TRIPLE-S MANAGEMENT CORP
Form 10-K
March 14, 2012

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, 2011

¨ 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.
¨ 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.
¨ 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 ¨ 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. ¨

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 ¨	Accelerated filer þ
Non-accelerated filer ¨	Smaller reporting company ¨

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

As of February 14, 2012, the registrant had 9,042,809 of its Class A common stock outstanding and 19,385,843 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 as of June 30, 2011 was approximately $432,179,582 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 27, 2012 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, 2011

Table of Contents

Table of Contents

Part I

Item 1. Business

General Description of Business and Recent Developments

Triple-S Management Corporation ("Triple-S", "TSM", the "Company", the "Corporation", "we", "us" or "our") is one of th significant players in the managed care industry in Puerto Rico, serving approximately 1,684,000 members across all regions, with a 21% market share in terms of premiums written in Puerto Rico for the nine-month period ended September 30, 2011. We have the exclusive right to use the Blue Cross and Blue Shield ("BCBS") name and mark 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") and beginning on November 1, 2011 we resumed our participation in this sector as an Administrative Service Only ("ASO") provider. miSalud is a government of Puerto Rico-funded managed care program for the medically indigent that is similar to the Medicaid program in the U.S.

We serve a wide range of customer segments - from corporate accounts, federal and local government employees and individuals to Medicare and Medicaid recipients - with a vast array 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, goodwill and other intangibles 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., the indirect parent company of American Health, Inc. (from now on referred to as "American Health" or "AH"), 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 $84.8 million, funded with unrestricted cash. The consolidated results of operations and financial condition of the Corporation included in this Annual Report on Form 10-K reflect the results of operations of AH from February 1, 2011 and were included within our Managed Care segment.

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 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.

Table of Contents

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 the 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 38 independent licensees as of December 31, 2011. Blue Cross Blue Shield ("BCBS") membership stood at 100.0 million members at December 31, 2011, which represents 32% 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, 2011 for the life insurance market approximated $1.2 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

The total property and casualty market in Puerto Rico in terms of gross premiums written as of September 30, 2011 was approximately $1.3 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 89% 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.

Table of Contents

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. 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 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 2008 and 2009, the real gross national product contracted by 2.9% and 4.0%, respectively. For fiscal year 2010, the real gross national product also contracted by 3.8%. On March 2011, the Puerto Rico Planning Board (the "Planning Board") announced that it was projecting a contraction of 1.0% in real gross national product for fiscal year 2011 and an increase of 0.7% in real gross national product for fiscal year 2012. The forecast for fiscal year 2012 takes into account the estimated effect of the projected growth of the U.S. economy, tourism activity, personal consumption expenditures, federal transfers to individuals and the acceleration of investment in construction due to the Government's local stimulus package and the establishment of public-private partnerships. It also takes into account the disbursement of the remaining ARRA funds, and the continuation of the implementation of the local tax reform.

Personal income, both aggregate and per capita, has shown a positive average growth rate from 1947 to 2010. In fiscal year 2010, aggregate personal income was $60.4 billion and personal income per capita was $15,203. During the fiscal year 2011, total employment averaged 1,177,000, a decline of 2.3% with respect to the same period of the prior year; and the unemployment rate averaged 15.9%. During the first three months of the fiscal year 2012, total employment averaged, 1,064,200, a decline of 1.0% with respect to the same period of the prior year; and the unemployment rate decreased to 16.0%.

The economy of Puerto Rico is closely linked to that of the 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.

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 modernized to provide for a leaner and more efficient process that fosters economic development. Furthermore, the government adopted (i) 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 (ii) 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 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. During the fiscal year 2010, the Government engaged various financial advisors to assist it in the evaluation and procurement of various projects in the energy, transportation, water and public school infrastructure sectors. During the fourth quarter of fiscal year 2010, the Government published desirability studies for four public-private partnership priority projects and commenced procurement for such projects. See ‘‘Item 1A. Risk Factors—Risks Related to Our Business—The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region.’’

Table of Contents

Products and Services

Managed Care

Through our subsidiaries TSS and AH, we offer a broad range of managed care products, including HMO plans, PPO plans, Medicare Supplement, Medicare Advantage and Medicare Part D. Managed care products represented approximately 89% of our consolidated premiums earned, net for each of the years ended December 31, 2011, 2010 and 2009. We design our products to meet the needs and objectives of a wide range of customers, including employers, professional and trade associations, 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 through our subsidiary TSS, 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 these programs’ 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, 2011, we had enrolled approximately 26,521 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2012.

Table of Contents

Administrative Services Only. In addition to our fully insured plans, we also offer our PPO products on a self-funded or ASO basis, under which we provide claims processing and other administrative services to employers and the Puerto Rico Medicaid program. 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 each of the years ended December 31, 2011, 2010 and 2009. 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 only 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 coverage through our independent producers.

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 each of the years ended December 31, 2011, 2010 and 2009. 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, tropical storms 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, 2011, 41.2% 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 brands, quality care, customer service efforts, size and quality of provider networks, flexibility of plan designs, financial strength and breadth of product offerings. We distribute and market our products through several different channels, including our salaried and commission-based internal sales force, direct mail, independent brokers and agents, telemarketing staff, and the internet.

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 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, AH, which will continue using its own name.

Table of Contents

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"), Puerto Rico Office of the Insurance Commissioner 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 184 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. The majority of our premiums (56% for both 2011 and 2010) were placed through our home service distribution channel selling directly to customers in their homes. TSV employs approximately 650 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 16 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, 2011, 2010 and 2009 TSIA placed approximately 52%, 49% and 47% of TSP's total premium volume, respectively. The general agencies contracted by TSP remit premiums net of their respective commission.

Table of Contents

Customers

Managed Care

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2011:

Market Sector	Enrollment at December 31, 2011	Percentage of Total Enrollment	
Commercial	711,508	42.3	%
Medicare	113,431	6.7	%
Medicaid	858,757	51.0	%
Total	1,683,696	100.0	%

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. This sector also includes professional and trade associations.

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") and through the Federal Employee Program of the Blue Cross Blue Shield Association. 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. Annually, the government qualifies 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 have contracts with CMS to provide extended Medicare coverage to Medicare beneficiaries under our Dual and Non-Dual products. 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.

Table of Contents

Our Dual products 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. TSS also offers a stand-alone Medicare Part D prescription drug benefits product.

Medicaid

In 1994, the government of Puerto Rico privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into eight geographical areas. Each of the eight geographical areas is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2011, this program provided healthcare coverage to over 1.5 million people. Mental health and drug abuse benefits are currently offered to Medicaid beneficiaries by behavioral healthcare companies and are therefore not part of the benefits covered by us.

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

We currently serve five out of the eight geographical regions on an ASO basis for 20 months commencing November 1, 2011. We anticipate we will be required to participate in a competitive bid process to retain the miSalud business following the expiration of our existing contract with ASES. See "Item 1. Business—Customers – Medicaid Sector". Our agreement with the government of Puerto Rico is subject to termination in the event of our non-compliance that is not corrected or cured to the satisfaction of the government entity overseeing Medicaid, or in the event that the government determines that there is an insufficiency of funds to finance the program.

Life Insurance

Our life insurance customers consist primarily of individuals, who hold approximately 475,000 policies. We also insure approximately 1,500 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 a 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.

Table of Contents

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. For 2011 our preliminary corporate accounts retention factor is 92%.

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 utilizing 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. 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, 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 services 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. In addition, TSS has 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. 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 enhanced 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.

Table of Contents

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 nationally recognized 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.

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 second quarter of 2012, when we expect to complete the full migration of TSS's commercial and Medicare membership. Total external costs for the entire project are expected to amount approximately $56.0 million.

We also plan to transition AH's membership to the new core business application and expect to complete the migration in 2014.

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 is 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 is 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, 2011, we had provider contracts with approximately 5,800 primary care physicians, 4,000 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 certain of our products, 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.

Table of Contents

We promote the use of electronic claims billing by our providers. Approximately 89% 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 83 % and 86% in 2011 and 2010, 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. We also contract some hospital services to be paid on diagnosis-related Groups (DRG) which is an all-inclusive rate per admission. 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.

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.

Table of Contents

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, 2011 we had approximately 1,684,000 members enrolled in our managed care segment. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 21% for the nine-month period ended September 30, 2011. 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 & Preferred Medicare Choice), Humana, Inc. and First Medical Health Plan, Inc.

Life Insurance

We are one of the leading providers of life insurance products in Puerto Rico. In 2010, we were the largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 13.6%. 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 Mass Mutual Financial Group. In the cancer sector, we were the second largest company with a market share of approximately 19%, 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, 2011, 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 casualty insurance market in Puerto Rico were Universal Insurance, 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 mark 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 affect on our business, financial condition and results of operations."

Table of Contents

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 . 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 of the United States, Hawaii, and Alaska. We hold the license for the U.S. Virgin Islands.

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.

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 2012 is $1,225,539. During the years ended December 31, 2011 and 2010, we paid fees to the BCBSA in the amount of $1,769,143 and $1,717,677, respectively. The BCBSA is a national trade association of 38 Member Plans, the primary function of which is to promote and preserve the integrity of the BCBS name and mark, 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 name and mark 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.

Table of Contents

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 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, including American Health Medicare which we acquired in 2011, that are considered important have been duly registered with the Department of State of Puerto Rico and the United States Patent and Trademark Office. It is our policy to register all our important and material trademarks in order to protect our rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the ''Blue Cross and Blue Shield'' name and mark in Puerto Rico and the U.S. Virgin Islands. See ''—Blue Cross and Blue Shield License''.

Regulation

Our business operations 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 the U.S. Department of Health and Human Services ("HHS")—directly and through its Office of the Inspector General ("OIG"), its Office of Civil Rights and Centers for Medicare and Medicaid Services ("CMS"), the U.S. Department of Justice, the U.S. Department of Labor ("DOL"), and the U.S. Office of Personnel Management ("OPM"). These government agencies have the right to:

grant, suspend and revoke licenses to transact business;

Table of Contents

regulate many aspects of the products and services we offer, including through the review and approval of health insurance rates in the individual and small group markets;

assess fines, penalties and/or sanctions;

review and approve our health insurance rates;

monitor our solvency and the 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 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 or Medicaid 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;

the implementation of regulations in July 2011 by the Office of the Commissioner to review and approve rates in the individual and small business markets; 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, the federal health reform legislation, known as the Patient Protection and Affordable Care Act was enacted. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, on March 30, 2010 (collectively, Pub. L. No. 111-148, and referred to herein as "ACA"), includes certain mandates that took effect in 2010 and 2011, as well as other requirements that are to be implemented over the next several years. Many aspects of ACA will be further articulated and clarified through regulation and guidance. ACA affects all aspects of the health care delivery and reimbursement system in the United States, including health insurers, managed care organizations, healthcare providers, employers, and U.S. states and territories.

The implementation of ACA 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, DOL, and the U.S. Department of the Treasury are issuing regulations in several phases implementing specific ACA provisions. While CMS recently issued a Final Rule that implements certain ACA 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 ACA provisions that could affect our business. Final regulations and guidance are anticipated in the near future and we will continue to assess ACA's impact on us as final regulations and guidance are issued.

Some of the more significant ACA issues that may affect our managed care business 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 restricting 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 requiring premium refunds for non-compliance;

Provisions requiring health plans to report to their members and HHS certain quality performance measures and their wellness promotion activities;

Table of Contents

Provisions that freeze premium payments to Medicare Advantage health plans and that tie such premium to the local Medicare fee for service costs. The adjustment will be phased in over 3 to 7 years depending on the amount of the eventual adjustment;

Provisions that tie Medicare Advantage premiums to achievement of certain quality performance measures;

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, currently referred to as the "mi Salud" program, available for years 2014 – 2019;

Funding provided to the government of Puerto Rico to either establish a health insurance exchange or fund the Puerto Rico Medicaid program, at the option of the government of Puerto Rico;

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 miSalud 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;
- security of electronically transmitted individually identifiable health information;
- geographic service areas;
- market conduct;
- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- 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;
- 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);

- 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;
- rate review and approval;
- reinsurance;
- issuance of new shares of capital stock;
- corporate governance; and
- permissible investments.

Table of Contents

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 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.

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 companies which manage individual financial, insurance and health information maintain the confidentiality of such information. The Commissioner of Insurance has promulgated regulations relating to the privacy of such information. As a result, managed care must periodically inform our clients of our privacy policies, and in the case of our property and casualty and life insurance subsidiaries, and allow our clients to opt-out if they do not want their financial information to be shared. 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.

Table of Contents

Managed Care Provider Services

Participating managed care providers of the dual-eligible sector of the population, administered by the Puerto Rico Health Insurance Administration ("ASES" by its Spanish acronym), 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 ("Rule 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, TSS 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 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. Because AH does not offer BCBS branded products, it does not have to comply with BCBSA minimum capital requirements.

Table of Contents

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, 2011 and 2010, we had $37.7 million and $35.9 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.

Medicare Generally

Medicare is the federal health insurance program created in 1965 for all people aged 65 and older (regardless of income or medical history), qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by CMS, with the day-to-day operations of the program (e.g., provider enrollment, claims payment) handled by private contractors under contract with CMS.

Medicare is divided into 4 distinct parts:

Part A covers, among other things, inpatient hospital stays, skilled nursing facility stays, home health visits (also covered under Part B), and hospice care. While there is no monthly premium for Medicare Part A, beneficiaries may be subject to significant deductibles and co-payments ($1,156 deductible for a hospital stay of up to 60 days in 2012). Part B covers physician visits, outpatient services, laboratory services, durable medical equipment, certain preventive services, and home health visits. Enrollment in Part B is voluntary and subject to an annual deductible ($140 in 2012). Beneficiaries who enroll in Medicare Part B pay a monthly premium ($99.90 for 2012) commonly deducted automatically from beneficiaries' monthly 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 the annual $140 deductible.

Table of Contents

Part C, also known as Medicare Advantage, allows beneficiaries to enroll in private health plans and receive Medicare covered benefits. Currently, about 12 million Medicare beneficiaries are enrolled nationally in a Medicare Advantage plan.
Part D is the voluntary, subsidized outpatient prescription drug benefit created under the Medicare Modernization Act of 2003 (the "MMA") that includes subsidies for beneficiaries with low incomes. Part D is offered through private plans that contract with Medicare, including stand alone prescription drug plans and Medicare Advantage prescription drug plans.

There also exist Medicare supplement plans, commonly known as "Medigap", to fill the gaps in traditional fee-for-service Medicare coverage. These Medigap policies are standardized by CMS, but funded and administered by private organizations.

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 healthcare provider 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 facilities and providers if the service is medically reasonable and necessary and meets other applicable national Medicare and/or local contractor coverage criteria. Generally, Medicare does not cover eyeglasses (exception for after cataract surgery), hearing aids, dentures and most dental services.

Since the 1980's, as an alternative to the traditional fee-for-service Medicare program, 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, which itself has subsequently undergone several changes.

Payments to Medicare Advantage Participating Plans

Medicare pays Medicare Advantage plans a capitated amount to provide Part A and B benefits. Medicare also pays plans for providing prescription drug benefits under Part D. Historically, Medicare reimbursed plans 95% of the average Medicare fee-for-service costs in each county based on the belief that plans were capable of more efficiently providing care than was the case under the Medicare program.

The federal government has changed the way payments to plans have been calculated to increase participation by plans. For example, the Balanced Budget Act of 1997 set a payment floor for rural counties. The Benefits Improvement and Protection Act of 2000 established payment floors for urban areas and increased the floor applicable to rural areas. The MMA increased payments across all areas.

Beginning in 2006, Medicare has used a bidding system by which plans submit bids based on costs per enrollee for Part A and Part B covered services. Bids are based on estimated costs per enrollee for the Medicare-covered services. The bids are then analyzed against a benchmark established by federal statute, and which vary by county/region. Essentially, the benchmarks are the maximum amount Medicare will pay a plan in a given county/area. When a bid is higher than the benchmark, enrollees pay the difference (through an additional premium) between the benchmark and the bid, in addition to any other Medicare premiums. If the bid is lower than the benchmark, the plan and Medicare share the difference, and the plan must use its share (known as a "rebate") to provide additional benefits to enrollees.

ACA changed the payment methodology for plans and reduced the benchmarks. For 2011, benchmarks were frozen at 2010 levels. Starting this year, decreases in benchmarks are to be phased-in over 3 to 6 years. The benchmarks will

range from 95% to 115% of Medicare fee-for-service costs. Per ACA and the results of a CMS demonstration project, bonus payments will be made to plans with higher quality ratings. Rebates will be reduced for all plans, but plans with higher quality ratings will keep a larger proportion of the rebate.

Budget Control Act

On August 2, 2011, the Budget Control Act of 2011 was enacted to reduce the deficit and avoid default on the national debt. If fully implemented, the law will cut $917 billion over 10 years in exchange for increasing the debt limit by $900 billion. A joint committee of Congress was established to develop debt reduction legislation by November 23, 2011 to cut at least $1.5 trillion over the coming 10 years. If the committee failed to agree on cuts by that date, Congress would grant a $1.2 trillion increase in the debt ceiling triggering across-the-board cuts ("sequestration") of spending equally split between defense and non-defense programs. These cuts, which apply to Medicare, but not Social Security or Medicaid, would go into effect starting in 2013 until 2021. The committee failed to reach an agreement on debt legislation by the required date; thus, sequestration will take effect. Medicare cuts would be limited to 2% and apply to Medicare providers and plans only.

Table of Contents

Medicaid Generally

Medicaid is a public insurance program intended for low-income individuals and families. Medicaid provides coverage to almost 60 million Americans, including children, pregnant women, and individuals with disabilities. To participate in Medicaid, states must cover certain groups but have the flexibility to cover other population groups. States may apply to CMS for waivers to provide coverage to populations beyond what is normally covered under the program. States are able to establish eligibility criteria within federal minimum standards. Under ACA, the national Medicaid minimum eligibility level is 133% of the federal poverty level ($30,657 for a family of 4 in 2012). This Medicaid eligibility expansion is effective January 1, 2014 but states can choose to expand coverage prior to that date. States are allowed to set Medicaid provider payment rates, and may reimburse providers through fee-for-service or managed care. They also have the flexibility to determine the type, amount, duration, and scope of services of their respective Medicaid programs, so long as within federal guidelines, although states are required to cover certain mandatory benefits. In Puerto Rico, the Medicaid program, currently referred to as the miSalud program and formerly known as Reform, is administered locally by ASES.

