TRIPLE-S MANAGEMENT CORP
Form 424B7
May 13, 2013
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**Filed Pursuant to Rule 424(b)(7)**
**Registration No. 333-187082**

The information in this preliminary prospectus supplement and the accompanying prospectus is not complete and may be changed. A registration statement relating to these securities has become effective under the Securities Act of 1933, as amended. This preliminary prospectus supplement and the accompanying prospectus are not an offer to sell these securities and they are not soliciting an offer to buy these securities in any jurisdiction where the offer or sale of these securities is not permitted.

SUBJECT TO COMPLETION, DATED MAY 13, 2013

**PRELIMINARY PROSPECTUS SUPPLEMENT**

**(To Prospectus dated May 3, 2013)**

# 5,400,368 Shares

# Triple-S Management Corporation

## Class B Common Stock

The selling shareholders identified in this prospectus supplement are offering 5,400,368 shares of our Class B common stock (the Shares ), par value $1.00 per share. We will not receive any of the proceeds from the sale of the Shares by the selling shareholders.

We may purchase up to $30 million of Shares in this offering at a price of $ per Share, which is the price to the public.

Our Class B common stock is listed on the New York Stock Exchange ( NYSE ) under the symbol GTS. The last reported sale price of our Class B common stock on May 10, 2013 was $19.53 per share.

**Investing in the Shares involves certain risks, including those described under the heading Risk Factors beginning on page S-12 of this prospectus supplement and in any documents incorporated herein by reference.**

| | Price to Public | Underwriting Discounts and Commissions | Proceeds to the Selling Shareholders |
|---|---|---|---|
| Per Share | $ | $ | $ |
| Total | $ | $ | $ |

The selling shareholders have granted the underwriters the right to purchase, within a period of 30 days beginning on the date of this prospectus supplement, up to 810,055 additional Shares, solely to cover over-allotments.

**Neither the Securities and Exchange Commission (the SEC ) nor any state securities commission has approved or disapproved these securities, or determined if this prospectus supplement or the accompanying prospectus is truthful or complete. Any representation to the contrary is a criminal offense.**

Delivery of the Shares will be made on or about May , 2013

Joint Bookrunning Managers

**Credit Suisse** **Wells Fargo Securities**

Co-Managers

**Stifel** **Oriental Wealth Management**

The date of this prospectus supplement is May , 2013

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**Prospectus Supplement**



**Prospectus**



We, the selling stockholders and the underwriters have not authorized any person to provide you with any information other than the information contained in or incorporated by reference in this prospectus supplement, the accompanying prospectus and any related free writing prospectus we provide to you that is required to be filed with the SEC. We, the selling stockholders and the underwriters take no responsibility for, and provide no assurance as to the reliability of, any other information that others may give to you. We, the selling stockholders and the underwriters are not making an offer to sell the Shares in any jurisdiction where the offer or sale is not permitted. You should assume that the information

appearing in this prospectus supplement, the accompanying prospectus, any such free writing prospectus and the documents incorporated by reference herein and therein is accurate only as of the date of the document in which such information appears. Our business, financial condition, results of operations and prospects may have changed since those dates.

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## ABOUT THIS PROSPECTUS SUPPLEMENT

This document is in two parts. The first part is this prospectus supplement, which describes the specific terms of the offering of Shares, identifies the selling shareholders and also adds to and updates information contained in the accompanying prospectus. The second part is the accompanying prospectus, which gives more general information. If information varies between this prospectus supplement and the accompanying prospectus, you should rely on the information in this prospectus supplement. You should read both this prospectus supplement and the accompanying prospectus together with the additional information described under Where You Can Find More Information.

The terms Triple-S, TSM, the Company, the Corporation, we, us and our each refer to Triple-S Management Corporation.

## WHERE YOU CAN FIND MORE INFORMATION

We file annual, quarterly and current reports, proxy statements and other information with the SEC. You may read and copy any document that we file at the Public Reference Room of the SEC at 100 F Street, N.E., Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. In addition, the SEC maintains an Internet site at http://www.sec.gov, from which interested persons can electronically access our SEC filings, including the registration statement and the exhibits and schedules thereto.

