protect Medicare beneficiaries and ensure that CMS contractors comply with the law. See Item 1. Business Regulation Legislative and Regulatory Initiatives for additional information.

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

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

***Employee Retirement Income Security Act of 1974***

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended ( ERISA ) a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor ( DOL ). ERISA regulates certain aspects of the relationships between us, the employers who maintain employee welfare benefit plans subject to

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ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

***Other Government Programs***

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

***Legislative and Regulatory Initiatives***

*Puerto Rico Initiatives*

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

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

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

*Federal Initiatives*

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

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

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

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

***Financial Information About Segments***

Operating revenues (with intersegment premiums/service revenues shown separately), operating income and total assets attributable to the reportable segments are set forth in note 29 to the audited consolidated financial statements for the years ended December 31, 2010, 2009 and 2008.

***Employees***

As of December 31, 2010, we had approximately 2,200 full-time employees and 330 temporary employees. Our managed care subsidiary has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 41% of our managed care subsidiary s 878 regular employees. The collective bargaining agreement expires on July 31, 2012. The Corporation considers its relations with employees to be good.

***Available Information***

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

***Special Note Regarding Forward-Looking Statements***

This Annual Report on Form 10-K contains forward-looking statements, as such term is defined in the Private Securities Litigation Reform Act of 1995. Forward-looking statements are statements that include information about possible or assumed future sales, results of operations, developments, regulatory approvals or other circumstances and may be found in the Items of this Annual Report on Form 10-K entitled Item 1. Business , Item 1A. Risk Factors , Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations and elsewhere in this Annual Report on Form 10-K. Statements that use the terms believe , expect , plan , intend , estimate , anticipate may , will , shall , should and similar expressions, whether in the positive or negative, are intended to identify forward-looking statements.

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

In addition, we operate in a highly competitive, constantly changing environment that is significantly influenced by very large organizations that have resulted from business combinations, aggressive marketing and pricing practices of competitors and regulatory oversight. The following is a summary of factors, the results of which, either individually or in combination, if markedly different from our planning assumptions, could cause our results

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to differ materially from those expressed in any forward-looking statements contained in this Annual Report on Form 10-K:

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

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

***Item 1A. Risk Factors***

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

***Risks Relating to our Capital Stock***

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

Beginning with our founding in 1959 and until 1994, we encouraged, and at times required, the doctors and dentists that comprised our provider network to acquire our shares. Between approximately 1985 and 1994, our predecessor managed care subsidiary, Seguros de Servicios de Salud de Puerto Rico, Inc. ( SSS ) generally entered into an agreement with each new physician or dentist who joined our provider network to sell the provider shares of SSS at a future date (each agreement, a share acquisition agreement ). These share acquisition agreements were necessary because there were not enough authorized shares of SSS available during this period and afterwards for issuance to all new providers. Each share acquisition agreement committed SSS to sell, and each new provider to purchase, five $40-par-value shares of SSS at $40 per share after SSS had increased its authorized share capital in compliance with the Puerto Rico Insurance Code and was in a position to issue new shares. Despite repeated efforts in the 1990s, SSS was not successful in obtaining shareholder approval to increase its share capital, other than in connection with the Corporation s reorganization in 1999, when SSS was merged into a newly-formed entity having authorized capital of 25,000 $40-par-value shares, or twice the number of authorized shares of SSS. SSS s shareholders did not, however, authorize the issuance of the newly formed entity s shares to providers or any other third party. In addition, subsequent to the reorganization, our shareholders did not approve attempts to increase our share capital in 2002 and 2003.

Notwithstanding the fact that TSS and its predecessor, SSS, were never in a position to issue new shares to providers as contemplated by the share acquisition agreements because shareholder approval for such issuance was