Medicaid is jointly funded by the federal government and the states with the federal government paying states for a specified percentage of program expenditures known as the Federal Medical Assistance Percentage ("FMAP"). The FMAP varies by state based on factors such as per capita income. The average state FMAP is about 57%, while the FMAP for Puerto Rico is 50%. FMAPs are adjusted based on a 3 year cycle. Generally, during economic recessions such as occurred starting in 2008, state revenues fall while Medicaid enrollment and spending rise. To help alleviate the shortfall, the federal government temporarily increased its share of Medicaid costs through the American Recovery and Reinvestment Act of 2009. However, that temporary fix ended starting in 2012, and while many states have enacted cost containment initiatives to help control costs, states continue to wrestle with falling revenue while Medicaid enrollment and spending increase.

Dual-Eligible Beneficiaries

A "dual-eligible" beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Medicaid, because of economic status. Dual-eligibles are a high cost population that account for a disproportionate share of government health care expenditures. According to a 2011 report issued by the Kaiser Commission on Medicaid and the Uninsured, there are approximately 9 million dual-eligibles, including 5.5 million low-income seniors and 3.4 million people with disabilities under age 65, receiving both Medicare and Medicaid benefits nationwide. Given the disproportionately high cost of treating dual-eligibles, there has been a spate of initiatives designed to address the issue. The government of Puerto Rico established a model that wraps-around benefits included in Medicaid that were not included in Medicare Advantage 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 Medicare Part D stand-alone prescription drug plans 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.

Additionally, ACA created the Federal Coordinated Health Care Office to better integrate Medicare and Medicaid benefits and improve coordination between federal and state governments. In July 2011, CMS announced three initiatives related to improving quality and lowering the cost of care for dual-eligibles: (i) a demonstration program to

test two new financial models designed to help states improve quality and share in lower costs resulting from better coordinated care for dual eligible beneficiaries; (ii) a demonstration program to help states improve the quality of care for people in nursing homes by focusing on reducing preventable inpatient hospitalizations; and (iii) a technical resource center available to all states to help them improve care for high-need, high-cost beneficiaries. The two new financial models provide for: (i) a state, CMS, and health plan that enter into a three-way contract where the managed care plan receives a prospective blended payment to provide comprehensive, coordinated care; and (ii) a state and CMS that enter into an agreement where the state would be eligible to benefit from savings resulting from managed fee-for-service initiatives designed to improve quality and reduce costs for both Medicare and Medicaid)

Table of Contents

Under ACA, 15 states (not including Puerto Rico) have been awarded contracts to support the design of demonstration projects that will aim to improve the coordination of care for people with Medicare and Medicaid coverage. Each of the selected states will receive up to $1 million to develop patient-centered demonstration projects that focus on coordinating primary, acute, behavioral, and long-term care services for dual-eligibles.

Special Needs Plans

Special Needs Plans were authorized in 2003 under the MMA to address Medicare beneficiaries with special care needs, particularly those with chronic conditions. Essentially, Medicare Advantage Special Needs Plans ("SNPs") are a type of Medicare Advantage Plan for people with certain chronic diseases and conditions or who have specialized needs (such as people who have both Medicare and Medicaid or people who live in certain institutions). Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies (list of covered drugs) to best meet the specific needs of the groups they serve.

The 15 approved chronic conditions include: chronic alcohol and other drug dependence; certain autoimmune disorders; cancer excluding pre-cancer conditions or in-situ status; certain cardiovascular disorders; chronic heart failure; dementia; diabetes mellitus; end-stage liver disease; end-stage renal disease requiring dialysis (any mode of dialysis); certain severe hematologic disorders; HIV/AIDS; certain chronic lung disorders; certain chronic and disabling mental health conditions; certain neurologic disorders; and stroke. It is expected that SNPs will increase to over 500 nationally, and much of the increase will be for dual-eligibles.

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

Fraud and Abuse Laws. Insurance providers in Puerto Rico are subject to local and federal laws that prohibit fraud and abuse, and are required to have anti-fraud units in place. In addition, entities, such as TSS and AH, 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. Insurance providers in Puerto Rico are subject to local and federal ant-kickback laws. These anti-kickback laws prohibit the payment, solicitation, offering or receipt of any form of remuneration (including kickbacks, bribes, and rebates) in exchange for business, and under federal law, 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 federal 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 2011, recoveries from civil health care matters brought under the False Claims Act were approximately $2.8 billion nationally.

Table of Contents

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

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 and require notification to members and the Secretary of HHS in the event of a breach of unsecured individually identifiable health information. Our managed care subsidiary is currently in material compliance with these security regulations.

In September 2010, we 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. We reported the incident to local and federal authorities and made public notices as required by applicable law. The incident is currently under review by the HHS Office of Civil Rights. 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"), enacted 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 related regulations, 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 mandating the use of standardized code sets and unique identifiers for employers and providers. Our managed care subsidiary believes that it is in material compliance with these requirements. In addition, the federal government will require that healthcare organizations, including health insurers, upgrade to updated and expanded

standardized code sets used for describing health conditions by converting from the ICD-9 diagnosis and procedure code set to the ICD-10 diagnosis and procedure code set. Our Managed Care subsidiaries have initiated projects to comply with the ICD-10 capabilities by the original October 1, 2012 compliance deadline, which has required a substantial investment. On February 14, 2012, HHS announced its intent to postpone the original October 2012 compliance deadline, but has yet to announce a new compliance date.

Table of Contents

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

Dodd-Frank Act

In 2010, Congress enacted the Dodd-Frank Wall-Street Reform and Consumer Protection Act (the "Dodd-Frank Act") which provides for a number of reforms and regulations in the corporate governance, financial reporting and disclosure, investments, tax and enforcement areas that affect our Triple-S. The SEC and other regulatory authorities engaged in rulemaking efforts under the Dodd-Frank Act throughout 2011, and additional rulemaking still continues, including the establishment of a Federal Insurance Office that will develop and coordinate federal policy on insurance matters. We are closely monitoring how these regulations impact the Company, however the full impact of the legislation may not be known for several years until regulations become fully effective.

Legislative and Regulatory Initiatives

Puerto Rico Initiatives

In December 2010, the Commissioner of Insurance adopted 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 Puerto Rico Legislature recently adopted a Health Insurance Code that replaces, in phases, the current Insurance Code for the topics related to health insurance. The main objective of the Code is to update the regulatory framework for this activity and harmonize local provisions with recently approved federal legislation. The chapters of the new Code that were adopted in the initial phase of implementation contain general dispositions, handling of prescription medicines, availability of health insurance for small and medium companies, prohibition of discretionary clauses, and

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.

Table of Contents

Federal Initiatives

The constitutionality of ACA is being challenged by at least 26 states, including Florida, Michigan and Virginia. On November 14, 2011, the Supreme Court granted review of a decision from the U.S. Court of Appeals for the Eleventh Circuit that struck down a key provision of ACA. The court had three petitions for review of the case; (i) the National Federation of Independent Business; (ii) 26 state plaintiffs, including Florida; and (iii) the Department of Justice. There are several questions and issues to be considered by the court:

Did Congress exceed its Constitutional powers when it enacted the individual mandate (in which individuals are required to maintain minimum essential coverage each month or pay a penalty)?

Is the lawsuit challenging the mandate barred by the tax Anti-Injunction Act (26 U.S.C. § 7421(a))?

Can the issue of the individual mandate be "severed" from the rest of ACA? (the Eleventh Circuit held that the individual mandate could be decoupled from the rest of ACA)

Is the Medicaid expansion provision in ACA valid? (the Eleventh Circuit rejected the states' argument that requiring states to expand Medicaid coverage or give up Medicaid funding was coercive)

The Supreme Court is scheduled to hear oral arguments on this challenge in March 2012, and a decision is expected by June 2012.

In addition to the constitutional challenges to ACA, members of the United States Congress continue to introduce legislation in an attempt to repeal or defund ACA. 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, 2011, 2010 and 2009.

Employees

As of December 31, 2011, we had approximately 2,900 full-time employees and 630 temporary employees. TSS has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 44.3% of our managed care subsidiary's 1,108 regular employees. The collective bargaining agreement expires on July 31, 2012. We have renewed our collective bargaining agreement until July 31, 2016. 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 (http://triplesmanagement.com), 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 (http://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.

Table of Contents

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’’, ‘‘a ‘‘project’’, ‘‘may’’, ‘‘will’’, ‘‘shall’’, ‘‘should’’ and similar expressions, whether in the positive or negative, are intended to forward-looking statements.

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

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

trends in health care costs and utilization rates;
ability to secure sufficient premium rate increases;
competitor pricing below market trends of increasing costs;
re-estimates of our policy and contract liabilities;
changes in government regulation of managed care, life insurance or property and casualty insurance;
significant acquisitions or divestitures by major competitors;
introduction and use of new prescription drugs and technologies;
a downgrade in our financial strength ratings;
litigation or legislation targeted at managed care, life insurance or property and casualty insurance companies;
ability to contract with providers 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.

Table of Contents

Risks Relating to our Capital Stock

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

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

Notwithstanding the fact that 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 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 four 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 69 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).

Table of Contents

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

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

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

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

In the event that claimants acquire shares of our managed care subsidiary, 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 19,321,524 shares of Class B common stock and 9,042,809 shares of Class A common stock outstanding as of December 31, 2011. 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.

Table of Contents

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, changes in the regulatory environment including the implementation of HIPAA amendments under the Stimulus, as well as others, such as implementation of ACA, 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. Also, the Office of the Commissioner of Insurance may disapprove proposed rate increases in the individual and small business markets. 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.

Table of Contents

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 operating revenues, 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, 2011, 2010 and 2009, contracts with CMS represented 43.6%, 24.6% and 27.4% of our consolidated premiums earned, net, respectively, and 12.5%, 45.2% and 33.9% of our consolidated operating income, respectively.

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, 2011, 2010 and 2009 premiums generated under this contract represented 6.7%, 6.9% and 6.7% of our consolidated premiums earned, net, respectively. The operating income generated under this contract represented 1.3%, 1.0% and 1.2% of our consolidated operating income during the years ended December 31, 2011, 2010 and 2009, respectively.

Medicaid: We participate in the government of Puerto Rico Health Reform Program (similar to Medicaid) to provide health coverage to medically indigent citizens in Puerto Rico. Since we obtained our first contract in 1995, we were the sole provider for two to three regions each year, until September 30, 2010 when our contracts with the government of Puerto Rico expired by their own terms. On October 17, 2011, TSS entered into a new contract with the government of Puerto Rico to resume the administration of the physical health component of this program in five designated service regions in Puerto Rico, effective November 1, 2011. TSS receives a monthly per-member, per-month administrative fee for its services and does not bear the insurance risk of the program. Under the terms of the contract, TSS is a third party administrator responsible for the provision of administrative services to subscribers in the following designated regions: West, North, Metro North, San Juan, Northeast and Virtual (the Virtual region covers services provided throughout Puerto Rico to children in foster care and certain victims of domestic violence) (collectively, the “Service Regions”). This program currently services approximately 859,000 members in these regions. The administrative services to be provided in the Service Regions include case, disease and utilization management, network management and credentialing, enrollment and enrollee services and claims administration, among others. TSS, however, is not financially responsible or otherwise at risk for the provision of services to subscribers in the Service Regions. The contract expires on June 30, 2013. Upon the expiration of the contract, the government of Puerto Rico usually commences an open bidding process. We intend to continue to participate in this program, but we may not be able to retain the right to service a particular geographical area in which we currently operate after the expiration of our current or any future contracts. The contract is subject to termination in the event of any non-compliance by TSS that is not corrected or cured to the satisfaction of the government entity overseeing

this program, or on 90 days' prior written notice in the event that the government determines that there is an insufficiency of funds to finance the program. For the year ended December 31, 2011, operating income generated under this contract represented 7.4% of our consolidated operating income.

Table of Contents

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

A change in our managed care commercial 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, 2011, 67.9% of our managed care commercial customers had fully insured arrangements and 32.1% had ASO arrangements, as compared to approximately 66.8% and 33.2%, respectively, as of December 31, 2010. 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.

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.

Table of Contents

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, 2011, we would be assessed approximately $160.9 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, 2011, 41.2%, or $63.0 million, of the premiums written in the property and casualty insurance segment and 4.9%, or $5.8 million, of the premiums written in the life insurance segment were ceded to reinsurers. 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. 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 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 2011, 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.

Table of Contents

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 2.2% between 2000 and 2010, however the national population rate grew 9.7% during the same period. According to the US Census Bureau, the older population is an important and growing segment of the United States population. In fact, more people were 65 years and older in 2010 than in any previous census. Between 2000 and 2010, the population 65 years and older increased at a faster rate (15.1%) than the total U.S. population. In Puerto Rico, for the same period, the population 65 years and older increased by 27.5 %. 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.

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

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

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

Table of Contents

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 conditions 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.

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;

Table of Contents

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, among others, which could generate higher returns on our investments. If we fail to comply with these laws and regulations, any investments exceeding regulatory limitations would be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital.

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, can significantly and adversely affect the value of our investment portfolio, our profitability and/or our financial position by:

Table of Contents

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, 2011 and 2010, we realized losses associated with other-than-temporary impairments of $0.3 million and $3.0 million, respectively. The gross unrealized losses of our available-for-sale and held-to-maturity securities were $3.1 million and $5.4 million at December 31, 2011 and 2010, respectively. The gross unrealized gains of our available-for-sale and held-to-maturity securities were $85.3 million and $44.6 million at December 31, 2011 and 2010, 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.

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.

Table of Contents

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, including Internet-enabled products and information, 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, fraud, error, 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. Our Managed Care segment began transitioning to the new application in 2010. The transitioning process is expected to continue into 2012, 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.

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

We face risks related to litigation.

In addition to the litigation risks discussed above in ''Risks Relating to Our Capital Stock'', we are, or may be in the future, a party to a variety of legal actions that affect any business, such as employment and employment

discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we may be subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include:

claims relating to the denial of managed care benefits;
medical malpractice actions;
allegations of anti-competitive and unfair business activities;

Table of Contents

provider disputes over compensation and termination of provider contracts;
disputes related to self-funded business;
disputes over co-payment calculations;
claims related to the failure to disclose certain business practices;
claims relating to customer audits and contract performance; and
claims by regulatory agencies or whistleblowers for regulatory non-compliance, including but not limited to fraud and health information privacy (including HIPAA).

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

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

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

Non-financial covenants in our secured term loan and note purchase agreements may restrict our operations.

We are a party to a secured loan with a commercial bank for an aggregate amount of $41.0 million, for which we had an outstanding balance of $19.4 million as of December 31, 2011. Also, we have an aggregate principal amount of $70.0 million of senior unsecured notes outstanding, consisting of a $35.0 million aggregate principal amount of 6.60% notes due 2020 and a $35.0 million aggregate principal amount of 6.70% notes due 2021 (collectively, the notes). The secured term loan and the note purchase agreements governing the notes contain non-financial covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These non-financial covenants could restrict our operations. In addition, if we fail to make any required payment under our secured term loan or note purchase agreements governing the notes or to comply with any of the non-financial covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our secured term loan or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the secured term loan, cease to make further extensions of credit. If the indebtedness under our secured term loan or note purchase agreements is accelerated, we may be unable to repay or re-finance the amounts due and our business may be materially adversely affected.

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

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

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

Table of Contents

We may pursue acquisitions in the future.

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

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

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

Risks Relating to Taxation

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

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

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

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

provide guidance as to the application of the PFIC rules to insurance companies. If the Company were treated as a PFIC for any taxable year, certain adverse consequences could apply to certain U.S. persons that own the Company's shares of Class B common stock.

Table of Contents

Risks Relating to the Regulation of Our Industry

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

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

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

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

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

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

Federal and Puerto Rico government authorities, including but not limited to the Commissioner of Insurance, ASES, CMS, the OIG, the Office of the Civil Rights of HHS, the U.S. Department of Justice, the U.S. Department of Labor, and the OPM, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations. We may also become the subject of non-routine regulatory or other investigations or proceedings brought by these or other authorities, and our compliance with and interpretation of applicable laws and regulations may be challenged. In addition, our regulatory compliance may also be challenged by private citizens under the "whistleblower provisions" of applicable laws. The defense of any such challenge could result in substantial cost, diversion of resources, and a possible material adverse effect on our business.

An adverse action could result in one or more of the following:

- recoupment of amounts we have been paid pursuant to our government contracts;
- mandated changes in our business practices;

Table of Contents

imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key employees;
loss of our right to participate in Medicare or other federal or local programs; damage to our reputation;
increased difficulty in marketing our products and services;
inability to obtain approval for future services or geographic expansions; and
loss of one or more of our licenses to act as an insurance company, preferred provider or managed care organization or other licensed entity or to otherwise provide a service.

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

Effective prevention, detection and control systems are critical to maintain regulatory compliance and prevent fraud and failure of these systems could adversely affect the Company.

Failure to prevent, detect or control systems related to regulatory compliance or the failure of employees to comply with our internal policies, including data systems security or unethical conduct by managers and employees, could adversely affect our reputation and also expose it to litigation and other proceedings, fines and penalties. Federal and state governments have made investigating and prosecuting health care and other insurance fraud and abuse a priority. Fraud and abuse prohibitions encompass a wide range of activities, including kickbacks for referral of members, billing for unnecessary medical services, improper marketing, and violations of patient privacy rights. The regulations and contractual requirements applicable to the Company are complex and subject to change. In addition, ongoing vigorous law enforcement, a highly technical regulatory scheme and the Dodd-Frank legislation and related regulations being adopted that enhance regulators' enforcement powers and whistleblower incentives and protections, mean that its compliance efforts in this area will continue to require significant resources.