The SEC allows us to incorporate by reference the information that we have filed, or that we may file in the future with them, which means that we can disclose important information to you by referring you to those documents. The information incorporated by reference is an important part of this prospectus, and information that we file later with the SEC will automatically update and supersede this information. We incorporate by reference the documents listed below and all documents we file pursuant to Section 13(a), 13(c), 14, or 15(d) of the Securities Exchange Act of 1934 (the Exchange Act ), as amended, on or after the date of this prospectus supplement and prior to the closing of this offering (other than, in each case, documents or information deemed to have been furnished and not filed in accordance with SEC rules):

(a) Annual Report on Form 10-K for the year ended December 31, 2012;

(b) Definitive Proxy Statement on Schedule 14A filed with the SEC on March 15, 2013 (solely to the extent incorporated by reference into Part III of our Annual Report on Form 10-K for the year ended December 31, 2012);

(c) Quarterly Report on Form 10-Q for the period ended March 31, 2013;

(d) Current Reports on Form 8-K filed on March 7, 2013 and May 1, 2013 (with respect to Item 5.07); and

(e) the description of our shares of Class B common stock set forth in our registration statement on Form 8-A (File No. 001-33865) filed on December 3, 2007 including any amendment for the purpose of updating such description.

You may request a copy of these filings at no cost, by writing or telephoning the office of Triple-S Management Corporation, Office of the Secretary, P.O. Box 363628, San Juan, Puerto Rico 00936-3628, (787) 749-4949.

Any statement contained in a document incorporated by reference in this prospectus supplement and the accompanying prospectus is modified or superseded for purposes of this prospectus supplement to the extent that a statement contained in this prospectus supplement or in any subsequently filed document that also is incorporated by reference herein modifies or supersedes such statement. Any statement so modified or superseded does not, except as so modified or superseded, constitute a part of this prospectus supplement and the accompanying prospectus.

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## SPECIAL NOTE ON FORWARD-LOOKING STATEMENTS

This prospectus supplement, the accompanying prospectus and the documents incorporated by reference herein and therein contain 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. Statements that use the terms believe, expect, plan, intend, estimate, anticipate, project, may, will, shall, shou expressions, whether in the positive or negative, are intended to identify forward-looking statements.

All forward-looking statements in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference herein and therein reflect, when made, our current views about future events and are based on assumptions and subject to risks and uncertainties. Although we believe our forward-looking statements are reasonable, actual results may differ materially from those anticipated in these forward-looking statements as a result of various factors, including those discussed under the caption Risk Factors herein, in our Annual Report on Form 10-K for the year ended December 31, 2012 and in our Quarterly Reports on Form 10-Q.

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 that 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 prospectus and the documents incorporated by reference herein:

- 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 federal or Puerto Rico 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; and

the other factors described under Risk Factors in this prospectus supplement.

The foregoing list should not be construed to be exhaustive. We believe the forward-looking statements in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference herein and therein 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

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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 expectations at the time such statements are made. 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.

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## SUMMARY

*This summary highlights information contained elsewhere in this prospectus supplement or the accompanying prospectus, but it may not contain all of the information that you should consider before deciding to invest in the Shares. You should carefully review this summary together with the more detailed information, financial statements and notes thereto contained elsewhere or incorporated by reference in this prospectus supplement, the accompanying prospectus and the documents incorporated by reference to which we refer you for a more complete understanding of this offering.*

### Our Company

We are one of the most significant players in the managed care industry in Puerto Rico, serving approximately 1,675,000 members across all regions as of March 31, 2013, with an estimated 28% market share in terms of premiums written in Puerto Rico for the year ended December 31, 2012. We have the exclusive right to use the Blue Cross and Blue Shield ( BCBS ) names and marks throughout Puerto Rico and the U.S. Virgin Islands and over 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial and Medicare markets. 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. 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 for *miSalud*. *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 also offer complementary products and services, including life insurance, accident and disability insurance and property and casualty insurance. We are one of the leading providers 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.

In the year ended December 31, 2012, we generated total operating revenues of approximately $2.4 billion, of which approximately 90% was derived from our managed care businesses and 10% from our life insurance and property and casualty insurance businesses. In the three months ended March 31, 2013, we generated total operating revenues of approximately $589.6 million, of which approximately 89% was derived from our managed care businesses and 11% from our life insurance and property and casualty insurance businesses.