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never obtained, and the fact that SSS on several occasions in the 1990s offered providers the opportunity to purchase shares of its treasury stock and such offers were accepted by very few providers, providers who entered into share acquisition agreements may claim that the share acquisition agreements entitled them to acquire our or TSS s shares at a subscription price equivalent to that provided for in the share acquisition agreements. SSS entered into share acquisition agreements with approximately 3,000 providers, the substantial majority of whom never came to own shares of SSS. Such share acquisition agreements provide for the purchase and sale of approximately 15,000 shares of SSS. If we or TSS were required to issue a significant number of shares in respect of these agreements, the interest of our existing shareholders would be substantially diluted. As of the date of this Annual Report on Form 10-K, only one judicial claim to enforce any of these agreements has been commenced. See Item 3. Legal Proceedings Hau et al Litigation (formerly known as Jordan et al) . Additionally, we have received inquiries with respect to less than 700 shares under share acquisition agreements. The share numbers set forth in this paragraph reflect the number of SSS shares provided for in the share acquisition agreements. Those agreements do not include anti-dilution protections and we do not believe that the amounts of any claims under the agreements with SSS should be multiplied to reflect our 3,000-for-one stock split. We cannot provide assurances, however, that claimants will not successfully seek to increase the size of their claims by reference to the stock split.

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

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

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

For much of our history, we and our predecessor entity have restricted the ownership or transferability of our shares, including by reserving to us or our predecessor a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, we and our predecessor, consistent with the requirements of our and our predecessor s bylaws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, former shareholders heirs who were not eligible to own or be transferred shares because they were not physicians or dentists at the time of their purported inheritance ( non-medical heirs ), may claim an entitlement to our shares or to damages with respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 former shareholders whose non-medical heirs may claim to have inherited up to 10,500,000 shares after giving effect to the 3,000-for-one stock split. As of the date of this Annual Report on Form 10-K, we are defending five judicial claims by non-medical heirs of former shareholders whose shares were repurchased upon their death seeking the return of or compensation for a total of 71 shares (prior to giving effect to the 3,000-for-one stock split). See Item 3. Legal Proceedings Claims by Heirs of Former Shareholders . In addition, we have received inquiries from non-medical heirs with respect to less than 700 shares (or 2,100,000 shares after giving effect to the 3,000-for-one stock split).

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

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

We designed our dual class structure of capital stock to offset the potential impact on the value of our Class B common stock attributable to any issuance of shares of common stock for less than market value in respect of a successful claim against us under any share acquisition agreement or by a non-medical heir. We believe that this

mechanism will effectively protect investors in our shares of Class B common stock against any potential dilution

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attributable to the issuance of any shares in respect of such claims at below market prices. We cannot, however, provide any assurances that this mechanism will be effective under all circumstances.

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

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

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

Sales of a substantial number of shares of our common stock in the public market, or the perception that large sales could occur, could cause the market price of our Class B common stock to decline. Either of these limits our future ability to raise capital through an offering of equity securities. There were 19,772,614 shares of Class B common stock and 9,042,809 shares of Class A common stock outstanding as of December 31, 2010. Our Class A common stock is no longer subject to contractual lockup; thus, such shares are freely tradable without restriction or further registration under the Securities Act by persons other than our affiliates within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the NYSE and will not be fungible with our listed shares of Class B common stock. In addition, at any time following the fifth anniversary of our initial public offering, or such earlier date after the first anniversary of the initial public offering as all claims with respect to which anti-dilution protections are afforded to shares of Class B common stock have been resolved, all or any portion of our shares of Class A common stock may at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock.

***Risks Related to Our Business***

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

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

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changes in the regulatory environment including the implementation of HIPAA amendments under the Stimulus, as well as others, such as implementation of PPACA, may adversely affect our ability to predict and manage managed care costs, as well as our business, financial condition and results of operations.

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

In addition to the challenge of managing managed care costs, we face pressure to contain premium rates. Our customers may move to a competitor at policy renewal to obtain more favorable premiums. Future Medicare premium rate levels may be affected by continuing government efforts to contain medical expense or other budgetary constraints. Changes in the Medicare Advantage program, including with respect to funding, may lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits, or reductions in the number of persons enrolled in or eligible for Medicare. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

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

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

Our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other managed care providers. We face heavy competition from other managed care plans to enter into contracts with hospitals, physicians and other providers in our provider networks. Consolidation in our industry, both on the provider side and on the managed care side, only exacerbates this competition. Currently certain providers are pressing for legislation that would allow them to collectively negotiate service fees through cooperatives. The failure to maintain or to secure new cost-effective managed care provider contracts may result in a loss in membership or higher medical costs. In addition, our inability to contract with providers could adversely affect our business.