In addition, provider or member fraud that is not prevented or detected could impact our medical costs or those of our self-insured customers. Further, during an economic downturn, our segments, including our Life Insurance and Property and Casualty segments may see increased fraudulent claims volume which may lead to additional costs because of an increase in disputed claims and litigation.

As a Medicare Advantage program participant, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties, and our Medicare Advantage contracts may be terminated or our operations may be required to change in a manner that has a material impact on our business.

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

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

Effective January 1, 2006, a revised rate calculation system based on a competitive bidding process was instituted for Medicare Advantage managed care plans, including our Dual and Non-Dual products. The statutory payment rate was relabeled as the benchmark amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. If the accepted bid is less than the benchmark, Medicare pays the plan its bid plus a rebate of 66.6% of the amount by which the benchmark exceeds the bid, if the star rating is 3.5 or 4 stars the

rebate is 71.7% of the amount by which the benchmark exceeds the bid and if the star rating is 4.5 or 5 stars the rebate is 73.3% of the amount by which the benchmark exceeds the bid. However, these rebates can only be used to enhance benefits or lower premiums and co-pays for plan members. If the bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid and the benchmark, which could affect our ability to attract enrollees. CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability.

Table of Contents

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

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

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

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

CMS has implemented a risk adjustment payment system for Medicare Advantage plans to improve the accuracy of payments and establish incentives for such plans to enroll and treat less healthy Medicare beneficiaries. CMS phased in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS for reconciliation with CMS's internal database. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. In addition, our own risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare payment revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of recording diagnosis code information, which has an impact on our risk scores.

Between 2003 and 2011, payments to Medicare Advantage plans are also adjusted by a ''budget neutrality'' factor that was implemented by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. However, this adjustment has been phased out. Furthermore, even with the enactment of ACA, MedPac and other constituencies continue to recommend that Congress enact legislation that would reduce Medicare Advantage payment to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program. We cannot provide assurance if, when or to what degree Congress may enact legislation including any such recommendation, but any reduction in Medicare Advantage rates could have a material adverse effect on our revenue, financial position, results of operations or cash flow.

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

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

Table of Contents

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

We are subject to change of control statutes applicable to insurance companies. These statutes regulate, among other things, the acquisition of control of an insurance company or a holding company of an insurance company. Under these statutes, no person may make an offer to acquire or to sell the issued and outstanding voting stock of an insurance company, which constitutes 10% or more of the issued and outstanding stock of an insurance company, or of the total stock issued and outstanding of a holding company of an insurance company, or solicit or receive funds in exchange for the issuance of new shares of the holding company's or its insurance subsidiaries' capital stock, without the prior approval of the Commissioner of Insurance. Our amended and restated articles of incorporation (the articles) prohibit any institutional investor from owning 10% or more of our voting power and any person that is not an institutional investor from owning 5% or more of our voting power. We cannot, however, assure you that ownership of our securities will remain below these thresholds. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles. If the Commissioner of Insurance determines that a change of control has occurred, we could be subject to fines and penalties, and in some instances the Commissioner of Insurance would have the discretion to revoke our operating licenses.

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

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

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

We are also subject to minimum capital requirements pursuant to our BCBSA license agreements. See "Risks Related to Our Business—The termination or modification of our license agreements to use the BCBS name and mark could have a material adverse effect on our business, financial condition and results of operations."

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

Certain implementing regulations of HIPAA require us to comply with standards regarding the formats for electronic transmission, and the privacy and security of certain health information within our company and with third parties, such as managed care providers, business associates and our members. While we have agreements in place with our business associates, we have limited control over their operations regarding the privacy and security of protected heath information. The HIPAA regulations also provide access rights and other rights for health plan beneficiaries with

respect to their health information. These regulations include standards for certain electronic transactions, including encounter and claims information, health plan eligibility and payment information. Compliance with HIPAA is enforced by HHS's Office for Civil Rights for privacy, CMS for security and electronic transactions, and by the U.S. Department of Justice for criminal violations, and by States Attorneys General once the HIPAA amendments under the Stimulus are implemented. In addition, CMS advised all Medicare Advantage plans, including TSS and AH, of CMS' intention to increase its enforcement activities of the privacy regulations under HIPAA with respect to Medicare beneficiaries. Further, the Gramm-Leach-Bliley Act imposes certain privacy and security requirements on insurers that may apply to certain aspects of our business as well.

Table of Contents

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

Puerto Rico insurance laws and regulations and provisions of our articles and bylaws could delay, deter or prevent a takeover attempt that shareholders might consider to be in their best interests and may make it more difficult to replace members of our board of directors and have the effect of entrenching management.

Puerto Rico insurance laws and the regulations promulgated thereunder, and our articles and bylaws may delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, they may prevent our shareholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if they are viewed as discouraging takeover attempts in the future.

Our license agreements with the BCBSA require that our articles contain certain provisions, including ownership limitations. See "Risks Relating to the Regulation of Our Industry—If we are deemed to have violated the insurance company change of control statutes in Puerto Rico, we may suffer adverse consequences."

Other provisions included in our articles and bylaws may also have anti-takeover effects and may delay, defer or prevent a takeover attempt that our shareholders might consider to be in their best interests. In particular, our articles and bylaws:

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

See also "Risks Relating to the Regulation of Our Industry—If we are deemed to have violated the insurance company change of control statutes in Puerto Rico, we may suffer adverse consequences."

Puerto Rico insurance laws and the regulations promulgated by the Commissioner of Insurance may also delay, defer, prevent or render more difficult a takeover attempt that our shareholders might consider to be in their best interests. For instance, the Commissioner of Insurance must review any merger, consolidation or new issue of shares of capital stock of an insurer or its parent company and make a determination as to the fairness of the transaction. Also, a director of an insurer must meet certain requirements imposed by Puerto Rico insurance laws.

These voting and other restrictions may operate to make it more difficult to replace members of our board of directors and may have the effect of entrenching management regardless of their performance.

Table of Contents

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own a seven story building located at 1441 F.D. Roosevelt Avenue, in San Juan, Puerto Rico, and two adjacent buildings, as well as the adjoining parking lot. In addition, we own five floors of a fifteen-story building located at 1510 F.D. Roosevelt Avenue, in Guaynabo, Puerto Rico. The properties are subject to liens under our credit facilities. See "Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operation – Liquidity and Capital Resources".

We also own land in the municipality of Mayagüez, Puerto Rico, in which we built a multi-segment customer service center. In addition to the properties described above, we or our subsidiaries are parties to operating leases that are entered into in the ordinary course of business.

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

Item 3. Legal Proceedings

As of December 31, 2011, the Company is a defendant in various lawsuits arising in the ordinary course of business. We are also defendants in various other claims and proceedings, some of which are described below. Furthermore, the Commissioner of Insurance, as well as other Federal and Puerto Rico government authorities, regularly make inquiries and conduct audits concerning the Corporation's compliance with applicable insurance and other laws and regulations.

Management believes that the aggregate liabilities, if any, arising from all such claims, assessments, audits and lawsuits will not have a material adverse effect on the consolidated financial position or results of operations of the Corporation. However, given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could have a material adverse effect on our financial condition, operating results and/or cash flows. Where the Corporation believes that a loss is both probable and estimable, such amounts have been recorded. In other cases, it is at least reasonably possible that the Corporation may incur a loss related to one or more of the mentioned pending lawsuits or investigations, but the Corporation is unable to estimate the range of possible loss which may be ultimately realized, either individually or in the aggregate, upon their resolution.

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

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

On April 24, 2002, Octavio Jordán, Agripino Lugo, Ramón Vidal, and others filed a suit against the Corporation, the Corporation's subsidiary TSS and others in the Court of First Instance for San Juan, Superior Section (the "Court of First Instance"), alleging, among other things, violations by the defendants of provisions of the Puerto Rico Insurance Code, antitrust violations, unfair business practices, RICO violations, breach of contract with providers, and damages

in the amount of $12 million. Following years of complaint amendments, motions practice and interim appeals up to the level of the Puerto Rico Supreme Court, the plaintiffs amended their complaint on June 20, 2008 to allege with particularity the same claims initially asserted but on behalf of a more limited group of plaintiffs, and increase their claim for damages to approximately $207 million. Plaintiffs amended their complaint for the third time in December 2010 and dropped all claims predicated on violations of the antitrust and RICO laws and the Puerto Rico Insurance Code. In addition, the plaintiffs voluntarily dismissed with prejudice any and all claims against officers of the Corporation and TSS. Two of the original plaintiffs were also eliminated from the Third Amended Complaint (TAC). The TAC alleges breach of six Share Acquisition Agreements, breach of the provider contract by way of discriminatory audits and improper payment of services rendered. Plaintiffs also allege a claim for libel and slander against a former President of TSM. In January 2011, we filed our response and a counterclaim for malicious prosecution and abuse of process. Discovery has been substantially completed. The Corporation is vigorously defending this claim.

Table of Contents

Dentists Association Litigation

On February 11, 2009, the Puerto Rico Dentists Association (Colegio de Cirujanos Dentistas de Puerto Rico) filed a complaint in the Court of First Instance against 24 health plans operating in Puerto Rico that offer dental health coverage. The Corporation and two of its subsidiaries, TSS and Triple-C, Inc. ("TCI"), were included as defendants. This litigation purports to be a class action filed on behalf of Puerto Rico dentists who are similarly situated.

The complaint alleges that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to dentists so that they are not paid in a timely and complete manner for the covered medically necessary services they render. The complaint also alleges, among other things, violations to the Puerto Rico Insurance Code, antitrust laws, the Puerto Rico racketeering statute, unfair business practices, breach of contract with providers, and damages in the amount of $150 million. In addition, the complaint claims that the Puerto Rico Insurance Companies Association is the hub of an alleged conspiracy concocted by the member plans to defraud dentists. There are numerous available defenses to oppose both the request for class certification and the merits. The Corporation intends to vigorously defend this claim.

Two codefendant plans, whose main operations are outside Puerto Rico, removed the case to federal court in Florida, which the plaintiffs and the other codefendants, including the Corporation, opposed. Following months of jurisdictional proceedings in the federal court system, the federal district court in Puerto Rico decided to retain jurisdiction on February 8, 2011. The defendants filed a joint motion to dismiss the case on the merits, because the complaint fails to state a claim upon which relief can be granted. On August 31, 2011, the District Court dismissed all of plaintiffs' claims except for its breach of contract claim, and ordered the parties to brief the issue of whether the court still has federal jurisdiction under the Class Action Fairness Act of 2005, which they have done. In addition, the plaintiffs moved the court to reconsider its August 31, 2011 decision and the defendants, arguing that the breach of contract claim failed to state a claim upon which relief can be granted, filed a motion for its dismissal. The parties are awaiting the court's decision on these post-judgment issues.

Colón Litigation

On October 15, 2007, José L. Colón-Dueño, a former holder of one share of TSS predecessor stock, filed suit against TSS and the Puerto Rico Commissioner of Insurance (the "Commissioner") in the Court of First Instance. The sale of that share to Mr. Colón-Dueño was voided in 1999 pursuant to an order issued by the Commissioner in which the sale of 1,582 shares to a number of TSS shareholders was voided. TSS, however, appealed the Commissioner's order before the Puerto Rico Court of Appeals, which upheld the order on March 31, 2000. Plaintiff requests that the court direct TSS to return his share of stock and compensate him for alleged damages in excess of $500,000 plus attorney's fees. On January 13, 2011, the Court of First Instance dismissed the case with prejudice and, on July 1, 2011, the Puerto Rico Court of Appeals confirmed such dismissal. Plaintiff filed a petition before the Puerto Rico Supreme Court on July 28, 2011, requesting the revision of the Court of Appeals' judgment. On December 7, 2011, Puerto Rico Supreme Court denied Plaintiff's petition. The dismissal of this complaint is now final and binding.

Claims by Heirs of Former Shareholders

The Corporation and TSS are defending four individual lawsuits, all filed in state court, from persons who claim to have inherited a total of 69 shares of the Corporation or one of its predecessors or affiliates (before giving effect to the 3,000-for-one stock split). While each case presents unique facts and allegations, the lawsuits generally allege that the redemption of the shares by the Corporation pursuant to transfer and ownership restrictions contained in the Corporation's (or its predecessors' or affiliates') articles of incorporation and bylaws was improper.

In one of these cases, the plaintiffs argued that the redemption of shares was fraudulent and was not subject to the two year statute of limitations contained in the local securities law. The Court of First Instance determined that the plaintiffs' claims are time barred under the local securities law. The plaintiffs appealed, and in January 2012, the Puerto Rico Court of Appeals upheld the dismissal, holding that even if the plaintiffs could have survived the securities law's two year statute of limitations, their complaint was time-barred under the Civil Code's four year statute of limitations on claims of fraud. The plaintiffs have until March 1, 2012 to file a petition for certiorari before the Puerto Rico Supreme Court.

Table of Contents

In the second case, the Puerto Rico Court of First Instance granted our motion to dismiss on grounds that the complaint was time-barred under the two year statute of limitations contained in the securities law, and the Puerto Rico Court of Appeals confirmed. Plaintiffs filed a petition for certiorari before the Puerto Rico Supreme Court that was granted on January 20, 2012. Plaintiffs have until March 13, 2012 to present their allegations, after which the Corporation has 30 days to respond.

In the third case, the court of First Instance denied our motion for summary judgment based on its determination that there are material issues of fact in controversy. In response to our appeal, the Puerto Rico Court of Appeals confirmed the decision of the Court of First Instance. Our request for reconsideration was denied in December 2011. The case is again before the Court of First Instance, pending further proceedings.

The fourth case was filed in November 2011. We filed a motion to dismiss before the Court of First Instance on grounds that the claim is time-barred, which the plaintiffs opposed. The court has not ruled on our motion.

Management believes all these claims are time barred under one or more statutes of limitations and other grounds and is vigorously defending them.

ACODESE Investigation

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

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

Intrusions into Triple-C, Inc. Internet IPA Database

On September 21, 2010, we learned from a competitor that a specific internet database managed by our subsidiary TCI containing information pertaining to individuals previously insured by TSS under the Government of Puerto Rico's Health Insurance Plan ("HIP") and to independent practice associations ("IPAs") that provided services to those individuals, had been accessed without authorization by certain of our competitor's employees from September 9 to September 15, 2010. TCI served as a third-party administrator for TSS in the administration of its HIP contracts until September 30, 2010. We conducted a thorough investigation with the assistance of external resources and identified the information that was accessed and downloaded into the competitor's system. The September 2010 intrusions may have potentially compromised protected health information of approximately 398,000 beneficiaries in the North and Metro-North regions of the HIP. Our investigation also revealed that protected health information of approximately 5,500 HIP beneficiaries, 2,500 Medicare beneficiaries and IPA data from all three HIP regions previously serviced by TSS was accessed through multiple, separate intrusions into the TCI IPA database from October 2008 to August

2010. We have no evidence indicating that the stolen information included Social Security numbers. We attempted to notify by mail all beneficiaries whose information may have been compromised by these intrusions. We also established a toll-free call center to address inquiries and complaints from the individuals to whom notice was provided. We received a total of approximately 1,530 inquiries and no complaints from these individuals.

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

Table of Contents

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

We notified the appropriate Puerto Rico and federal government agencies of these events, and gave public notice of the breaches as required under Puerto Rico and federal law. We received a number of inquiries and requests for information related to these events from these government agencies and are cooperating with them. The Puerto Rico government agency that oversees the HIP levied a fine of $100,000 on TSS in connection with these incidents, but following our request for reconsideration, the agency withdrew the fine until the pertinent federal authorities conclude their investigations of this matter. On August 16, 2011, the Office for Civil Rights of the U.S. Department of Health and Human Services initiated a review of TSS's and TCI's compliance with the security and privacy rules promulgated under the Health Insurance Portability and Accountability Act of 1996, in connection with these data breaches. The Company at this time cannot reasonably assess the outcome of these investigations or their impact on the Company.

Joint Underwriting Association Litigations

On August 19, 2011, plaintiffs, purportedly a class of motor vehicle owners, filed an action in the United States District Court for the District of Puerto Rico against the Puerto Rico Joint Underwriting Association ("JUA") and 18 other defendants, including Triple-S Propiedad, Inc. ("TSP"), alleging violations under the Puerto Rico Insurance Code, the Puerto Rico Civil Code, the Racketeer Influenced and Corrupt Organizations Act ("RICO") and the local statute against organized crime and money laundering. JUA is a private association created by law to administer a compulsory public liability insurance program for motor vehicles in Puerto Rico ("CLI"). As required by its enabling act, JUA is composed of all the insurers that underwrite private motor vehicle insurance in Puerto Rico and exceed the minimum underwriting percentage established in such act. TSP is a member of JUA.

In this lawsuit entitled Noemí Torres Ronda, et al v. Joint Underwriting Association, et al., plaintiffs allege that the defendants illegally charged and misappropriated a portion of the CLI premiums paid by motor vehicle owners in violation of the Puerto Rico Insurance Code. Specifically, they claim that because the defendants do not incur in acquisition or administration costs allegedly totaling 12% of the premium dollar, charging for such costs constitutes the illegal traffic of premiums. Plaintiffs also claim that the defendants, as members of JUA, violated RICO through various inappropriate actions designed to defraud motor vehicle owners located in Puerto Rico and embezzle a portion of the CLI premiums for their benefit.

Plaintiffs seek the reimbursement of funds for the class amounting to $406.6 million, treble damages under RICO, and equitable relief, including a permanent injunction and declaratory judgment barring defendants from their alleged conduct and practices, along with costs and attorneys' fees.

On December 30, 2011, TSP and other insurance companies filed a joint motion to dismiss, arguing that plaintiffs' claims are barred by the filed rate doctrine, inasmuch a suit cannot be brought, even under RICO, to amend the compulsory liability insurance rates that were approved by the Puerto Rico Legislature and the Commissioner of Insurance. The motion also argues that since RICO is not a federal statute that specifically relates to the business of insurance, and its application in the claims at issue would frustrate state policy and interfere with Puerto Rico's insurance administrative regime, the McCarran-Ferguson Act precludes plaintiffs' claims. Finally, we argued that plaintiffs failed to allege the necessary elements of an actionable RICO claim, or, in the alternative, their damages claim is time barred. Plaintiffs requested an extension of time until February 16, 2012 to respond to our motion.