### Products and Services

#### Managed Care

Through our subsidiaries, Triple-S Salud, Inc. ( TSS ) and American Health, Inc. ( AH or American Health ), we offer a broad range of managed care products, including Health Maintenance Organization ( HMO ) plans, Preferred Provider Organization ( PPO ) plans, Medicare Supplement, Medicare Advantage, Medicare Part D and Medicaid plans. Managed care products represented approximately 90% of our consolidated premiums earned, net for each of the years ended December 31, 2012, 2011 and 2010. 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

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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:

*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.

*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, 2012, we had enrolled approximately 25,224 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2013.

*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

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employers and *miSalud*. 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, 2012, 2011 and 2010. 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 ( P&C ) insurance products through our subsidiary Triple-S Propiedad, Inc. ( TSP ). Property and casualty insurance premiums represented approximately 4% of our consolidated premiums earned, net for each of the years ended December 31, 2012, 2011 and 2010. 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.

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. Nearly 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, 2012, approximately 39% 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 insured, we believe that the risk of our reinsurers not paying balances due to us is low.

## Our Competitive Strengths

**Strong Brand Recognition and Reputation in Puerto Rico.** We believe that the strength of the Triple-S brand, which we have built throughout our 50+ year operating history in Puerto Rico, and our exclusive license to use the BCBS marks, gives us a significant competitive advantage. As the largest managed care company in Puerto Rico, we serve approximately 45% of the total population and we have the broadest provider network, including over 8,000 physicians. In addition to having one of the most recognized brands in Puerto Rico, we

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believe we enjoy a competitive advantage as a result of our participation in the BlueCard program, which provides our members with coverage for medical attention throughout the United States, the primary travel destination of Puerto Rico residents.

**Attractive Puerto Rico Market.** The Puerto Rico economy is largely driven by the manufacturing and services sectors, and is supported by the presence of major global corporations, with 55 of the Fortune 100 companies having operations on the island. The aging demographics in Puerto Rico make it an attractive region for growth in Medicare, as Puerto Rico s Medicare beneficiary population is approximately 19% of its population, nearly 300 basis points higher than the overall U.S. Furthermore, this segment of the population is growing 30 basis points faster in Puerto Rico than in the overall U.S. We also believe that the high population density on the island facilitates efficiencies in our marketing and outreach efforts.

**Leading Managed Care Platforms.** We are the leading managed care player in Puerto Rico in both the commercial and *miSalud* markets, and we are the #3 Medicare Advantage player on the island following our acquisition of American Health in February 2011. We offer a broad array of both risk and non-risk based managed care solutions and serve multiple customer segments, including corporate customers, individuals, federal government employees, and Medicare eligibles. Our strong provider network and commitment to customer service have helped us to achieve a 97%+ retention rate in 2012 among our major corporate customers.

**Strong Complementary Businesses.** To enhance our relationships with managed care customers, we offer life, disability and P&C insurance products designed to complement the sale of our managed care products and services. Together, our life, disability and P&C businesses account for approximately one-third of our annual operating profit, and we believe that the broad range of our managed care and complementary products provides us with significant opportunities to develop additional points of distribution, particularly among the insurance agencies of Puerto Rico-based financial institutions. In addition, approximately 33% of our sales agents are licensed to sell both life insurance and managed care products.

**Proven and Experienced Management Team.** We have been a market leader in managed care in Puerto Rico for over 50 years and believe that the extensive experience of our management team provides us with a unique competitive advantage. Our President and Chief Executive Officer, Ramón Ruiz-Comas, has been a member of Triple-S s management team for the past 23 years. Mr. Ruiz is also a member of the Board of Directors of the Blue Cross Blue Shield Association ( BCBSA ) and serves as the Chairman of its Audit Committee. Pablo Almodóvar-Scalley, the President of our managed care segment, has also been a member of our management team for the past 23 years. Susan Rawlings, President of our Medicare Advantage unit, has over 20 years of experience in the managed care sector.