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

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

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

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

*Medicare:* We provide services through our Medicare Advantage products pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if the process for bidding materially changes or if any of these contracts are terminated, our business could be materially impaired. During each of the years ended December 31, 2010, 2009 and 2008, contracts with CMS represented 24.6%, 27.4% and 25.9% of our consolidated premiums earned, net, respectively, and 45.2%, 33.9% and 12.4% of our consolidated operating income, respectively.

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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 OPM that is subject to termination in the event of noncompliance not corrected to the satisfaction of the OPM. During each of the years ended December 31, 2010, 2009 and 2008 premiums generated under this contract represented 6.9%, 6.7% and 7.3% of our consolidated premiums earned, net, respectively. The operating income generated under this contract represented 1.0%, 1.2% and 1.1% of our consolidated operating income during the years ended December 31, 2010, 2009 and 2008, respectively.

If any of these contracts is terminated for any reason, including by reason of any noncompliance by us, or not renewed or replaced by a comparable contract, our consolidated premiums earned would be materially adversely affected.

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

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

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than ASO products and those managed care products where employer groups retain the risk, such as self-funded financial arrangements. There has been a trend in recent years among our Commercial customers of moving from fully-insured plans to ASO, or self-funded arrangements. As of December 31, 2010, 69.4% of our managed care customers had fully insured arrangements and 30.6% had ASO arrangements, as compared to approximately 66.1% and 33.9%, respectively, as of December 31, 2009. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

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

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

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

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

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Our license agreements with the BCBSA contain certain requirements and restrictions regarding our operations and our use of the BCBS name and mark. Failure to comply with any of these requirements and restrictions could result in the termination of a license agreement. The standards under a license agreement may be modified in certain instances by the BCBSA. From time to time there have been proposals considered by the BCBSA to modify the terms of a license agreement to restrict various potential business activities of licensees. To the extent that such amendments to a license agreement are adopted in the future, they could have a material adverse effect on our future expansion plans or results of operations.

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

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

Upon termination of a license agreement, the BCBSA would impose a Re-establishment Fee upon us, which would allow the BCBSA to re-establish a Blue Cross Blue Shield presence in the vacated service area with another managed care company. The fee is currently $98.33 per licensed enrollee. If the re-establishment fee were applied to our total Blue Cross Blue Shield enrollees as of December 31, 2010, we would be assessed approximately $77.6 million by the BCBSA.

See Item 1. Business Blue Cross and Blue Shield License for more information.

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

Reinsurance is the practice of transferring part of an insurance company s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. In the year ended December 31, 2010, 40.0%, or $63.7 million, of the premiums written in the property and casualty insurance segment and 5.0%, or $5.6 million, of the premiums written in the life insurance segment were ceded to reinsurers. In the year ended December 31, 2009, 41.3%, or $67.5 million, of the premiums written in the property and casualty insurance segment and 5.7%, or $6.1 million, of the premiums written in the life insurance segment were ceded to reinsurers. The premiums ceded and the availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

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

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

We are subject to loss and credit risk with respect to the reinsurers with whom we deal. In accordance with general industry practices, our property and casualty and life insurance subsidiaries annually purchase reinsurance to lessen the impact of large unforeseen losses and mitigate sudden and unpredictable changes in our net income and shareholders equity. Reinsurance contracts do not relieve us from our obligations to policyholders. In the event

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that all or any of the reinsurance companies are unable to meet their obligations under existing reinsurance agreements or pay on a timely basis, we will continue to be liable to our policyholders notwithstanding such defaults or delays. If our reinsurers are not capable of fulfilling their financial obligations to us, our insurance losses would increase, which would negatively affect our financial condition and results of operations.

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

Ratings assigned by A.M. Best are an important factor influencing the competitive position of the property and casualty insurance companies in Puerto Rico. In 2010, A.M. Best maintained our property and casualty insurance subsidiary s rating of A- (the fourth highest of A.M. Best s 16 financial strength ratings) with a stable outlook. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary s rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings.