A similar case entitled Maria Margarita Collazo Burgos, et al. v. La Asociación de Suscripcion Conjunta del Seguro de Responsabilidad Obligatorio (JUA), et al., was filed against JUA and its members, including TSP, in the Puerto

Rico Court of First Instance, San Juan Part on January 28, 2010. This litigation is a putative class action lawsuit brought on behalf of motor vehicle owners in Puerto Rico. Plaintiffs in this lawsuit allege that each of the defendants engaged in similar activities and conduct as those alleged in the Torres Ronda litigation and claim the recovery of $225 million for the class pertaining to the acquisition and administration costs of the CLI, allegedly charged in violation of the Puerto Rico Insurance Code's provisions prohibiting the illegal traffic of premiums. TSP is vigorously contesting this action.

Table of Contents

Given the early stage of these cases, the Corporation cannot assess the probability of an adverse outcome, or the reasonable financial impact that any such outcome may have on the Corporation. The Corporation intends to vigorously defend these lawsuits.

Item 4. Mine Safety Disclosures

None.

Part II

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

Market Information

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

The following table presents high and low sales prices of our Class B common stock for the each quarter of the years ended December 31, 2011 and 2010:

	High	Low
2011		
First quarter	$20.80	$17.88
Second quarter	22.92	19.15
Third quarter	24.90	15.06
Fourth quarter	20.81	14.45
2010		
First quarter	$18.67	$15.85
Second quarter	20.12	17.30
Third quarter	21.34	14.65
Fourth quarter	21.23	16.15

On March 6, 2012 the closing price of our Class B common stock on the NYSE was $22.50.

Holders

As of February 14, 2012, there were 9,042,809 and 19,385,843 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A common stock as of February 14, 2012 was 2,064. The number of our holders of Class B common stock as of February 14, 2012 was 3,084.

Dividends

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

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

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

Table of Contents

Securities Authorized for Issuance Under Equity Compensation Plan

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2012 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Recent Sales of Unregistered Securities

Not applicable.

Purchases of Equity Securities by the Issuer

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

(Dollar amounts in millions, except per share data)	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Programs 1	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Programs (in millions)
October 1, 2011 to October 31, 2011	169,205	$17.73	169,205	$ 13.20
November 1, 2011 to November 30, 2011	41,700	$17.64	41,700	$ 12.50
December 1, 2011 to December 31, 2011	-	-	-	$ 12.50

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

Table of Contents

Performance Graph

The following graph compares the cumulative total return to shareholders on our Class B common stock for the period from December 7, 2007, the date our Class B common stock began trading on the NYSE, through December 31, 2010, with the cumulative total return over such period of (i) the Standard and Poor's 500 Stock Index (the S&P 500 Index) and (ii) the Morgan Stanley Healthcare Payor Index (the MSHP Index). For illustrative purposes, the graph assumes an investment of $100 on December 7, 2007 in each of our Class B common stock, the S&P 500 Index and the MSHP Index. The performance graph is not necessarily indicative of future performance.

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

	Period Ending					
Index	12/7/2007	12/31/2007	12/31/2008	12/31/2009	12/31/2010	12/31/2011
Triple-S Management Corporation	100.00	133.40	75.91	116.17	125.94	132.15
S&P 500	100.00	97.59	60.03	74.11	83.58	83.58
Morgan Stanley Healthcare Payor Index	100.00	100.38	45.37	69.59	79.94	107.80

Table of Contents

Item 6. Selected Financial Data

Statement of Earnings Data

	2011	2010	2009	2008	2007
(Dollar amounts in millions, except per share data)					
Years ended December 31,					
Premiums earned, net	$ 2,054.5	$ 1,901.1	$ 1,869.1	$ 1,692.4	$ 1,483.6
Administrative service fees	38.5	39.6	48.6	19.2	14.0
Net investment income	48.2	49.1	52.1	56.2	47.2
Total operating revenues	2,141.2	1,989.8	1,969.8	1,767.8	1,544.8
Net realized investments gains (losses)	18.6	2.5	0.6	(13.9)	5.9
Net unrealized investment gain (loss) on trading securities	(7.3)	5.4	10.5	(21.1)	(4.1)
Other income (expense), net	0.7	0.9	1.3	(2.5)	3.2
Total revenues	2,153.2	1,998.6	1,982.2	1,730.3	1,549.8
Benefits and expenses:					
Claims incurred	1,716.3	1,596.8	1,605.8	1,431.8	1,223.8
Operating expenses	347.6	305.0	279.4	251.9	237.5
Total operating costs	2,063.9	1,901.8	1,885.2	1,683.7	1,461.3
Interest expense	10.8	12.6	13.3	14.7	15.9
Total benefits and expenses	2,074.7	1,914.4	1,898.5	1,698.4	1,477.2
Income before taxes	78.5	84.2	83.7	31.9	72.6
Income tax expense	20.5	17.4	14.9	7.1	14.1
Net income	$ 58.0	$ 66.8	$ 68.8	$ 24.8	$ 58.5
Basic net income per share (1):	$ 2.02	$ 2.30	$ 2.33	$ 0.77	$ 2.15
Diluted net income per share:	$ 2.01	$ 2.28	$ 2.33	$ 0.77	$ 2.15
Dividend declared per common share (2):	$ -	$ -	$ -	$ -	$ 0.82

Balance Sheet Data

	2011	2010	2009	2008	2007
December 31,					
Cash and cash equivalents	$71.8	$45.0	$40.4	$46.1	$240.2

Total assets	$1,880.6	$1,759.4	$1,648.7	$1,559.2	$1,659.5
Long-term borrowings	$114.4	$166.0	$167.7	$169.3	$170.9
Total stockholders' equity	$677.0	$617.3	$537.8	$485.9	$482.5

Table of Contents

Additional Managed Care Data (3)

	2011		2010		2009		2008		2007	
Years ended December 31,										
Medical loss ratio	87.2	%	88.1	%	89.9	%	88.9	%	87.0	%
Operating expense ratio	12.9	%	11.6	%	10.7	%	10.5	%	11.2	%
Medical membership (period end)	1,683,696		788,881		1,347,033		1,195,450		977,190	

(1) Further details of the calculation of basic earnings per share are set forth in notes 2 and 23 of the audited consolidated financial statements for the years ended December 31, 2011, 2010 and 2009.
(2) Shareowners holding qualifying shares were excluded from dividend payment.
(3) Does not reflect inter-segment eliminations.

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

This financial discussion contains an analysis of our consolidated financial position and financial performance as of December 31, 2011 and 2010, and consolidated results of operations for 2011, 2010 and 2009. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

Overview

We are the one of the most significant players in the managed care industry in Puerto Rico and have over 50 years of experience in this industry. We offer a broad portfolio of managed care and related products in the Commercial and the Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plans ("PDP")) markets. We also participated in the government of Puerto Rico Health Care Plan (similar to Medicaid) ("Medicaid") up to September 30, 2010, and beginning on November 1st, 2011 we resumed our participation in this sector by administering the provision of the physical health component in designated service regions in the Commonwealth of Puerto Rico ("the government of Puerto Rico").

We have the exclusive right to use the Blue Cross and Blue Shield name and mark throughout Puerto Rico and U.S. Virgin Islands. As of December 31, 2011 we serve approximately 1,684,000 members across all regions of Puerto Rico. For the years ended December 31, 2011 and 2010 respectively, our managed care segment represented approximately 89.9% and 89.4% of our total consolidated premiums earned, net, and approximately 68.6% and 72.4% of our operating income. We also have significant positions in the life insurance and property and casualty insurance markets. Our life insurance segment had a market share of approximately 13.6% (in terms of premiums written) for 2010. Our property and casualty segment had a market share of approximately 8% (in terms of direct premiums) during the nine-month period ended September 30, 2011.

We participate in the managed care market through our subsidiaries, Triple-S Salud, Inc. ("TSS") and AH. TSS is a BCBSA licensee, which provides us with exclusive use of the Blue Cross and Blue Shield Association ("BCBSA") licensee, which provides us with exclusive use of the Blue Cross and Blue Shield name and mark throughout Puerto Rico and U.S. Virgin Islands.

We participate in the life insurance market through our subsidiary, Triple-S Vida, Inc. (“TSV”), and in the property and casualty insurance market through our subsidiary, Triple-S Propiedad, Inc. (“TSP”). TSV and TSP represented approximately 5.5% and 4.8%, respectively, of our consolidated premiums earned, net for the year ended December 31, 2011 and 22.9% and 6.0%, respectively, of our operating income for that period.

The Commissioner of Insurance of the Commonwealth of Puerto Rico (“Commissioner of Insurance of Puerto Rico”) recognizes only statutory accounting practices for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Puerto Rico insurance laws and for determining whether its financial condition warrants the payment of a dividend to its stockholders. No consideration is given by the Commissioner of Insurance of Puerto Rico to financial statements prepared in accordance with U.S. generally accepted accounting principles (GAAP) in making such determinations. See note 26 to our audited consolidated financial statements.

Table of Contents

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

(Dollar amounts in millions)	Years ended December 31, 2011	2010	2009
Premiums earned, net:			
Managed care	$1,846.4	$1,700.3	$1,677.1
Life insurance	113.0	105.8	100.1
Property and casualty insurance	97.6	99.2	96.2
Intersegment premiums earned	(2.5)	(4.2)	(4.3)
Consolidated premiums earned, net	$2,054.5	$1,901.1	$1,869.1
Administrative service fees:			
Managed care	$43.0	$43.2	$51.3
Intersegment administrative service fees	(4.5)	(3.6)	(2.7)
Consolidated administrative service fees	$38.5	$39.6	$48.6
Operating income:			
Managed care	$53.0	$63.8	$57.2
Life insurance	17.7	17.3	14.6
Property and casualty insurance	4.5	3.6	8.8
Intersegment and other	2.1	3.3	4.0
Consolidated operating income	$77.3	$88.0	$84.6

Results of Operations

Revenue

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

Managed Care Premium Revenue. Our revenue primarily consists of premiums earned from the sale of managed care products to the Commercial market sector, including corporate accounts, federal government employees, local government employees, individual accounts and Medicare Supplement, as well as to the Medicare Advantage (including PDP) and, up to September 30, 2010, the Medicaid sectors. We receive a monthly payment from or on behalf of each member enrolled in our managed care plans (excluding ASO). We recognize all premium revenue in our managed care business during the month in which we are obligated to provide services to an enrolled member. Premiums we receive in advance of that date are recorded as unearned premiums.

Premiums are set prospectively, meaning that a fixed premium rate is determined at the beginning of each contract year and revised at renewal. We renegotiate the premiums of different groups as their existing annual contracts become due. Our Medicare Advantage contracts entitle us to premium payments from CMS on behalf of each

Medicare beneficiary enrolled in our plans, generally on a per member per month ("PMPM") basis. We submit rate proposals to CMS in June for each Medicare Advantage product that will be offered beginning January 1 of the subsequent year in accordance with the competitive bidding process under the MMA. Retroactive rate adjustments are made periodically with respect to our Medicare Advantage plans based on the aggregate health status and risk scores of our plan participants.

Table of Contents

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

Administrative Service Fees. Administrative service fees include amounts paid to us for administrative services provided to self-insured contracts. We provide a range of customer services pursuant to our administrative services only ("ASO") contracts, including claims administration, billing, access to our provider networks and membership services. Effective November 1st, 2011, TSS entered into a new contract with the government of Puerto Rico, to administer the provision of the physical health component of the miSalud program (similar to Medicaid) in designated service regions in Puerto Rico. Administrative service fees are recognized in the month in which services are provided.

Other Premium Revenue. Other premium revenue includes premiums generated from the sale of life insurance and property and casualty insurance products. Premiums on traditional life insurance policies are reported as earned when due. Premiums on accident and health and other short-term contracts are recognized as earned, primary on a pro rata basis over the contract period. Premiums on credit life policies are recognized as earned in proportion to the amounts of insurance in force. Group insurance premiums are billed one month in advance and a grace period of one month is provided for premium payment. If the insured fails to pay within the one-month grace period, we may cancel the policy. We recognize premiums on property and casualty contracts as earned on a pro rata basis over the policy term. Property and casualty policies are subscribed through general agencies, which bill policy premiums to their clients in advance or, in the case of new business, at the inception date and remit collections to us, net of commissions. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheet as unearned premiums and is transferred to premium revenue as earned.

Investment Income and Other Income. Investment income consists of interest and dividend income from investment securities and other income primarily consist of net unrealized gains (losses) of derivative instruments. See note 4 to our audited consolidated financial statements.

Expenses

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

The medical loss ratio ("MLR"), which is calculated by dividing managed care claims incurred by managed care premiums earned, net is one of our primary management tools for measuring these costs and their impact on our profitability. The MLR is affected by the cost and utilization of services. The cost of services is affected by many factors, in particular our ability to negotiate competitive rates with our providers. The cost of services is also influenced by inflation and new medical discoveries, including new prescription drugs, therapies and diagnostic procedures. Utilization rates, which reflect the extent to which beneficiaries utilize healthcare services, significantly influence our medical costs. The level of utilization of services depends in large part on the age, health and lifestyle of our members, among other factors. As the MLR is the ratio of claims incurred to premiums earned, net it is

affected not only by our ability to contain cost trends but also by our ability to increase premium rates to levels consistent with or above medical cost trends. We use MLRs both to monitor our management of healthcare costs and to make various business decisions, including what plans or benefits to offer and our selection of healthcare providers.

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

Table of Contents

Membership

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

Effective November 1st, 2011, TSS entered into a new contract with the Government to administer the provision of the physical health component of the miSalud program (similar to Medicaid) in designated service regions in the Commonwealth of Puerto Rico.

In February 7, 2011, our subsidiary TSS completed the AH acquisition, as of December 31, 2011, the Medicare membership attributable to AH was 47,552.

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

	As of December 31,		
	2011	2010	2009
Commercial (1)	711,508	725,328	737,286
Medicare (2)	113,431	63,553	69,605
Medicaid (3)	858,757	-	540,142
Total	1,683,696	788,881	1,347,033

(1) Commercial membership includes corporate accounts, self-funded employers, individual accounts, Medicare Supplement, Federal government employees and local government employees.
(2) Includes Medicare Advantage as well as stand-alone PDP plan membership.
(3) Medicaid membership as of December 31, 2011 includes self-funded members from the miSalud program. Before 2010, Medicaid membership includes rated and self-funded members.

Table of Contents

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2011, 2010 and 2009.

(Dollar amounts in millions)	2011	2010	2009
Years ended December 31,			
Revenues:			
Premiums earned, net	$2,054.5	$1,901.1	$1,869.1
Administrative service fees	38.5	39.6	48.6
Net investment income	48.2	49.1	52.1
Total operating revenues	2,141.2	1,989.8	1,969.8
Net realized investment gains	18.6	2.5	0.6
Net unrealized investment gain (loss) on trading securities	(7.3)	5.4	10.5
Other income, net	0.7	0.9	1.3
Total revenues	2,153.2	1,998.6	1,982.2
Benefits and expenses:			
Claims incurred	1,716.3	1,596.8	1,605.8
Operating expenses	347.6	305.0	279.4
Total operating costs	2,063.9	1,901.8	1,885.2
Interest expense	10.8	12.6	13.3
Total benefits and expenses	2,074.7	1,914.4	1,898.5
Income before taxes	78.5	84.2	83.7
Income tax expense	20.5	17.4	14.9
Net income	$58.0	$66.8	$68.8

Year ended December 31, 2011 compared with the year ended December 31, 2010

Operating Revenues

Consolidated premiums earned, net increased by $153.4 million, or 8.1%, to $2.1 billion during the year ended December 31, 2011 compared to the year ended December 31, 2010. The increase was mostly the result of a higher member months enrollment in the Medicare business attributed to new members acquired from AH, offset in part by the termination of the Medicaid contracts effective September 30, 2010.

The decrease in the administrative service fees of the Managed Care segment of $1.1 million, or 2.8%, to $38.5 million in the 2011 period is attributed to a lower self-funded member months enrollment.

Consolidated net investment income decreased by $0.9 million, or 1.8%, to $48.2 million during the year ended December 31, 2011 mostly as the result of lower yields in fixed income investments acquired during the period.

Net Realized Investment Gains

Consolidated net realized investment gains of $18.6 million during the year ended December 31, 2011 are the result of net realized gains from the sale of debt and equity securities, including our trading portfolio.

Net Unrealized Loss on Trading Securities and Other Income, Net

The combined balance of our consolidated net unrealized loss on trading securities and other income, net decreased by $12.9 million, to $6.6 million during the year ended December 31, 2011. This decrease is attributable to the effect of the sale of the trading portfolio and market fluctuations during this period.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2011 increased by $119.5 million, or 7.5%, to $1.7 billion when compared to the claims incurred during the year ended December 31, 2010, mostly due to claims incurred in the Managed Care segment. This increase is principally due to the claims incurred related to the AH acquisition, offset in part by the termination of the Medicaid contracts effective September 30, 2010. The consolidated loss ratio decreased by 50 basis points to 83.5%.

Table of Contents

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2011 increased by $42.6 million, or 14.0%, to $347.6 million as compared to the operating expenses during the year ended December 31, 2010, primarily due to the acquisition of AH. For the year ended December 31, 2011, the consolidated operating expense ratio increased by 90 basis points to 16.6%. The higher operating expense ratio is mainly due to additional operating costs incurred by the Managed Care segment in order to maintain the level of services offered to members and providers while transitioning to its new IT system and a higher amount of self-insured contracts after resuming our participation in the Medicaid sector. Also contributing to the higher operating expense ratio are the expenses related to the AH operations, which run at a higher operating expense ratio than the Medicaid business lost in 2010. Approximately $7.6 million of the expense associated to the AH operations are related to the amortization of intangible assets.