## Our Strategy

**Expand Operating Margins and Improve Clinical Outcomes.** As we continue to expand and grow our managed care platform, we are also focusing on a number of initiatives to improve clinical outcomes while also lowering our medical costs. For example, we recently signed a new pharmacy benefits management ( PBM ) contract to help us better manage our drug expenditures. In addition, we have introduced new clinical management programs to reduce unnecessary procedures through the application of electronic medical records. We also remain focused on reducing our operating expenses through the consolidation of our financial and human resources IT systems and the centralization of certain of our corporate functions.

**Implement New Cost Containment Initiatives.** As we continue to build scale and diversify our managed care business, we remain focused on pursuing new strategies aimed at improving efficiencies, reducing costs and improving clinical outcomes. For example, we are improving alignment among our patients and physicians by refining our plan designs based on narrower physician networks. Similarly, in 2012, we acquired a majority stake

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in a Puerto Rico health clinic. We believe we are a pioneer in the delivery of integrated care solutions. As we continue to explore partnership opportunities to strengthen our integrated care model, our goal is to drive better clinical outcomes and reduce overall costs by improving coordination with and among our providers, including physicians.

**Grow Medicare Advantage Business.** We intend to leverage our American Health platform and our BCBS affiliation to expand our share of the Medicare Advantage market in Puerto Rico. We entered the Medicare Advantage market in 2005 and, as of March 31, 2013, we were the #3 player in that market with a market share of approximately 23%. Puerto Rico represents an attractive growth opportunity for Medicare, as the population over the age of 65 is expected to grow approximately 2% per annum until 2025. Given our leadership in serving multiple segments of the managed care population, we are also making proactive efforts to capture the high incidence of dual-eligibles in Puerto Rico and increase our STAR ratings in order to enhance our participation in CMS quality bonus program.

**Pursue Cross-Selling and Related Opportunities.** To expand our relationships with our managed care customers, we intend to capitalize on cross-selling opportunities by taking advantage of our leading brand name and using our internal and external sales forces to sell both managed care and complementary products such as life, disability, and P&C insurance. We have established relationships with leading financial institutions in Puerto Rico, which we believe will allow us to further develop business opportunities in P&C and life insurance products through these institutions agency operations.

**Enhance Shareholder Value through Disciplined Capital Deployment.** We believe that profitable growth, both organic and through acquisitions, is an important part of our business. Since our initial public offering, we have acquired two leading managed care businesses, La Cruz Azul de Puerto Rico and American Health, both of which expanded our customer base and improved our growth profile. We remain focused on acquiring managed care plans and complementary services that expand our product offerings or our geographic footprint, and we continue to explore future opportunities to expand our business outside Puerto Rico into adjacent markets, with a particular focus on Latin America and Hispanic communities in the mainland United States. In addition to any future strategic investments, we remain committed to delivering value to shareholders through opportunistic share repurchase activity.

## The Conversion

Immediately prior to the closing of this offering, we will convert 6,660,423 shares of our Class A common stock into Class B common stock. We refer to this conversion herein as the Conversion. 5,400,368 (or 6,210,423 if the underwriters exercise their over-allotment option in full) of such converted shares will be the Shares sold in this offering. The remaining 1,260,055 shares (or 450,000 shares if the underwriters exercise their over-allotment option in full) converted as part of the Conversion but not sold in the offering, will be subject to a contractual 180-day lock-up period. See Underwriting. On a pro forma basis after giving effect to the Conversion, there were 2,382,386 shares of Class A common stock outstanding as of March 31, 2013.

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**THE OFFERING**

| | |
|---|---|
| Issuer | Triple-S Management Corporation |
| Class B common stock offered by the selling stockholders | 5,400,368 Shares (or 6,210,423 Shares if the underwriters exercise their over-allotment option in full) |
| Class B common stock outstanding after this offering(1) | shares |
| Purchase by Issuer | We may purchase up to $30 million of Shares in this offering at a price of $ per Share, which is the price to the public. |
| Over-allotment option | The selling shareholders have granted the underwriters an option to purchase up to 810,055 additional Shares to cover over-allotments, if any, at the public offering price, less the underwriting discount, within 30 days from the date of this prospectus supplement |
| Voting rights | One vote per Share |
| Use of proceeds | Triple-S will not receive any proceeds from this offering |
| Risk factors | See Risk Factors beginning on page S-12 of this prospectus supplement for a discussion of risks you should carefully consider before deciding to invest in the Shares |
| U.S. federal income tax consequences | For the U.S. federal income tax consequences of the holding and disposition of shares of our Class B common stock, see Material United States Federal Income Tax Considerations |
| NYSE symbol | Our Class B common stock is listed on the NYSE under the symbol GTS |