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

*Managed Care*

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of our managed care company. In addition, the managed care market in Puerto Rico is mature. According to the U.S. Census Bureau, Puerto Rico s population decreased by 6.1% between April 1, 2010 and July 2009, however the national population rate grew 0.5% during the same period. According to the US Census Bureau, between 2010 and 2050, the United States is projected to experience rapid growth in its population over 65 years. This population is projected to more than double from 2010 to 2050. A similar trend is expected for the Puerto Rico population. As a result, in order to increase our profitability we must increase our membership in the Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically. In Puerto Rico, several managed care plans and other entities were awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans. These other plans entered that market in 2006 and 2007. We anticipate that they can aggressively market their benefits to our current and our prospective members. Although we believe that we market an attractive offering, there are no assurances that we will be able to compete successfully with these other plans for new members, or that our current members will not choose to terminate their relationship with us and enroll in these other plans. Concentration in our industry also has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. The parent companies of some of our competitors are larger and have greater financial and other resources than we do. We may have difficulty competing with larger managed care companies, which can create downward price pressures on premium rates. We may not be able to compete successfully against current and future competitors. Competitive pressures faced by us may adversely affect our business, financial condition and results of operations.

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

*Complementary Products*

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

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

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

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

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

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

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

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

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

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

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

customers in the future at prices we consider adequate.

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

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

identify profitable new geographic markets to enter;

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

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

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

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

identify, train and retain qualified employees;

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

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

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

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

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

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

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

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

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

Disclosures About Market Risk for an analysis of our exposure to interest and equity price risks and the procedures in place to manage these risks. Our investment portfolios may lose money in future periods, which could have a material adverse effect on our financial condition.

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, and real estate and equity investments, amongst others, which could generate higher returns on our investments. If we fail to comply with these laws and

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

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

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

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

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

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

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

Reducing our ability to issue other securities.

The volatility and disruption in the securities and credit markets has impacted our investment portfolio. We evaluate our investment securities for other-than-temporary impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. It also requires us to make certain assessments about the potential recovery of the assets we hold. For the purpose of determining gross realized gains and losses, the cost of investment securities is based upon specific identification. During the years ended December 31, 2010 and 2009, we realized losses associated with other-than-temporary impairments of $3.0 million and $7.1 million, respectively. The gross unrealized losses of our available-for-sale and held-to-maturity securities were $5.4 million and $14.9 million at December 31, 2010 and 2009, respectively. The gross unrealized gains of our available-for-sale and held-to-maturity securities were $47.8 million and $26.4 million at December 31, 2010 and 2009, respectively. Given current market conditions, there is a continuing risk that further declines in fair value may occur and additional material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

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

***The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region.***

Substantially all of our business activity is with insureds located throughout Puerto Rico, and as such, we are subject to the risks associated with the Puerto Rico economy. The major factors affecting the economy are, among others, high oil prices, the slowdown of economic activity in the United States, and the continuing economic uncertainty generated by the budgetary deficiency affecting the government of Puerto Rico.

The Puerto Rico government is currently facing a structural deficit between recurring government revenues and expenses. On March 9, 2009, the Governor signed the multi-year Fiscal Stabilization and Economic Reconstruction Plan, which provides for additional revenue generation measures, sets forth a cost reduction plan, including a reduction in public-sector employment, and provides for a number of financial initiatives geared towards achieving a balanced budget in four years. Since the government is an important source of employment in Puerto Rico, these

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

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

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

Our operations are highly dependent on the efforts of our senior executives, each of whom has been instrumental in developing our business strategy and forging our business relationships. While we believe that we could find replacements, the loss of the leadership, knowledge and experience of our executive officers could adversely affect our business. Replacing many of our executive officers might be difficult or take an extended period of time because a limited number of individuals in the industries in which we operate have the breadth and depth of skills and experience necessary to successfully operate and expand a business such as ours. We do not currently maintain key-man life insurance on any of our executive officers nor do we have a non-competition agreement in place with any executive officer, other than our Chief Executive Officer.

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

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

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. If we are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments on a timely basis, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses. We selected Quality Care Solutions, Inc., a wholly owned subsidiary of The TriZetto Group, Inc, to implement new core business applications for our managed care segment. We completed an initial assessment during 2007 and commenced the implementation of the new application in 2008. Our Managed Care segment began transitioning to the new application in 2010. The transitioning process is expected to continue into 2011, when we expect to complete the full migration. If we are unsuccessful in implementing these improvements in a timely manner or if these improvements do not meet our customers requirements, we may not be able to recoup these costs and expenses and effectively compete in our industry.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other events or developments could result in compromises or breaches of our security system and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The internet is a public network and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our providers or regulators.

We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be adversely affected by cancellation of contracts and loss of members if security breaches are not prevented or appropriately remediated.