Income tax expense

Consolidated income tax expense during the year ended December 31, 2011 increased by $3.1 million, or 17.8%, to $20.5 million as compared to the income tax expense during the year ended December 31, 2010. The effective tax rate increased by 540 basis points, to 26.1%, during the year ended December 31, 2011. The consolidated income tax expense includes a one-time charge of $6.4 million resulting from the reduction of the net deferred tax assets following the reduction in income tax rates after the enactment of the new Puerto Rico tax reform, which was effective January 2011. This tax reform decreased corporations maximum tax rate from 39% to 30% and eliminated the additional tax rate imposed on a temporary basis. Partially offsetting the effect of this adjustment to net deferred tax assets, is a reduction in the taxable income of in the Managed Care segment, which operates at a higher effective tax rate, and the use of tax credits in the 2011 period.

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

Operating Revenues

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

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

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

Net Realized Investment Gains

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

Net Unrealized Gains on Trading Securities and Other Income, Net

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

Table of Contents

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2010 decreased by $9.0 million, or 0.6%, to $1.6 billion when compared to the claims incurred during the year ended December 31, 2009. This decrease is principally due to the termination of the Medicaid contracts effective September 30, 2010 offset in part by increased claims in the Managed Care segment's Commercial business as a result of higher volume. The consolidated loss ratio decreased by 190 basis points to 84.0%, mostly as the result of lower MLRs in the Managed Care segment's Commercial and Medicare businesses.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2010 increased by $25.6 million, or 9.2%, to $305.0 million as compared to the operating expenses during the year ended December 31, 2009. The consolidated operating expense ratio increased by 110 basis points, to 15.7%, primarily attributed to higher costs associated to the implementation of a new information system in the managed care segment, intangible asset amortization, and the effect of the lower volume of business in the Managed care segment after the termination of the Medicaid contracts effective September 30, 2010.

Income tax expense

Consolidated income tax expense during the year ended December 31, 2010 increased by $2.5 million to $17.4 million as compared to the income tax expense during the year ended December 31, 2009. The effective tax rate increased by 290 basis points to 20.7% primarily due to the use of tax credits during the 2009 period and a higher taxable income in the Managed Care segment, which operates at a higher effective tax rate.

Table of Contents

Managed Care Operating Results

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico: Commercial, Medicare (including Medicare Advantage and PDP) and Medicaid. For the year ended December 31, 2011, the Commercial sector represented 46.1% and 41.0% of our consolidated premiums earned, net and operating income, respectively. Premiums earned, net and operating income generated from our Medicare contracts (including PDP) during the year ended December 31, 2011 represented 43.6% and 12.5%, respectively, of our consolidated earned premiums, net and operating income, respectively.

(Dollar amounts in millions)	2011	2010	2009
Operating revenues:			
Medical premiums earned, net:			
Commercial	$947.1	$947.1	$822.1
Medicare	896.6	468.4	506.9
Medicaid	2.7	284.8	348.1
Medical premiums earned, net	1,846.4	1,700.3	1,677.1
Administrative service fees	43.0	43.2	51.3
Net investment income	17.5	19.8	21.6
Total operating revenues	1,906.9	1,763.3	1,750.0
Medical operating costs:			
Medical claims incurred	1,610.5	1,497.8	1,508.2
Medical operating expenses	243.4	201.7	184.6
Total medical operating costs	1,853.9	1,699.5	1,692.8
Medical operating income	$53.0	$63.8	$57.2
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	5,806,053	5,982,094	5,421,586
Self-funded	2,744,431	2,966,291	2,726,036
Total Commercial member months	8,550,484	8,948,385	8,147,622
Medicaid:			
Fully-insured	-	3,078,288	4,016,332
Self-funded	1,718,888	1,782,426	2,321,144
Total Medicaid member months	1,718,888	4,860,714	6,337,476
Medicare:			
Medicare Advantange	1,132,634	670,250	742,666
Stand-alone PDP	105,987	112,297	117,700
Total Medicare member months	1,238,621	782,547	860,366
Total member months	11,507,993	14,591,646	15,345,464
Medical loss ratio	87.2 %	88.1 %	89.9 %
Operating expense ratio	12.9 %	11.6 %	10.7 %

Year ended December 31, 2011 compared with the year ended December 31, 2010

Medical Operating Revenues

Medical premiums earned for the year ended December 31, 2011 increased by $146.1 million, or 8.6%, to $1.8 billion when compared to the medical premiums earned during the year ended December 31, 2010. This increase is principally the result of the following:

Medical premiums generated by the Medicare business increased by $428.2 million, or 91.4%, to $896.6 million. This fluctuation is the result of an overall increase in the member months enrollment of this business by 456,074, or 58.3%, when compared with the same period in 2010. Increase in member months enrollment was attributed to new members acquired from AH effective February 1, 2011, offset in part by a decrease in member months in our legacy products. Total member months from AH amounted to 475,780 during the year ended December 31, 2011.

Table of Contents

Medical premiums earned in the Medicaid business decreased by $282.1 million, to $2.7 million during the year ended December 31, 2011. This fluctuation results from the termination of the Medicaid contracts effective September 30, 2010. The premiums earned that are reflected in the 2011 period result from adjustments that increased the amount receivable corresponding to the risk sharing agreement with the government of Puerto Rico included in the Metro-North region contract.

Medical premiums generated by the Commercial business remained in line with prior year at $947.1 million. This is the result of a decrease in member months enrollment of 176,041, or 2.9%, and higher average premium rates per member of approximately 3.0%. Premium rate increases were consistent with claims trends.

Administrative service fees decreased by $0.2 million, to $43.0 million during the 2011 period, mainly due to a decrease in self-funded member months enrollment of 285,398 members. Such decrease primarily results from a lower self-insured commercial member months enrollment during the 2011 period; offset in part by a increase in member months from the miSalud program effective November 1, 2011.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2011 increased by $112.7 million, or 7.5%, to $1.6 billion, when compared to the year ended December 31, 2010. The MLR of the segment experienced a decrease of 90 basis points during the 2011 period, to 87.2%. These fluctuations are primarily attributed to the effect of the following:

The medical claims incurred of the Medicare business increased by $408.3 million during the 2011 period primarily due to the acquisition of AH effective February 1, 2011. Total claims incurred during the 2011 period related to the AH business amounted to $385.4 million. The Medicare MLR was 89.4%, which is 550 basis points higher than the MLR for the prior year. The MLR excluding prior period reserve developments in the 2011 and 2010 periods and risk-score adjustments presents an increase of 500 basis points. The higher adjusted MLR is due to higher utilization trends in our non-dual product as compared to last year as well as to the addition of AH which has a higher MLR than our Medicare legacy products.

The medical claims incurred of the Medicaid business were $258.0 million lower than the prior year mostly due to the termination of the Medicaid contracts effective September 30, 2010.

The medical claims incurred of the Commercial business decreased by $37.6 million during the 2011 period and its MLR decreased by 410 basis points. The MLR excluding the effect of prior period reserve developments in the 2011 and 2010 periods presents a decrease of 440 basis points, mostly as the result of lower utilization trends in 2011 and our strict underwriting guidelines.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2011 increased by $41.7 million, or 20.7%, to $243.4 million when compared to the year ended December 31, 2010, primarily due to the acquisition of AH. Total operating expenses during the year ended December 31, 2011 related to the AH business amounted to $44.9 million, approximately $7.6 million of which are related to the amortization of intangible assets. The operating expense ratio increased by 130 basis points, from 11.6% in 2010 to 12.9% in 2011. This increase is mainly due to additional operating costs incurred in order to maintain the level of services offered to members and providers while transitioning to the new IT system and a higher amount of self-insured contracts after resuming our participation in the Medicaid sector. Also contributing to the increased operating expense ratio are the expenses associated to the AH operations, which run with a higher operating expense ratio than the Medicaid business lost in 2010.

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

Medical Operating Revenues

Medical premiums earned for the year ended December 31, 2010 increased by $23.2 million, or 1.4%, to $1.7 billion when compared to the medical premiums earned during the year ended December 31, 2009. This increase is principally the result of the following:

Table of Contents

Medical premiums generated by the Commercial business increased by $125.0 million, or 15.2%, to $947.1 million. This fluctuation is primarily the result of an increase in member months enrollment of 560,508, or 10.3%, and higher average premium rates per member of approximately 4.4%. Increase in member months was mainly attributed to the La Cruz Azul acquisition in July 2009 and organic growth, mostly in large accounts. Premium rate increases were consistent with claims trends.

Medicare premiums decreased by $38.5 million, or 7.6%, to $468.4 million, primarily due to a lower member months enrollment of approximately 77,819 or 9.0%, mostly in our dual eligible product, particularly during the first half of the year and resulting from changes in our product offering. In addition, the premiums for the year ended December 31, 2010 reflect a lower final risk score adjustment as compared to 2009. The 2010 and 2009 periods include the net effect of approximately $3.0 million and $8.7 million in adjustments related to CMS final risk score adjustment corresponding to prior periods. These fluctuations were partially offset by higher average premium rates, mostly due to higher risk scores in our dual-eligible product.

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

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

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2010 decreased by $10.4 million, or 0.7%, to $1.5 billion, when compared to the year ended December 31, 2009. The MLR of the segment presented a decrease of 180 basis points during the 2010 period, to 88.1%. These fluctuations are primarily attributed to the effect of the following:

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

The medical claims incurred of the Medicare business decreased by $52.6 million during the 2010 period primarily due to the lower member months enrollment. The MLR for the year was 83.9%, 410 basis points lower than 2009. Adjusting the MLR for changes in prior period reserve developments and risk score premium adjustments, the 2010 MLR would have decreased by 270 basis points as compared to the adjusted MLR for 2009. The lower adjusted MLR is primarily the result of the new risk sharing agreement with our providers in the dual-eligible product, changes in benefits and higher average premium rates.

The medical claims incurred of the Reform business decreased by $64.7 million and its MLR decreased by 230 basis points during the year ended December 31, 2010. Excluding the effect of prior period reserve developments and premium adjustments, the MLR would have increased 130 basis points, mostly resulting from a lower premium yield due to the extension of prior year's Medicaid contracts without premium rate increases until September 2010.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2010 increased by $17.1 million, or 9.3%, to $201.7 million when compared to the year ended December 31, 2009. The increase in the operating expenses is mainly due to the segment's higher volume in the Commercial business, as well as to the costs related to the implementation of a new information system and a higher amortization of intangibles. The operating expense ratio increased by 90 percentage points, from 10.7% in 2009 to 11.6% in 2010. The higher operating expense ratio is primarily the result of expenses related to the implementation of the segment's new IT system, including information systems consultants and depreciation and amortization expense, which increased by approximately $6.2 million. The higher operating expense ratio was also attributed to the effect of the termination of the Medicaid contracts. In addition, the operating expenses were affected by an increase of $1.4 million related to a new product launched during January 2010 and higher charges and amortization expense related to the intangible assets recorded after the LCA acquisition by approximately $2.3 million. In the 2009 period a contingent property tax accrual of approximately $7.5 million was recorded, offset in part by the effect of $3.6 million related to the settlement of an insurance recovery receivable of legal expenses. This contingent property tax accrual was approximately $2.1 million higher than the actual payment made during the 2010 period.

Table of Contents

Life Insurance Operating Results

(Dollar amounts in millions)	2011	2010	2009
Years ended December 31,			
Operating revenues:			
Premiums earned, net			
Premiums earned, net	$118.8	$111.4	$106.2
Premiums earned ceded	(5.8)	(5.6)	(6.1)
Net premiums earned	113.0	105.8	100.1
Commission income on reinsurance	-	-	-
Premiums earned, net	113.0	105.8	100.1
Net investment income	18.5	17.1	16.8
Total operating revenues	131.5	122.9	116.9
Operating costs:			
Policy benefits and claims incurred	57.5	49.8	50.3
Underwriting and other expenses	56.3	55.8	52.0
Total operating costs	113.8	105.6	102.3
Operating income	$17.7	$17.3	$14.6
Additional data:			
Loss ratio	50.9%	47.1%	50.2%
Expense ratio	49.8%	52.7%	51.9%

Year ended December 31, 2011 compared with the year ended December 31, 2010

Operating Revenues

Premiums earned, net for the segment increased by $7.2 million, or 6.8%, to $113.0 million during the year ended December 31, 2011 as compared to the year ended December 31, 2010, primarily as the result of higher sales in the Individual Life and Cancer lines of business during the period.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred increased by $7.7 million, or 15.5%, to $57.5 million during the year ended December 31, 2011. This fluctuation is primarily the result of higher claims received, as well as to a higher average claim amount, in the Cancer line of business, and also to an increase in the liability for future policy benefits that was driven by new business subscribed in the period. The loss ratio for the period increased from 47.1% in 2010 to 50.9% in 2011, or 380 basis points.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $0.5 million, or 0.9%, to $56.3 million during the year ended December 31, 2011 primarily the result the higher of the volume of business of this segment and a slowdown in the amortization of deferred policy acquisition costs resulting from increased persistency in certain products within the Individual Life line of business. The increased premiums earned resulted in a lower operating expense ratio, which decreased by 290 basis points, from 52.7% in 2010 to 49.8% in 2011.

Table of Contents

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

Operating Revenues

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

Policy Benefits and Claims Incurred

Policy benefits and claims incurred during the year ended December 31, 2010 decreased by $0.5 million, or 1.0%, to $49.8 million during the year ended December 31, 2010. This fluctuation is primarily the result of a reduction in the change in the liability for future policy benefits when compared to 2009, resulting from a change in the mix of business subscribed by the segment. As a result of the reduction in policy benefits, the loss ratio improved by 310 percentage points, to 47.1% during the year ended December 31, 2010.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $3.8 million, or 7.3%, to $55.8 million during the year ended December 31, 2010 primarily the result of a higher amortization of deferred policy acquisition costs and the higher volume of business of this segment. The segment's operating expense ratio increased by 80 basis points, to 52.7% during the 2010 period.

Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	2011	2010	2009
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$152.9	$159.2	$163.3
Premiums ceded	(63.0)	(63.7)	(67.5)
Change in unearned premiums	7.7	3.7	0.4
Premiums earned, net	97.6	99.2	96.2
Net investment income	9.5	10.1	11.7
Total operating revenues	107.1	109.3	107.9
Operating costs:			
Claims incurred	48.2	49.2	47.3
Underwriting and other operating expenses	54.4	56.5	51.8
Total operating costs	102.6	105.7	99.1
Operating income	$4.5	$3.6	$8.8
Additional data:			
Loss ratio	49.4%	49.6%	49.2%
Expense ratio	55.7%	57.0%	53.8%

Year ended December 31, 2011 compared with the year ended December 31, 2010

Operating Revenues

Total premiums written during the year ended December 31, 2011 decreased by $6.3 million, or 4.0%, to $152.9 million, mostly resulting from lower premiums in the Dwelling and Commercial Property Mono-line and Commercial Auto insurance products; offset in part by higher sales in the Commercial Multi-Peril products. The commercial business remains under soft market conditions, thus reducing premium rates and increasing competition for renewals and new business.

Premiums ceded to reinsurers during the year ended December 31, 2011 decreased by approximately $0.7 million, or 1.1%, to $63.0 million. The ratio of premiums ceded to premiums written increased by 120 basis points, to 41.2% in 2011. This fluctuation was primarily the result of higher Commercial Property cessions which were increased from 32% to 37%.

Table of Contents

The change in unearned premiums presented an increase of $4.0 million, to $7.7 million during the year ended December 31, 2011, primarily as the result of the lower volume of premiums written during this period.

Claims Incurred

Claims incurred during the year ended December 31, 2011 decreased by $1.0 million, or 2.0%, to $48.2 million. The loss ratio decreased by 20 basis points, to 49.4% during the year ended December 31, 2011, as a result of favorable loss experience in the Commercial Auto line of business resulting from lower claim amounts in the claims reported during the current period; offset in part by an increase in Commercial Multi-Peril line of business. Although the current period reflects $1.6 million of net losses related to Tropical Storm Irene, the 2010 period was impacted by several large losses caused by fires and liability claims in excess of $1.9 million.

Underwriting and Other Expenses

Underwriting and other operating expenses for the year ended December 31, 2011 decreased by $2.1 million, or 3.7%, to $54.4 million. This decrease is primarily due to a lower commission expense as a result of lower premiums; offset in part by an increase in the provision for uncollectible amounts. The operating expense ratio decreased by 130 percentage points during the same period, to 57.7% in 2011.

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

Operating Revenues

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

Premiums ceded to reinsurers during the year ended December 31, 2010 decreased by approximately $3.8 million, or 5.6%, to $63.7 million. The ratio of premiums ceded to premiums written decreased by 130 basis points, to 40.0% in 2010. This fluctuation was the result of the a reduction of reinsurance cessions in quota share contracts for commercial and personal property insurance risks of 3.0% and 2.2%, respectively.

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

Claims Incurred

Claims incurred during the year ended December 31, 2010 increased by $1.9 million, or 4.0%, to $49.2 million. The loss ratio increased by 40 basis points, to 49.6% during the year ended December 31, 2010, primarily due to an unfavorable loss experience in the Commercial Multi-peril, General Liability, and Personal Auto insurance.

Underwriting and Other Expenses

Underwriting and other operating expenses for the year ended December 31, 2010 increased by $4.7 million, or 9.1%, to $56.5 million. This increase is primarily due to a higher amortization of deferred policy acquisition costs resulting from the lower premiums subscribed during this year. The operating expense ratio increased by 320 percentage points during the same period, to 57.0% in 2010 due to the lower volume of business of the segment.