(1) Based on the number of shares that were issued and outstanding as of March 31, 2013, and after giving effect to the Conversion and the purchase and retirement by us of Shares in this offering. See Purchase by Issuer above. Unless we specifically state otherwise, the information in this prospectus supplement as to the number of shares outstanding does not reflect awards of our Class B common stock available for issuance under our 2007 Incentive Plan. Certain shares of our Class B common stock outstanding after this offering, including those converted as part of the Conversion but not sold in the offering and those owned by our directors and executive officers and the selling shareholders, will be subject to a contractual 180-day lock-up period. See Shares Eligible for Future Sale and Underwriting.

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## SUMMARY CONSOLIDATED FINANCIAL DATA

The table below provides a summary of our historical consolidated financial data for each of the three years in the period ended December 31, 2012 and for the three-month periods ended March 31, 2013 and 2012. We derived the statement of earnings data for the three months ended March 31, 2013 and 2012, and the balance sheet data as of March 31, 2013 and 2012, from our unaudited consolidated financial statements included elsewhere in this prospectus supplement. We derived the statement of earnings data for the three years in the period ended December 31, 2012, and the balance sheet data as of December 31, 2012, 2011 and 2010 from our audited consolidated financial statements included elsewhere in this prospectus supplement.

Our unaudited consolidated financial statements have been prepared on the same basis as our audited consolidated financial statements and, in our opinion, reflect all adjustments, consisting only of normal and recurring adjustments, necessary for a fair presentation of this data in all material respects. The results for any interim period are not necessarily indicative of the results that may be expected for a full year or any other period.

You should read this summary consolidated financial data together with Management s Discussion and Analysis of Financial Condition and Results of Operations and our audited and unaudited consolidated financial statements and accompanying notes thereto included elsewhere in this prospectus supplement.

| | Three Months Ended March 31, | | Year Ended December 31, | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2012 | 2011 | 2010 |
| | (in millions, except per share data) | | | | |
| **Statement of Earnings Data** | | | | | |
| Revenues: | | | | | |
| Premiums earned, net | $ 550.0 | $ 547.3 | $ 2,253.4 | $ 2,054.5 | $ 1,901.1 |
| Administrative service fees | 27.1 | 27.5 | 110.1 | 38.5 | 39.6 |
| Net investment income | 11.3 | 11.2 | 46.8 | 48.2 | 49.1 |
| Other operating revenues | 1.2 | 1.0 | 4.3 | | |
| Total operating revenues | 589.6 | 587.0 | 2,414.6 | 2,141.2 | 1,989.8 |
| Net realized investment gains | 1.9 | 1.7 | 5.2 | 18.6 | 2.5 |
| Net unrealized investment gain (loss) on trading securities | | | | (7.3) | 5.4 |
| Other income, net | 0.5 | 1.1 | 2.2 | 0.7 | 0.9 |
| Total revenues | 592.0 | 589.8 | 2,422.0 | 2,153.2 | 1,998.6 |
| Benefits and expenses: | | | | | |
| Claims incurred | 452.0 | 475.6 | 1,919.8 | 1,716.3 | 1,596.8 |
| Operating expenses | 114.9 | 102.5 | 425.2 | 347.6 | 305.0 |
| Total operating costs | 566.9 | 578.1 | 2,345.0 | 2,063.9 | 1,901.8 |
| Interest expense | 2.4 | 2.6 | 10.6 | 10.8 | 12.6 |
| Total benefits and expenses | 569.3 | 580.7 | 2,355.6 | 2,074.7 | 1,914.4 |
| Income before taxes | 22.7 | 9.1 | 66.4 | 78.5 | 84.2 |
| Income tax expense | 5.5 | 1.6 | 12.5 | 20.5 | 17.4 |
| Net income | 17.2 | 7.5 | 53.9 | 58.0 | 66.8 |
| Net loss attributable to non-controlling interest | 0.0 | 0.0 | (0.1) | | |
| Net income attributable to Triple-S Management Corporation | $ 17.2 | $ 7.5 | $ 54.0 | 58.0 | 66.8 |
| Basic net income per share(1) | $ 0.61 | $ 0.27 | $ 1.91 | 2.02 | 2.30 |

| | | | | | |
|---|---|---|---|---|---|
| Diluted net income per share | $ 0.61 | $ 0.26 | $ 1.90 | 2.01 | 2.28 |

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| | As of March 31, | | As of December 31, | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2012 | 2011 | 2010 |
| | | | (in millions) | | |
| **Balance Sheet Data** | | | | | |
| Cash and cash equivalents | $ 62.6 | $ 135.6 | $ 89.6 | $ 71.8 | $ 45.0 |
| Total assets | 2,088.3 | 2,029.6 | 2,059.3 | 1,880.6 | 1,759.4 |
| Long-term borrowings | 100.8 | 127.7 | 101.3 | 114.4 | 166.0 |
| Total stockholders equity | 787.8 | 700.7 | 762.1 | 677.0 | 617.3 |

| | Three Months Ended March 31, | | Year Ended December 31, | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2012 | 2011 | 2010 |
| **Additional Managed Care Data(2)** | | | | | |
| Medical loss ratio(3) | 85.7% | 90.5% | 88.8% | 87.2% | 88.1% |
| Operating expense ratio | 15.8% | 13.8% | 14.5% | 12.9% | 11.6% |
| Medical membership (period-end) | 1,674,696 | 1,704,005 | 1,721,114 | 1,683,696 | 788,881 |

(1) Further details of the calculation of basic earnings per share are set forth in notes 2 and 22 of the audited consolidated financial statements for the years ended December 31, 2012, 2011 and 2010, included herein.
(2) Does not reflect inter-segment eliminations.
(3) Calculated by dividing managed care claims incurred by managed care premiums earned, net.

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## RISK FACTORS

*Investing in the Shares involves a high degree of risk. You should carefully consider the following risks and all other information contained or incorporated by reference in this prospectus supplement and accompanying prospectus before investing in the Shares. The risks and uncertainties described below are not the only ones we face. Additional risks and uncertainties not presently known to us or that are currently deemed immaterial may also impair our business operations. The occurrence of any of the following risks could materially affect our business, financial condition, operating results, and cash flows.*

### Risks Related 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 such new 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 (the 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, 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 prospectus supplement, only one judicial claim to enforce any of these agreements has been commenced. We have reached an agreement in open court to settle this claim, and are currently negotiating a written settlement agreement and general release. See note 13 to our unaudited consolidated financial statements included elsewhere in this prospectus supplement. Additionally, we have received inquiries with respect to fewer 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

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agreements never occurred, and any obligation that SSS may, or that 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 such 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 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 and 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 prospectus supplement, we are defending six 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 note 13 to our unaudited consolidated financial statements included elsewhere in this prospectus supplement. In addition, we have received inquiries from non-medical heirs with respect to fewer than 700 shares (or 2,100,000 shares after giving effect to the 3,000-for-one stock split).

We believe that we should prevail in litigation with respect to these matters; however, we cannot predict the outcome of any such litigation. 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 capital stock structure 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 as a result of a successful claim against us under any share acquisition agreement or by a non-medical heir. See Certain of our current and former providers may bring materially dilutive claims against us and Heirs of certain of our former shareholders may bring materially dilutive claims against us. We cannot provide any assurances that this mechanism will be effective under all circumstances, particularly as the number of outstanding Class A shares is decreased by the Conversion.

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 to our Class B common stock will not be challenged by providers party to share acquisition agreements 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.

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In the event that claimants acquire shares of 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 at any time because 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. Pursuant to the Conversion we will convert 6,660,423 of the approximately 9 million outstanding Class A shares into Class B shares. See Summary The Conversion.