Table of Contents

Liquidity and Capital Resources

Cash Flows

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

(dollar amounts in millions)	2011	2010	2009
Years ended December 31,			
Sources of cash:			
Net cash provided by operating activities	$162.5	$37.7	$72.6
Proceeds from annuity contracts	31.8	10.7	4.3
Proceeds from exercise stock options	0.2	-	-
Net proceeds from borrowings	-	40.6	-
Other	4.4	0.2	-
Total sources of cash	198.9	89.2	76.9
Uses of cash:			
Net purchases of investment securities	(13.6)	(23.7)	(17.3)
Cash settlements of stock options	(2.4)	-	-
Capital expenditures	(16.3)	(19.2)	(18.7)
Payments of long-term borrowings	(51.6)	(26.4)	(1.6)
Payments of short-term borrowings	(15.6)	-	-
Surrenders of annuity contracts	(6.6)	(9.1)	(7.1)
Repurchase and retirement of common stock	(11.3)	(6.2)	(32.3)
Acquisition of business, net of cash of $30.1 million	(54.7)	-	-
Total uses of cash	(172.1)	(84.6)	(82.6)
Net increase (decrease) in cash and cash equivalents	$26.8	$4.6	$(5.7)

Year ended December 31, 2011 compared to year ended December 31, 2010

Cash flows from operating activities increased by $124.8 million for the year ended December 31, 2011 as compared to the year ended December 31, 2010, principally due to the effect of higher premiums collections by $289.9 million and increase in net proceeds from our trading portfolio by $51.9 million, offset in part by an increase in claims paid, cash paid to suppliers and employees and income tax paid by $125.6 million, $76.7 million and $15.2 million, respectively. The increase in premiums and service fee collected is principally the effect of the AH acquisition as well as to the collection of past due Medicaid balances. The higher net proceeds from our trading portfolio results from the sale of our trading portfolio. The fluctuations in claims paid and cash paid to suppliers and employees is primarily as the result of the effect of the AH acquisition. The increase in income tax payments results from the use of tax credits during the year ended December 31, 2010.

During the year ended December 31, 2011 we received higher net proceeds from policyholder deposits, increasing by $23.6 million when compared to the prior year primarily as the result of new annuity products that are more attractive to prospective policyholders.

Net acquisition of investment securities decreased by $10.1 million during the year ended December 31, 2011 when compared to the prior year. This fluctuation is primarily due to a reduction in the acquisition of investment securities as part of our decision to increase liquidity to pay for the AH acquisition and to repay some of our long-term borrowings.

Net proceeds from borrowings decreased by $40.6 million during the year ended December 31, 2011. The decrease in borrowings is the net result of proceeds from securities sold under agreements of repurchases amounting to $15.6 million and $25.0 million from a long-term repurchase agreement to partially repay a long-term borrowing during 2010.

Payments of long-term borrowings increased by $25.2 million during the year ended December 31, 2011 as the result of the repayment of our senior unsecured notes.

Table of Contents

Net payments of short-term borrowings increased by $15.6 million during the year ended December 31, 2011 to address timing differences between cash receipts and disbursements.

In the 2011 period we cash-settled 432,567 stock options for $2.4 million, its fair value on settlement date.

On September 29, 2010 we announced the commencement of a $30.0 million share repurchase program. We paid approximately $11.3 million under the stock repurchase program during the year ended December 31, 2011.

On February 7, 2011, we acquired AH at a cost of $54.7 million, net of $30.1 million of cash acquired.

The increase of $4.2 million in the other source of cash is attributed to changes in the amount of outstanding checks over bank balances in the 2011 period.

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

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

Net acquisition of investment securities increased by $6.4 million during the year ended December 31, 2010 when compared to the prior year.

Net proceeds from borrowings increased by $40.6 million during the year ended December 31, 2010. The increase in borrowings is the net result of proceeds from securities sold under agreements of repurchases amounting to $15.6 million and $25.0 million from a long-term repurchase agreement to partially repay a long-term borrowing.

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

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

On September 29, 2010 we announced the immediate commencement of a $30.0 million share repurchase program. We paid approximately $6.2 million under the stock repurchase program during the year ended December 31, 2010. During the year ended December 31, 2009 we paid approximately $32.3 million under the $40.0 million stock repurchase program that began in December 2008.

Financing and Financing Capacity

We have several short-term facilities available to address timing differences between cash receipts and disbursements. These short-term facilities are mostly in the form of arrangements to sell securities under repurchase agreements. As of December 31, 2011, we had $210.0 million of available credit under these facilities. There are no outstanding short-term borrowings under these facilities as of December 31, 2011.

As of December 31, 2011, we had the following senior unsecured notes payable:

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

On December 21, 2005, we issued and sold $60.0 million of our 6.6% senior unsecured notes due December 2020 (the 6.6% notes). The 6.6% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at par, in whole or in part, as determined by us. The proceeds obtained from this issuance were used to pay the ceding commission to GA Life on the effective date of the coinsurance funds withheld reinsurance agreement. On October 1, 2010 we repaid $25.0 million of the principal of these senior unsecured notes.

Table of Contents

On November 1, 2010, we entered into a $25.0 million arrangement to sell securities under repurchase agreements that matures on November 2015. The repurchase agreement pays interest quarterly at 1.96%. The investment securities underlying such agreements were delivered to the financial institution with whom the agreement was transacted. The dealers may have loaned, or used as collateral such securities in the normal course of business operations. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on our consolidated balance sheet. At December 31, 2011 investment securities available for sale with fair value of $28.1 million (face value of $27.8 million) were pledged as collateral under this agreement. The proceeds obtained from this agreement were used to repay $25.0 million of the 6.6% notes.

The 6.6% notes and the 6.7% notes contain certain non-financial covenants. At December 31, 2011, we are in compliance with these covenants.

In addition, we are a party to a secured term loan with a commercial bank in Puerto Rico. This secured loan bears interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus 100 basis points and requires monthly principal repayments of $0.1 million. As of December 31, 2011, this secured loan had an outstanding balance of $19.4 million and average annual interest rate of 1.33%.

This secured loan is guaranteed by a first lien on our land, buildings and substantially all leasehold improvements, as collateral for the term of the agreements under a continuing general security agreement. This secured loan contains certain non-financial covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2011, we are in compliance with these covenants. Failure to meet these non-financial covenants may trigger the accelerated payment of the secured loan's outstanding balances.

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

Planned Capital Expenditures

Our managed care business is currently in a project to change a significant part of its operations computer system. This project is expected to be carried out in phases until the second quarter in 2012. Total external costs for the entire project are expected to amount approximately $56.0 million. Our managed care business expects to incur costs of approximately $2.0 million during 2012. We estimate that $1.2 million of the costs expected to be incurred in 2012 will be capitalized over the system's useful life and the remaining amount will be expensed. This amount is expected to be paid out of the operating cash flows of our managed care business.

In addition, during February 2012 the Company began a project to implement a new Enterprise Resource Planning (ERP) system. Total costs for the project are expected to amount approximately $13.0 million. This amount is expected to be paid out of our operating cash flows.

Contractual Obligations

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

The table below describes the payments due under our contractual obligations, aggregated by type of contractual obligation, including the maturity profile of our debt, operating leases and other long-term liabilities, and excludes an

estimate of the future cash outflows related to the following liabilities:

Unearned premiums – This amount accounts for the premiums collected prior to the end of coverage period and does not represent a future cash outflow. As of December 31, 2011, we had $94.8 million in unearned premiums.

Policyholder deposits – The cash outflows related to these instruments are not included because they do not have defined maturities, such that the timing of payments and withdrawals is uncertain. There are currently no significant policyholder deposits in paying status. As of December 31, 2011, our policyholder deposits had a carrying amount of $76.8 million.

Table of Contents

Other long-term liabilities – Due to the indeterminate nature of their cash outflows, $121.2 million of other long-term liabilities are not reflected in the following table, including $77.5 million of liability for pension benefits, $24.6 million in deferred tax liabilities, and $19.1 million in liabilities to the Federal Employees' Health Benefits Plan Program.

		Contractual obligations by year					
(Dollar amounts in millions)	Total	2012	2013	2014	2015	2016	Thereafter
Long-term borrowings (1)	$ 162.4	$ 7.0	$ 7.0	$ 7.0	$ 32.0	$ 6.5	$ 102.9
Operating leases	25.4	5.6	4.1	3.8	3.6	3.0	5.3
Purchase obligations (2)	166.1	161.8	2.0	1.2	0.8	0.3	-
Claim liabilities (3)	354.0	265.5	56.5	9.5	9.0	4.8	8.7
Estimated obligation for future policy benefits (4)	993.3	79.1	67.2	63.1	59.6	56.0	668.3
	$ 1,701.2	$ 519.0	$ 136.8	$ 84.6	$ 105.0	$ 70.6	$ 785.2

(1) As of December 31, 2011, our long-term borrowings consist of our 6.6% senior unsecured notes payable, our 6.7% senior unsecured notes payable, a $25.0 million arrangement to sell securities under repurchase agreements which requires quarterly interest payments at 1.96%, and a loan payable to a commercial bank. Total contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.6% and 6.7% senior unsecured notes and the arrangement to sell securities under repurchase agreements, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity dates of the notes in 2020, 2021, and 2015 respectively. We may redeem the senior unsecured notes starting five years after issuance; however no redemption is considered in this schedule. The interest payments related to our loan payable were estimated using the interest rate applicable as of December 31, 2011. The actual amount of interest payments of the loan payable will differ from the amount included in this schedule due to the loan's variable interest rate structure. See the "Financing and Financing Capacity" section for additional information regarding our long-term borrowings.

(2) Purchase obligations represent payments required by us under material agreements to purchase goods or services that are enforceable and legally binding and where all significant terms are specified, including: quantities to be purchased, price provisions and the timing of the transaction. Other purchase orders made in the ordinary course of business for which we are not liable are excluded from the table above. Estimated pension plan contributions amounting to $13.0 million were included within the total purchase obligations. However, this amount is an estimate which may be subject to change in view of the fact that contribution decisions are affected by various factors such as market performance, regulatory and legal requirements and plan funding policy.

(3) Claim liabilities represent the amount of our claims processed and incomplete as well as an estimate of the amount of incurred but not reported claims and loss-adjustment expenses. This amount does not include an estimate of claims to be incurred subsequent to December 31, 2011. The expected claims payments are an estimate and may differ materially from the actual claims payments made by us in the future. Also, claim liabilities are presented gross, and thus do not reflect the effects of reinsurance under which $37.2 million of reserves had been ceded at December 31, 2011.

(4) Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. A significant portion of the estimated obligation for future policy benefits to be paid included in this table considers contracts under which we are currently not making payments and will not make payments until the occurrence of an insurable event not under our control, such as death, illness, or the surrender of a policy. We have estimated the timing of the cash flows related to these contracts based on historical experience as well as expectations of future payment patterns. The amounts presented in the table above represent

the estimated cash payments for benefits under such contracts based on assumptions related to the receipt of future premiums and assumptions related to mortality, morbidity, policy lapses, renewals, retirements, disability incidence and other contingent events as appropriate for the respective product type. All estimated cash payments included in this table are not discounted to present value nor do they take into account estimated future premiums on policies in-force as of December 31, 2011 and are gross of any reinsurance recoverable. The $993.3 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $254.2 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual experience and the assumptions used in the estimation of these payments.

Table of Contents

Off-Balance Sheet Arrangements

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

Restriction on Certain Payments by the Corporation's Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the "Commissioner of Insurance of Puerto Rico"). These regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by the insurance subsidiaries to TSM.

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

As of December 31, 2011, our insurance subsidiaries were in compliance with such minimum capital requirements.

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

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

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

Solvency Regulation

To monitor the solvency of the operations, the BCBSA requires us and TSS to comply with certain specified levels of RBC. RBC is designed to identify weakly capitalized companies by comparing each company's adjusted surplus to its required surplus (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2011, both we and TSS estimated RBC ratio were above the 200% of our RBC required by the BCBSA and the 375% of our RBC level required by the BCBSA to avoid monitoring.

Other Contingencies

Legal Proceedings

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

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

Table of Contents

Guarantee Associations

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared to be insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. During the years ended December 31, 2011, 2010 and 2009, no assessment or payment was made in connection with insurance companies declared insolvent. It is the opinion of management that any possible future guarantee association assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

Pursuant to the Puerto Rico Insurance Code, our property and casualty insurance subsidiary is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED). The syndicate was organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the syndicate cannot meet their obligations. During 2011, 2010 and 2009, no assessment or payment was made for this contingency. It is the opinion of management that any possible future syndicate assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

In addition, pursuant to Article 12 of Rule LXIX of the Insurance Code, our property and casualty insurance subsidiary is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the Association). The Association was organized in 1997 to underwrite insurance coverage of motor vehicle property damage liability risks effective January 1, 1998. As a participant, the segment shares the risk proportionally with other members based on a formula established by the Insurance Code. During the years 2011, 2010 and 2009, the Association distributed the Company a dividend based on the good experience of the business amounting to $1.3 million in 2011 and 2010 and $1.1 million in 2009.

Critical Accounting Estimates

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

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

Table of Contents

Claim Liabilities

Claim liabilities by segment as of December 31, 2011 were as follows:

(Dollar amounts in millions)

Managed care	$262.2
Life insurance	43.4
Property and casualty insurance	85.7
Consolidated	$391.3

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

We recognize claim liabilities as follows:

Managed Care Segment

At December 31, 2011, claim liabilities for the managed care segment amounted to $262.2 million and represented 67.0% of our total consolidated claim liabilities and 21.8% of our total consolidated liabilities.

Claim liabilities are determined employing actuarial methods that are commonly used by managed care actuaries and meet Actuarial Standards of Practice, which require that the claim liabilities be adequate under moderately adverse circumstances. The segment determines the amount of the liability by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project a best estimate of claim liabilities. Under this process, historical claims incurred dates are compared to actual dates of claims payment. This information is analyzed to create "completion" or "development" factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of claim liabilities are then determined by subtracting the actual paid claims from the estimate of the total expected claims incurred. The majority of unpaid claims, both reported and unreported, for any period, are those claims which are incurred in the final months of the period. Since the percentage of claims paid during the period with respect to claims incurred in those months is generally very low, the above-described completion factor methodology is less reliable for such months. In order to complement the analysis to determine the unpaid claims, historical completion factors and payment patterns are applied to incurred and paid claims for the most recent twelve months and compared to the prior twelve month period. Incurred claims for the most recent twelve months also take into account recent claims expense levels and health care trend levels (trend factors). Using all of the above methodologies, our actuaries determine based on the different circumstances the unpaid claims as of the end of period.

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

Circumstances to be considered in developing our best estimate of reserves include changes in enrollment, utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns, and claim submission patterns. A comparison or prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 87% of the claims are paid within three months after the last day of the month in which they were incurred and about 8% are within the next three months, for a total of 95% paid within six months after the last day of the month in which they were incurred.

Table of Contents

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

As described above, completion factors and claims trend factors can have a significant impact on determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2011 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

(Dollar amounts in millions)

Completion Factor 1 (Decrease) Increase		Claims Trend Factor 2 (Decrease) Increase	
In completion factor	In unpaid claim liabilities	In claims trend factor	In unpaid claim liabilities
-0.6%	$9.6	0.75%	$10.3
-0.4%	6.5	0.50%	6.8
-0.2%	3.2	0.25%	3.4
0.2%	(3.2)	-0.25%	(3.4)
0.4%	(6.3)	-0.50%	(6.8)
0.6%	(9.5)	-0.75%	(10.3)

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

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

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments, or run-out becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred claims related to prior years result from claims being settled for amounts less than originally estimated. The reverse is true of reserve shortfalls. Medical claim liabilities are usually described as having a "short tail": which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 95%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 5% related to claims incurred prior to the previous calendar year-end. Management has not noted any significant emerging trends in claim frequency and severity and the normal fluctuations in enrollment and utilization trends from year to year.

Table of Contents

The following table shows the variance between the segment's incurred claims for current period insured events and the incurred claims for such years had they been determined retrospectively (the "Incurred claims related to current period insured events" for the year shown plus or minus the "Incurred claims related to prior period insured events" for the following year as included in note 10 to the audited consolidated financial statements). This table shows that the segments' estimates of this liability have approximated the actual development.

(Dollar amounts in millions)	2010	2009	2008
Years ended December 31,			
Total incurred claims:			
As reported (1)	$1,503.3	$1,512.1	$1,348.9
On a retrospective basis	1,495.6	1,506.5	1,352.0
Variance	$7.7	$5.6	$(3.1)
Variance to total incurred claims as reported	0.5%	0.4%	-0.2%

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

Management expects that substantially all of the development of the 2011 estimate of medical claims payable will be known during 2012 and that the variance of the total incurred claims on a retrospective basis when compared to reported incurred claims will be similar to the prior years.

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

Through the management of our cash flows and investment portfolio.

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

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

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

Life Insurance Segment

At December 31, 2011, claim liabilities for the life insurance segment amounted to $43.4 million and represented 11.1% of total consolidated claim liabilities and 3.6% of our total consolidated liabilities.

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

Claim reserve reviews are generally conducted on a monthly basis, in light of continually updated information. We review reserves using current inventory of policies and claims data. These reviews incorporate a variety of actuarial

methods, judgments and analysis.

The key assumption with regard to claim liabilities for our life insurance segment is related to claims incurred prior to the end of the year, but not yet reported to our subsidiary. A liability for these claims is estimated based upon experience with regards to amounts reported subsequent to the close of business in prior years. There are uncertainties in the development of these estimates; however, in recent years our estimates have resulted in immaterial redundancies or deficiencies.

Table of Contents

Property and Casualty Insurance Segment

At December 31, 2011, claim liabilities for the property and casualty insurance segment amounted to $85.7 million and represented 21.9% of the total consolidated claim liabilities and 7.1% of our total consolidated liabilities.

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

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

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

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

At December 31, 2011, the actuarial reserve range determined by the actuaries was from $84 million to $94 million. Management reviews the results of the reserve estimates in order to determine any appropriate adjustments in the recording of reserves. Adjustments to reserve estimates are made after management's consideration of numerous factors, including but not limited to the magnitude of the difference between the actuarial indication and the recorded reserves, improvement or deterioration of actuarial indications in the period, the maturity of the accident year, trends observed over the recent past and the level of volatility within a particular line of business. In general, changes are made more quickly to more mature accident years and less volatile lines of business. Varying the net expected loss ratio by +/-1% in all lines of business for the six most recent accident years would increase/decrease the claims incurred by approximately $5.7 million.

Liability for Future Policy Benefits

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

occurrence of other covered events. We compute the amounts for actuarial liabilities in conformity with GAAP.

Liabilities for future policy benefits for whole life and term insurance products and active life reserves for accident and health products are computed by the net level premium method, using interest assumptions ranging from 5.0% to 5.75% and withdrawal, mortality, morbidity and maintenance expense assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health unpaid claim reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.