**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. On a pro forma basis, after giving effect to the Conversion but without giving effect to any purchase of Shares by us in this offering, there were 26,059,262 shares of Class B common stock and 2,382,386 shares of Class A common stock outstanding as of March 31, 2013. Following this offering, 2,866,621 of our shares of Class B common stock (2,056,566 shares if the underwriters exercise their over-allotment option in full), representing shares converted as part of the Conversion and not sold in the offering and other Class B shares owned by our directors and executive officers and the selling shareholders, will be subject to a 180-day contractual lock-up period. See Shares Eligible for Future Sale and Underwriting. 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 of 1933 (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, 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. See Shares Eligible for Future Sale.

**The price of our Class B common stock may be volatile and may be affected by market conditions beyond our control.**

Our share price is likely to fluctuate in the future because of the volatility of the stock market in general and a variety of factors, including those discussed under Risk Factors herein, many of which are beyond our control. Market fluctuations could result in volatility in the price of shares of our Class B common stock, which could lead to a decline in the value of your investment. In addition, if our operating results fail to meet the expectations of stock analysts or investors, or if we are perceived by the market to suffer material business or reputational damage, we may experience a significant decline in the trading price of our Class B common stock.

**Risks Related to Our Business**

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

Substantially all of our managed care revenue is generated by premiums consisting of monthly payments per member that are established by contracts with our commercial customers or CMS (as defined below) (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

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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 (as defined below) amendments under the Stimulus (as defined below), as well as others, such as implementation of ACA (as defined below), 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 Commissioner of Insurance of the Commonwealth of Puerto Rico ( 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.

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

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

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**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 the Centers for Medicare and Medicaid Services ( CMS ). These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is cancellable 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, 2012, 2011 and 2010, contracts with CMS represented 47.6%, 43.6% and 24.6% of our consolidated premiums earned, net, respectively, and 5.0%, 12.5% and 45.2% 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 Office of Personnel Management ( 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, 2012, 2011 and 2010 premiums generated under this contract represented 6.4%, 6.7% and 6.9% of our consolidated premiums earned, net, respectively. The operating income generated under this contract represented 1.6%, 1.3% and 1.0% of our consolidated operating income during the years ended December 31, 2012, 2011 and 2010, respectively.

*Medicaid*

We participate in *miSalud* 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 895,000 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 years ended December 31, 2012 and 2011, operating income generated under this contract represented 46.0% and 7.4% of our consolidated operating income, respectively.

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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.

**The new local government administration is currently evaluating the implementation of some new initiatives through a regional pilot program in an effort to increase access to healthcare through the addition of new beneficiaries to the *miSalud* program, and the creation of a standard basic coverage aimed to promote the use of preventive health services and organ transplant benefits.**

This basic coverage is expected to be extensive to all the inhabitants of Puerto Rico. These new initiatives may impact utilization of health care services and the medical loss ratio ( MLR ). As of the date of this prospectus supplement, there is uncertainty on how these initiatives will be implemented and their likelihood of success.

**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, 2012, 68.4% of our managed care commercial customers had fully insured arrangements and 31.6% had ASO arrangements, as compared to approximately 67.9% and 32.1%, respectively, as of December 31, 2011. 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. For additional information on how each reportable segment determines its claim liabilities, and the variables considered in the development of this amount, see 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 names and marks 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 names and marks in Puerto Rico and the U.S. Virgin Islands. We believe that the BCBS names and marks 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 names and marks. 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

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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 names and marks in Puerto Rico and the U.S. Virgin Islands. Furthermore, the BCBSA would be free to issue a license to use the BCBS names and marks in Puerto Rico and the U.S. Virgin Islands to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Accordingly, termination of a license agreement could have a material adverse effect on our business, financial condition and results of operations.

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

Upon termination of a license agreement, the BCBSA would impose a Re-establishment Fee upon us, which would allow the BCBSA to re-establish a BCBS 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 BCBS enrollees as of December 31, 2012, we would be assessed approximately $164.2 million by the BCBSA. See Business Blue Cross and Blue Shield License.

**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, 2012, 39.0%, or $63.5 million, of the premiums written in the property and casualty insurance segment and 6.0%, or $8.0 million, of the premiums written in the life insurance segment were ceded to reinsurers. 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. 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 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

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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 2012, A.M. Best maintained our property and casualty insurance subsidiary s rating of A- (the fourth highest of A.M. Best s 16 financial strength ratings) with a stable outlook. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary s rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings.