Table of Contents

The liabilities for all products, except for universal life and deferred annuities, are based upon a variety of actuarial assumptions that are uncertain. The most significant of these assumptions is the level of anticipated death and health claims. Other assumptions that are less significant to the appropriate level of the liability for future policy benefits are anticipated policy persistency rates, investment yields, and operating expense levels. These are reviewed frequently by our subsidiary's external actuaries, to assure that the current level of liabilities for future policy benefits is sufficient, in combination with anticipated future cash flows, to provide for all contractual obligations. For all products, except for universal life and deferred annuities, the basis for the liability for future policy benefits is established at the time of issuance of each contract and would only change if our experience deteriorates to the point that the level of the liability is not adequate to provide for future policy benefits. We do not currently expect that level of deterioration to occur.

Deferred Policy Acquisition Costs and Value of Business Acquired

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

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

The schedules of amortization of life insurance deferred policy acquisition costs (DPAC) and VOBA are based upon actuarial assumptions regarding future events that are uncertain. For all products, other than universal life and deferred annuities, the most significant of these assumptions is the level of contract persistency and investment yield rates. For these products the basis for the amortization of DPAC and VOBA is established at the issue of each contract and would only change if our segment's experience deteriorates to the point that the level of the liability is not adequate. We do not currently expect that level of deterioration to occur. For the universal life and deferred annuity products, amortization schedules are based upon the level of historic and anticipated gross profit margins, from the date of each contract's issued (or purchase, in the case of VOBA). These schedules are based upon several actuarial assumptions that are uncertain, are reviewed annually and are modified if necessary. The most significant of these assumptions are anticipated universal life claims, investment yield rates and contract persistency. Based upon the most recent actuarial reviews of all of the assumptions, we do not currently anticipate material changes to the level of these amortization schedules.

The property and casualty business acquisition costs consist of commissions incurred during the production of business and are deferred and amortized ratably over the terms of the policies. The method used in calculating deferred acquisition costs limits the amount of such deferred costs to actual costs or their estimated realizable value, whichever is lower.

Impairment of Investments

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

Table of Contents

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

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

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

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

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

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

During the years ended December 31, 2011, 2010 and 2009 we recognized other-than-temporary impairments amounting to $0.3 million, $3.0 million and $7.1 million, respectively, on fixed income, equity securities and perpetual preferred stocks classified as available for sale. As of December 31, 2011, the investments in securities of $1.1 billion is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $863.6 million, or 75.3%, are securities in obligations of U.S. government-sponsored enterprises, U.S. Treasury securities, obligations of the Commonwealth of Puerto Rico, municipal securities, obligations of U.S. states and its political subdivisions, mortgage backed and collateralized mortgage obligations that are U.S. agency-backed. The remaining $283.4 million, or 27.4%, are from corporate fixed, equity securities and mutual funds. The net unrealized gain as of December 31, 2011 of the available-for-sale and held-to-maturity portfolios amounted to $82.1 million.

The impairment analysis as of December 31, 2011 indicated that, other than those securities for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was considered other-than-temporarily impaired as of that date; however, several factors are beyond management's control, such as the following: financial condition of the issuer, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management's judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income.

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

Table of Contents

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2011 and 2010 is included in note 3 to the audited consolidated financial statements.

Allowance for Doubtful Receivables

We estimate the amount of uncollectible receivables in each period and establish an allowance for doubtful receivables. The allowance for doubtful receivables amounted to $23.9 million and $20.0 million as of December 31, 2011 and 2010, respectively. The amount of the allowance is based on the age of unpaid accounts, information about the customer's creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

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

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

Goodwill and Other Intangible Assets

Our consolidated goodwill at December 31, 2011 was $25.4 and other intangible assets were $33.3.

We follow FASB guidance for business combinations and goodwill and other intangible assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under the guidance, goodwill is not amortized but is tested for impairment at least annually. Furthermore, goodwill is allocated to reporting units for purposes of the annual impairment test. Our impairment tests require us to make assumptions and judgments regarding the estimated fair value of our reporting units, which include goodwill and other intangible assets.

We complete our annual impairment tests of existing goodwill during the fourth quarter of each year. These tests involve the use of estimates related to the fair value of the goodwill reporting unit and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed during interim periods when potential impairment indicators exist or other changes in our business occur.

Fair value is estimated using the income and market approaches for our goodwill reporting units. Use of the income and market approaches for our goodwill impairment test reflects our view that both valuation methodologies provide a reasonable estimate of fair value.

The income approach is developed using assumptions about future revenue, expenses and net income derived from our internal planning process. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted average cost of capital. Market valuations are based on observed multiples of certain measures including membership, revenue and EBITDA (earnings before interest, taxes, depreciation and amortization) and include market comparisons to publicly traded companies in our industry.

While we believe we have appropriately allocated the purchase price of our acquisitions, this allocation requires many assumptions to be made regarding the fair value of assets and liabilities acquired. In addition, estimated fair values developed based on our assumptions and judgments might be significantly different if other reasonable assumptions and estimates were to be used. If estimated fair values are less than the carrying values of the reporting unit or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record impairment losses against future income.

Table of Contents

Other Significant Accounting Policies

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

Recently Issued Accounting Standards

In September 2011, the FASB issued guidance to simplify how entities, both public and nonpublic, test goodwill for impairment. The amendments in the guidance permit an entity to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test described in Topic 350. This guidance is effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011. We are currently evaluating the impact, if any, the adoption of this guidance will have on the financial position or results of operations.

In July 2011, the FASB issued guidance to address questions about how health insurers should recognize and classify in their income statements fees mandated by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. A health insurer's portion of the annual fee becomes payable to the U.S. Treasury once the entity provides health insurance for any U.S. health risk for each applicable calendar year. The amendments specify that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. This guidance is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. We are currently evaluating the impact, if any, the adoption of this guidance will have on the financial position or results of operations.

In June 2011, the FASB issued guidance to improve the comparability, consistency, and transparency of financial reporting and to increase the prominence of items reported in other comprehensive income. The FASB decided to eliminate the option to present components of other comprehensive income as part of the statement of changes in stockholders' equity. The amendments require that all non-owner changes in stockholders' equity be presented either in a single continuous statement of comprehensive income or in two separate but consecutive statements. In the two-statement approach, the first statement should present total net income and its components followed consecutively by a second statement that should present total other comprehensive income, the components of other comprehensive income, and the total of comprehensive income. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2011. The FASB issued updated guidance temporarily eliminating the presentation requirements for reclassification adjustments, while the Board considers certain operational concerns about these requirements after several concerns were raised about undue complexity within the income statement, potentially compromising clarity of financial statements. We do not expect the adoption of this guidance to have an impact on our financial position or results of operations.

In May 2011, the FASB issued guidance that changes the wording used to describe many of the requirements in GAAP for measuring fair value and for disclosing information about fair value measurements that result in common fair value measurement and disclosure requirements in GAAP and International Financial Reporting Standards ("IFRS"). For many of the requirements, FASB does not intend the amendments in this guidance to result in a change in the application of the requirements in Topic 820. Some of the amendments clarify the FASB's intent about the application of existing fair value measurement requirements. Other amendments change a particular principle or requirement for measuring fair value or for disclosing information about fair value measurements. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2011. We do not expect the adoption of this guidance to have an impact on our financial position or results of operations.

In April 2011, the FASB issued guidance to improve the accounting for repurchase agreements (repos) and other agreements that both entitle and obligate a transferor to repurchase or redeem financial assets before their maturity. The Board determined that the criterion pertaining to an exchange of collateral should not be a determining factor in assessing effective control. The Board concluded that the assessment of effective control should focus on a transferor's contractual rights and obligations with respect to transferred financial assets, not on whether the transferor has the practical ability to perform in accordance with those rights or obligations. The Board also concluded that the remaining criteria are sufficient to determine effective control. Consequently, the amendments remove the transferor's ability criterion from the consideration of effective control for repos and other agreements that both entitle and obligate the transferor to repurchase or redeem financial assets before their maturity. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2011. The guidance should be applied prospectively to transactions or modifications of existing transactions that occur on or after the effective date. We do not expect the adoption of this guidance to have an impact on our financial position or results of operations.

Table of Contents

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

Other than the accounting pronouncement disclosed above, there were no other new accounting pronouncements issued that had or are expected to have a material impact on our financial position, operating results or disclosures.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

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

Market Risk Exposure

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

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

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

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

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

Table of Contents

Our investment portfolio is predominantly comprised of obligations of U.S. government-sponsored enterprises, U.S. Treasury securities, obligations of state and political subdivisions, obligations of the Commonwealth of Puerto Rico, municipal securities and obligations of U.S. states and its political subdivisions and obligations from U.S. and Puerto Rican government instrumentalities. These investments comprised approximately 75.2% of the total portfolio value as of December 31, 2011, of which 25.2% consisted of U. S. agency-backed mortgage backed securities and collateralized mortgage obligations. The remaining balance of the investment portfolio consists of mutual funds, investments in local stocks from well-known financial institutions and investments in corporate bonds.

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

- the market risk information is limited by the assumptions and parameters established in creating the related sensitivity analysis, including the impact of prepayment rates on mortgages; and
- the model assumes that the composition of assets and liabilities remains unchanged throughout the year.

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

Interest Rate Risk

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

Equity Price Risk

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

Risk Measurement

Trading Portfolio

Our trading securities at December 31, 2010 are a source of market risk. As of December 31, 2010, our trading portfolio was comprised of investments in publicly-traded common stocks. The securities in the trading portfolio are believed by management to be high quality and are diversified across industries and readily marketable. Trading securities are recorded at fair value, and changes in fair value are included in operations. The fair value of the investments in trading securities is exposed to equity price risk. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2010 the hypothetical loss in the fair value of these investments would have been approximately $5.1 million. The trading portfolio was sold during this period.

Other than Trading Portfolio

Our available-for-sale and held-to-maturity securities are also a source of market risk. As of December 31, 2011 approximately 87.3% and 100.0% of our investments in available-for-sale and held-to-maturity securities,

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

Table of Contents

Interest Rate Risk

We have evaluated the net impact to the fair value of our fixed income investments of a significant one-time change in interest rate risk using a combination of both statistical and fundamental methodologies. From these shocked values a resultant market price appreciation/depreciation can be determined after portfolio cash flows are modeled and evaluated over instantaneous 100, 200 and 300 basis point rate shifts. Techniques used in the evaluation of cash flows include Monte Carlo simulation through a series of probability distributions over 200 interest rate paths. Necessary prepayment speeds are compiled using Salomon Brothers Yield Book, which sources numerous factors in deriving speeds, including but not limited to: historical speeds, economic indicators, street consensus speeds, etc. Securities evaluated by us under these scenarios include mortgage pass-through certificates and collateralized mortgage obligations of U.S. agencies, and private label structures, provided that cash flows information is available. The following table sets forth the result of this analysis for the years ended December 31, 2011 and 2010.

(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2011:			
Base Scenario	$ 1,003.1		
+100bp	949.6	(53.5)	(5.3)%
+200bp	896.9	(106.2)	(10.6)%
+300bp	843.6	(159.5)	(15.9)%
December 31, 2010:			
Base Scenario	$ 991.6		
+100bp	940.4	(51.2)	(5.2)%
+200bp	886.1	(105.5)	(10.6)%
+300bp	836.5	(155.1)	(15.6)%

We believe that an interest rate shift in a 12-month period of 100 basis points represents a moderately adverse outcome, while a 200 basis point shift is significantly adverse and a 300 basis point shift is unlikely given historical precedents. Although we classify 98.6% of our fixed income securities as available-for-sale, our cash flows and the intermediate duration of our investment portfolio should allow us to hold securities until maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Equity Price Risk

Our equity securities in the available-for-sale portfolio are comprised primarily of stock of several Puerto Rican financial institutions and mutual funds. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2011 and 2010, the hypothetical loss in the fair value of these investments would have been approximately $14.4 million and $5.2 million, respectively.

Other Risk Measurement

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

We have invested in a hybrid instrument, including a derivative component, with a market value of approximately $10.0 million and $10.6 million as of December 31, 2011 and 2010 in order to diversify our investment in securities and participate in foreign stock markets.

Table of Contents

In 2005, we invested in $5.0 million in each of two structured note agreements, under which the interest income received is linked to the performance of the Dow Jones Euro STOXX 50 and Nikkei 225 Equity Indices (the Indices). Under these agreements the principal invested by us is protected, the only amount that varies according to the performance of the Indices is the interest to be received upon the maturity of the instruments. Should the Indices experience a negative performance during the holding period of the structured notes, no interest will be received and no amount will be paid to the issuer of the structured notes. The contingent interest payment component within the structured note agreements meets the definition of an embedded derivative. In accordance with current accounting guidance the embedded derivative component of the structured note is separated from the structured notes and accounted for separately as a derivative instrument. The derivative component of the structured notes exposes us to credit risk and market risk. We minimize credit risk by entering into transactions with counterparties that we believe to be high-quality based on their credit ratings. The market risk is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. As of December 31, 2011 the fair value of the derivative component of the structure notes are not significant since maturity date will be on May 2012, and the value is near at par value. The fair value as of December 31, 2010 was $0.7 million. Assuming an immediate decrease of 10% in the period-end Indices as of December 31, 2011 and 2010, the hypothetical loss in the estimated fair value of the derivative component of the structured notes would have been approximately $0.1 million. The investment component of the structured notes, which had a fair value of $10.0 million and $9.9 million as of December 31, 2011 and 2010, respectively, is accounted for as a held-to-maturity debt security and is included within “investment in securities” in the consolidated balance sheet and its risk measurement is evaluated along the other investments in “— Other Than Trading Portfolio” above.

Item 8. Financial Statements and Supplementary Data

Financial Statements

For our audited consolidated financial statements as of December 31, 2011 and 2010 and for each of the three years ended December 31, 2011 see Index to financial statements in “Item 15. Exhibits and Financial Statements Schedules” to this Annual Report on Form 10-K.

Table of Contents

Selected Quarterly Financial Data

	2011				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$485,271	$509,843	$ 525,371	$ 533,983	$2,054,468
Administrative service fees	6,595	6,962	5,210	19,692	38,459
Net investment income	11,798	12,654	12,061	11,713	48,226
Total operating revenues	503,664	529,459	542,642	565,388	2,141,153
Net realized investment gains	5,893	6,995	5,569	140	18,597
Net unrealized investment losses on trading securities	(1,141)	(119)	(6,007)	-	(7,267)
Other (loss) income, net	14	466	(169)	405	716
Total revenues	508,430	536,801	542,035	565,933	2,153,199
Benefits and expenses					
Claims incurred	402,573	427,941	442,399	443,341	1,716,254
Operating expenses	82,711	85,882	83,623	95,374	347,590
Total operating costs	485,284	513,823	526,022	538,715	2,063,844
Interest expense	3,127	2,957	2,499	2,272	10,855
Total benefits and expenses	488,411	516,780	528,521	540,987	2,074,699
Income before taxes	20,019	20,021	13,514	24,946	78,500
Income tax expense (benefit)					
Current	(153)	2,147	1,161	3,537	6,692
Deferred	9,802	788	740	2,442	13,772
Total income taxes	9,649	2,935	1,901	5,979	20,464
Net income	$10,370	$17,086	$ 11,613	$ 18,967	$58,036
Basic net income per share	$0.36	$0.59	$ 0.40	$ 0.67	$2.02
Diluted net income per share	$0.36	$0.59	$ 0.40	$ 0.67	$2.01

During the three months ended December 31, 2011, we recorded certain out-of-period adjustments that affected our consolidated results of operations of each of the previous three quarters as well as those of our Managed Care segment, related to the distribution of premium revenue within our businesses, the accounting of pharmacy rebates and the effect of considering certain claims paid data in the estimation of claim liabilities. The effect of these out-of-period adjustments in previous periods were the following:

The consolidated and Managed Care premiums would have increased by $0.4 million and $1.6 million during the three months ended March 31, 2011 and June 30, 2011, respectively.

The consolidated and Managed Care claims incurred would have increased by $2.4 million during the three months ended March 31, 2011 and decreased by $0.7 and $1.8 million during the three months ended June 30, 2011 and September 30, 2011, respectively.

As a result of these out-of-period adjustments the consolidated income before tax was overstated by $2.0 million during the three months ended March 31, 2011 and understated by $2.3 million and $1.8 million during the three months ended June 30, 2011 and September 30, 2011, respectively.

We assessed the impact of the adjustments needed to account for these errors in their appropriate periods and concluded that recording these adjustment in the consolidated results of operations in the three months ended December 31, 2011, rather than restating the quarters affected, was quantitatively and qualitatively not material to the results of operations, financial position, or cash flows corresponding to each of the quarters that comprise the year ended December 31, 2011. These out-of-period adjustments involve only reported quarterly results and, because they were corrected during the last quarter of the year, have no effect on the results of operations, financial position and cash flows for the year ended December 31, 2011.

Table of Contents

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

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

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

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

In connection with the preparation of this Annual Report on Form 10-K, management, under the supervision and with the participation of the chief executive officer and corporate controller, conducted an evaluation of the effectiveness of our “disclosure controls and procedures” as of the end of this period (as such term is defined under Exchange Act Rule 13a-15(e)). Disclosure controls and procedures are designed to ensure that information required to be disclosed by the issuer in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms and that such information is accumulated and communicated to management, including the chief executive officer and corporate controller, to allow timely decisions regarding required disclosures. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility

that judgments in decision-making can be faulty, and breakdowns as a result of simple errors or mistake. Accordingly, even effective disclosure controls and procedures can only provide reasonable assurance of achieving their control objectives. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions.

Table of Contents

Based on this evaluation, our chief executive officer and corporate controller have concluded that as of December 31, 2011, which is the end of the period covered by this Annual Report on Form 10-K, our disclosure controls and procedures are effective to a reasonable level of assurance.

Management's Report on Internal Control Over Financial Reporting

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

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

provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and

provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

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

Management, under the supervision and with the participation of the chief executive officer and corporate controller, assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2011 based on criteria described in the "Internal Control—Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on that assessment and those criteria, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2011 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company's consolidated financial statements for external reporting purposes in accordance with GAAP.

Management has excluded Socios Mayores en Salud Holdings, Inc. and its subsidiaries, the indirect parent company of American Health, Inc. (from now on referred to as "AH") from its assessment of internal control over financial reporting as of December 31, 2011 because it was acquired by the Company in a purchase business combination during 2011. AH is a wholly-owned subsidiary whose total assets and total revenues represent 9% and 20%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2011.

The effectiveness of our internal control over financial reporting as of December 31, 2011 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which is included in this Annual Report on Form 10-K.

Table of Contents

Changes in Internal Control Over Financial Reporting

No changes in our internal control over financial reporting (as such term is defined in the Exchange Act Rule 13a-15(f)) occurred during the fiscal quarter ended December 31, 2011 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2012 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 11. Executive Compensation

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2012 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2012 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2012 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 14. Principal Accountant Fees and Services

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2012 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Table of Contents

Item 15. Exhibits and Financial Statements Schedules

Financial Statements and Schedules

Financial Statements	Description
F-1	Reports of Independent Registered Public Accounting Firm
F-2	Consolidated Balance Sheets as of December 31, 2011 and 2010
F-3	Consolidated Statements of Earnings for the years ended December 31, 2011, 2010 and 2009
F-4	Consolidated Statements of Stockholders' Equity and Comprehensive Income for the years ended December 31, 2011, 2010 and 2009
F-5	Consolidated Statements of Cash Flows for the years ended December 31, 2011, 2010 and 2009
F-7	Notes to Consolidated Financial Statements – December 31, 2011, 2010 and 2009

Financial Statements Schedules	Description
S-1	Schedule II – Condensed Financial Information of the Registrant
S-2	Schedule III – Supplementary Insurance Information
S-3	Schedule IV – Reinsurance
S-4	Schedule V – Valuation and Qualifying Accounts

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

Exhibits

Exhibits	Description
3(i)(a)	Amended and Restated Articles of Incorporation (incorporated herein by reference to Exhibit 3(i)(d) to TSM's Annual Report on Form 10-K for the Year Ended December 31, 2007 (File No. 001-33865).
3(i)(b)	Amendment to Article Tenth of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation, incorporated by reference to Exhibit 3(i)(b) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865).

3(i)(c)	Articles of Incorporation of Triple-S Management Corporation, as currently in effect, incorporated by reference to Exhibit 3(i)(c) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865).
3(ii)	Amended and Restated Bylaws of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3.1 to TSM's Current Report on Form 8-K filed on June 11, 2010 (File No. 001-33865)).

Table of Contents

Exhibits	Description
10.1	Agreement between the Puerto Rico Health Insurance Administration and TSS to administer the provision of the physical health component of the miSalud program in designated service regions (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on October 24, 2012 (File No. 001-33865)).
10.2	Amendment to the Medicare Platino Contract (Medicare Wraparound) between the Puerto Rico Health Insurance Administration and TSS for the provision of wraparound coverage to health insurance dual-eligible population until December 31, 2011 (incorporated herein by reference to Exhibit 10.4 to TSM's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010 (File No. 001-33865)).
10.3	Federal Employees Health Benefits Contract (incorporated herein by reference to Exhibit 10.5 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.4	Credit Agreement with FirstBank Puerto Rico in the amount of $41,000,000 (incorporated herein by reference to Exhibit 10.6 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.5	Credit Agreement with FirstBank Puerto Rico in the amount of $20,000,000 (incorporated herein by reference to Exhibit 10.7 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.6	Non-Contributory Retirement Program (incorporated herein by reference to Exhibit 10.8 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.7	Blue Shield License Agreement by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.11 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.8	Blue Shield Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.12 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.9	Blue Cross License Agreements by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.13 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.10	Blue Cross Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.14 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.11	

6.30% Senior Unsecured Notes Due September 2019 Note Purchase Agreement, dated September 30, 2004, between Triple-S Management Corporation, Triple-S, Inc. and various institutional accredited investors (incorporated herein by reference to Exhibit 10.15 to TSM's Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).

Table of Contents

Exhibits	Description
10.12	6.60% Senior Unsecured Notes Due December 2020 Note Purchase Agreement, dated December 15, 2005, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.16 to TSM's Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).
10.13	6.70% Senior Unsecured Notes Due December 2021 Note Purchase Agreement, dated January 23, 2006, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.1 to TSM's Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2006 (File No. 001-33865)).
10.14	TSM 2007 Incentive Plan, dated October 16, 2007 (incorporated herein by reference to Exhibit C to TSM's 2007 Proxy Statement (File No. 001-33865)).
10.15	Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS dated August 16, 2007 (incorporated herein by reference to Exhibit 10.15 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.16	Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(a) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.17	Addendum Number Two to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(b) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.18	Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(c) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.19	Work Order Agreement between Quality Care Solutions, Inc. and TSS (incorporated herein by reference to Exhibit 10.16 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.20	Employment Contract between Ramón M. Ruiz Comas and TSM (incorporated herein by reference to Exhibit 10.24 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
11.1	Statement re computation of per share earnings; an exhibit describing the computation of the earnings per share has been omitted as the detail necessary to determine the computation of earnings per share can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K.

21*	List of Subsidiaries of TSM.
23.1*	Consent of Independent Registered Public Accounting Firm (PricewaterhouseCoopers LLP).
31.1*	Certification of the President and Chief Executive Officer required by Rule 13a-14(a)/15d-14(a).
31.2*	Certification of the Corporate Controller required by Rule 13a-14(a)/15d-14(a).
32.1*	Certification of the President and Chief Executive Officer required pursuant to 18 U.S. Section 1350.

Table of Contents

Exhibits	Description
32.2*	Certification of the Corporate Controller required pursuant to 18 U.S. Section 1350.
99.1	Incentive Compensation Recoupment Policy.

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

* Filed herein.

Table of Contents

SIGNATURES

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

Triple-S Management Corporation
Registrant

By: /s/Ramón M. Ruiz-Comas — Date: March 14, 2012
Ramón M. Ruiz-Comas
President and Chief Executive Officer

By: /s/ Liliana Rivera-Corcino — Date: March 14, 2012
Liliana Rivera-Corcino
Corporate Controller

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

By: /s/ Luis A. Clavell-Rodríguez — Date: March 14, 2012
Luis A. Clavell-Rodríguez
Director and Chairman of the Board

By: /s/ Vicente J. León-Irizarry — Date: March 14, 2012
Vicente J. León-Irizarry
Director and Vice-Chairman of the Board

By: /s/ Jesús R. Sánchez-Colón — Date: March 14, 2012
Jesús R. Sánchez-Colón
Director and Assistant Secretary of the Board

By: /s/ Adamina Soto-Martínez — Date: March 14, 2012
Adamina Soto-Martínez
Director

By: /s/ Carmen Ana Culpeper-Ramírez — Date: March 14, 2012
Carmen Ana Culpeper-Ramírez
Director

Table of Contents

By:	/s/ Jorge L. Fuentes-Benejam Jorge L. Fuentes-Benejam Director	Date: March 14, 2012
By:	/s/ Antonio F. Faría-Soto Antonio F. Faría-Soto Director	Date: March 14, 2012
By:	/s/ Manuel Figueroa-Collazo Manuel Figueroa-Collazo Director	Date: March 14, 2012
By:	/s/ Jaime Morgan-Stubbe Jaime Morgan-Stubbe Director	Date: March 14, 2012
By:	/s/ Juan E. Rodríguez-Díaz Juan E. Rodríguez-Díaz Director	Date: March 14, 2012
By:	/s/ Francisco J. Toñarely-Barreto Francisco J. Toñarely-Barreto Director	Date: March 14, 2012

Triple-S Management Corporation
Consolidated Financial Statements
December 31, 2011, 2010, and 2009

Report of Independent Registered Public Accounting Firm

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

In our opinion, the consolidated financial statement listed in the index appearing under Item 15 present fairly, in all material respects, the financial position of Triple-S Management Corporation and its subsidiaries (the Company) at December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2011 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the index appearing under Item 15 present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control Over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

A company’s internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company’s internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company’s assets that could have a material effect on the financial statements.

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

As described in Management’s Report on Internal Control Over Financial Reporting, management has excluded Socios Mayores en Salud Holdings, Inc. and its subsidiaries ("American Health") from its assessment of internal control over

financial reporting as of December 31, 2011 because it was acquired by the Company in a purchase business combination during 2011. We have also excluded American Health from our audit of internal control over financial reporting. American Health is a wholly-owned subsidiary whose total assets and total revenue represent 9% and 20%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2011.

/s/ PricewaterhouseCoopers LLP

San Juan, Puerto Rico
March 14, 2012

CERTIFIED PUBLIC ACCOUNTANTS
(OF PUERTO RICO)
License No. 216 Expires Dec. 1, 2013
Stamp E16126 of the P.R. Society of
Certified Public Accountants has been
affixed to the file copy of this report

Triple-S Management Corporation
Consolidated Balance Sheets
December 31, 2011 and 2010
(dollar amounts in thousands, except per share data)

Assets	2011	2010
Investments and cash		
Equity securities held for trading, at fair value (cost of $43,832 in 2010)	$-	$51,099
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $913,555 in 2011 and $947,957 in 2010)	988,894	977,586
Equity securities (cost of $138,167 in 2011 and $42,750 in 2010)	144,408	51,507
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $14,252 in 2011 and $15,424 in 2010)	13,684	14,615
Policy loans	6,307	5,887
Cash and cash equivalents	71,834	45,021
Total investments and cash	1,225,127	1,145,715
Premium and other receivables, net	287,184	325,780
Deferred policy acquisition costs and value of business acquired	155,788	146,086
Property and equipment, net	81,872	76,745
Deferred tax asset	28,707	29,445
Goodwill	25,397	426
Other assets	76,502	35,173
Total assets	$1,880,577	$1,759,370
Liabilities and Stockholders’ Equity		
Claim liabilities	391,259	360,210
Liability for future policy benefits	254,194	236,523
Unearned premiums	94,772	98,341
Policyholder deposits	76,753	49,936
Liability to Federal Employees’ Health Benefits Program	19,051	15,018
Accounts payable and accrued liabilities	151,052	136,567
Deferred tax liability	24,603	12,655
Short term borrowings	-	15,575
Long term borrowings	114,387	166,027
Liability for pension benefits	77,547	51,246
Total liabilities	1,203,618	1,142,098
Commitments and contingencies		
Stockholders’ equity		
Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 9,042,809 at December 31, 2011 and 2010	9,043	9,043
Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 19,321,524 and 19,772,614 shares at December 31, 2011 and 2010, respectively	19,322	19,773
Additional paid-in capital	144,302	155,299
Retained earnings	485,729	427,693
Accumulated other comprehensive income, net	18,563	5,464
Total stockholders' equity	676,959	617,272

Total liabilities and stockholders' equity	$1,880,577	$1,759,370

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

Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Earnings
December 31, 2011, 2010 and 2009
(dollar amounts in thousands, except per share data)

	2011	2010	2009
Revenues			
Premiums earned, net	$2,054,468	$1,901,100	$1,869,084
Administrative service fees	38,459	39,546	48,643
Net investment income	48,226	49,145	52,136
Total operating revenues	2,141,153	1,989,791	1,969,863
Net realized investment gains (losses):			
Total other-than-temporary impairment losses on securities	(257)	(2,997)	(7,118)
Net realized gains, excluding other-than-temporary impairment losses on securities	18,854	5,529	7,732
Total net realized investment gains	18,597	2,532	614
Net unrealized investment gains (losses) on trading securities	(7,267)	5,433	10,497
Other income, net	716	889	1,237
Total revenues	2,153,199	1,998,645	1,982,211
Benefits and expenses			
Claims incurred	1,716,254	1,596,789	1,605,872
Operating expenses	347,590	304,995	279,418
Total operating costs	2,063,844	1,901,784	1,885,290
Interest expense	10,855	12,658	13,270
Total benefits and expenses	2,074,699	1,914,442	1,898,560
Income before taxes	78,500	84,203	83,651
Income tax expense (benefit):			
Current	6,594	14,348	19,197
Deferred	13,870	3,054	(4,326)
Total income taxes	20,464	17,402	14,871
Net income	$58,036	$66,801	$68,780
Basic net income per share	$2.02	$2.30	$2.33
Diluted net income per share	$2.01	$2.28	$2.33

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

Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Stockholders' Equity and Comprehensive Income
December 31, 2011, 2010 and 2009
(dollar amounts in thousands, except per share data)

	Class A Common Stock	Class B Common Stock	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
Balance, December 31, 2008	$9,043	$22,105	$179,504	$292,112	$ (17,665)	$ 485,099
Share-based compensation	-	-	3,897	-	-	3,897
Grant of restricted Class B common stock	-	27	-	-	-	27
Repurchase and retirement of common stock	-	(2,022)	(24,098)	-	-	(26,120)
Comprehensive income						
Net income	-	-	-	68,780	-	68,780
Net unrealized change in fair value of available for sale securities	-	-	-	-	3,539	3,539
Defined benefit pension plan						
Prior service credit, net	-	-	-	-	(273)	(273)
Actuarial gain	-	-	-	-	2,823	2,823
Total comprehensive income						74,869
Balance, December 31, 2009	9,043	20,110	159,303	360,892	(11,576)	537,772
Share-based compensation	-	-	1,878	-	-	1,878
Grant of restricted Class B common stock	-	16	-	-	-	16
Repurchase and retirement of common stock	-	(353)	(5,882)	-	-	(6,235)
Comprehensive income						
Net income	-	-	-	66,801	-	66,801
Net unrealized change in fair value of available for sale securities	-	-	-	-	23,602	23,602
Defined benefit pension plan						
Prior service credit, net	-	-	-	-	(265)	(265)
Actuarial loss	-	-	-	-	(6,297)	(6,297)
Total comprehensive income						83,841
Balance, December 31, 2010	9,043	19,773	155,299	427,693	5,464	617,272
Share-based compensation	-	173	1,899	-	-	2,072
Cash settlement of options under share-based compensation plan	-	-	(2,420)	-	-	(2,420)
Stock issued upon exercise of stock options	-	88	1,191			1,279
	-	(712)	(11,667)	-	-	(12,379)

Repurchase and retirement of common stock						
Comprehensive income						
Net income	-	-	-	58,036	-	58,036
Net unrealized change in fair value of available for sale securities	-	-	-	-	35,394	35,394
Defined benefit pension plan						
Prior service credit, net	-	-	-	-	(304)	(304)
Actuarial loss	-	-	-	-	(21,991)	(21,991)
Total comprehensive income						71,135
Balance, December 31, 2011	$9,043	$19,322	$144,302	$485,729	$ 18,563	$ 676,959

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

Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Cash Flows
December 31, 2011, 2010 and 2009

(dollar amounts in thousands, except per share data)

	2011	2010	2009
Cash flows from operating activities			
Net income	$58,036	$66,801	$68,780
Adjustments to reconcile net income to net cash provided by operating activities			
Depreciation and amortization	22,229	15,500	9,643
Net amortization of investments	3,912	4,511	744
Provision (reversal of provision) for doubtful receivables	7,837	(5,200)	10,489
Deferred tax expense (benefit)	13,870	3,054	(4,326)
Net realized investment gains	(18,597)	(2,532)	(614)
Net unrealized (gains) losses on trading securities	7,267	(5,433)	(10,497)
Share-based compensation	2,072	1,894	3,924
Proceeds from trading securities sold			
Equity securities	53,066	4,871	4,240
Acquisition of securities in trading portfolio			
Equity securities	(2,764)	(6,506)	(6,132)
Gain (loss) on sale of property and equipment	(13)	6	-
(Increase) decrease in assets			
Premium and other receivables, net	54,622	(47,648)	(46,263)
Deferred policy acquisition costs and value of business acquired	(9,702)	(6,169)	(13,570)
Other deferred taxes	71	6,658	900
Other assets	(18,245)	5,223	(1,593)
Increase (decrease) in liabilities			
Claim liabilities	(11,998)	(236)	36,736
Liability for future policy benefits	17,671	13,904	15,074
Unearned premiums	(4,288)	(10,001)	(1,799)
Policyholder deposits	1,554	733	1,665
Liability to FEHBP	4,033	2,016	1,845
Accounts payable and accrued liabilities	(18,106)	(3,790)	3,339
Net cash provided by operating activities	162,527	37,656	72,585

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

Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Cash Flows
December 31, 2011, 2010 and 2009
(dollar amounts in thousands, except per share data)

	2011	2010	2009
Cash flows from investing activities			
Proceeds from investments sold or matured			
Securities available for sale			
Fixed maturities sold	$240,034	$121,968	$241,368
Fixed maturities matured	104,728	175,483	189,144
Equity securities sold	38,022	41,802	9,877
Securities held to maturity			
Fixed maturities matured	1,941	2,587	7,819
Acquisition of investments			
Securities available for sale			
Fixed maturities	(265,356)	(337,569)	(459,705)
Equity securities	(129,328)	(21,957)	(3,684)
Securities held to maturity			
Fixed maturities	(755)	(1,050)	(1,502)
Other investments	(2,500)	(5,000)	-
Net (disbursements) repayment for policy loans	(420)	53	(489)
Acquisition of business, net of $30,070 of cash acquired	(54,680)	-	-
Net capital expenditures	(16,337)	(19,222)	(18,706)
Net cash used in investing activities	(84,651)	(42,905)	(35,878)
Cash flows from financing activities			
Repurchase and retirement of common stock	(11,289)	(6,235)	(32,355)
Cash settlement of stock options	(2,420)	-	-
Proceeds from exercise of stock options	189	-	-
Change in outstanding checks in excess of bank balances	4,409	281	(5,645)
Repayments of long-term borrowings	(51,640)	(26,367)	(1,640)
Net change in short-term borrowings	(15,575)	15,575	-
Proceeds from long-term borrowings	-	25,000	-
Proceeds from annuity contracts	31,809	10,691	4,307
Surrenders of annuity contracts	(6,546)	(9,051)	(7,093)
Net cash provided by (used in) financing activities	(51,063)	9,894	(42,426)
Net increase (decrease) in cash and cash equivalents	26,813	4,645	(5,719)
Cash and cash equivalents			
Beginning of year			