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

*Managed Care*

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of our managed care company. In addition, the managed care market in Puerto Rico is mature. According to the U.S. Census Bureau, Puerto Rico s population decreased by 2.2% between 2000 and 2010, however the U.S. population rate grew 9.7% during the same period. According to the U.S. 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.

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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.

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. See 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 The termination or modification of our license agreements to use the BCBS names and marks 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.

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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;
- 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.

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**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. 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.

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:

- 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; and
- reducing our ability to issue other securities.

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 three months ended March 31, 2013 and 2012 there were no realized losses associated with other-than-temporary impairments. During the year ended December 31, 2012, there were no realized losses associated with other-than-temporary impairments, as compared to the $0.3 million in 2011. The gross unrealized losses of our available-for-sale and held-to-maturity securities were $0.3 million, $0.4 million and $3.1 million at March 31, 2013, December 31, 2012 and 2011, respectively. The gross unrealized gains of our available-for-sale and held-to-maturity securities were $128.9 million, $121.3 million and $85.3 million at March 31, 2013, December 31, 2012 and 2011, respectively. Given current market conditions, there is a continuing risk that declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

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We believe our cash balances, investment securities, operating cash flows, and funds available under 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 corporate customers and individuals 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, oil prices, the 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 continues to face a deficit between recurring government revenues and expenses. The Government has implemented and is currently implementing initiatives geared towards achieving a balanced budget, which are likely to include tax increases. These measures could have the effect of intensifying the current recessionary cycle.

Also, the Employees Retirement System of the government of Puerto Rico ( Employees Retirement System ) anticipates that based on the current contributions and benefit structure, its future cash flow needs for disbursement of benefits to participants, administrative expenses and debt service are likely to continue to exceed the sum of the employer and employee contributions received and its investment and other recurring income. Despite a recent pension reform, the Employees Retirement System may still not have sufficient funds to meet its future cash flow needs.

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. See Management s Discussion and Analysis of Financial Condition and Results of Operations Puerto Rico s Economy.

**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. We only have non-competition agreements in place with four executive officers, including our chief executive officer and chief financial officer.

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

Our business and operations may be affected if we do not maintain and upgrade our information systems and the integrity of our proprietary information. We are materially dependent on our information systems, including Internet-enabled products and information, for all aspects of our business operations. 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 adopting 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.

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Our information systems and applications require an ongoing commitment of significant resources to maintain, upgrade and enhance existing systems and develop new systems in order to keep pace with continuing changes in information processing technology, evolving industry and regulatory standards, compliance with legal requirements (such as a new set of standardized diagnostic codes, known as ICD-10), and changing operational needs. In addition, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable to such third parties failure to perform adequately. If we are unable to maintain effective and efficient information systems, or our failure to efficiently and effectively consolidate our information systems to eliminate redundant or obsolete applications, could have a material adverse effect on our business, financial condition and results of operations. If the information we rely upon to run our business were found to be inaccurate or unreliable or if we fail to maintain our information systems and data integrity effectively 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, have problems in determining medical cost estimates and establishing appropriate pricing and reserves, loss of members, and difficulty in attracting new members, regulatory problems, increases in operating expenses or suffer other adverse consequences.

In addition, federal regulations require that we begin using ICD-10 by October 2014, which will require significant information technology investment. If we fail to adequately implement ICD-10, we may incur losses with respect to the resources invested and have other material adverse effects on our business and results of operations. In order to become ICD-10 compliant, we need to upgrade the version of TSS s core business application, which we completed implementing in the third quarter of 2012. TSS is coordinating ICD-10 implementation efforts with BCBS, service providers, clearing houses, local and federal government stakeholders in order to insure a timely compliance.

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. We are taking all needed security measures to prevent security breaches, and ensure our business operations won t be adversely affected by potential security breaches.

In September 2010, we learned of a breach and other unauthorized access to a specific internet database managed by Triple-C, Inc. ( TCI ). See note 13 to our unaudited consolidated financial statements included elsewhere in this prospectus supplement. 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.

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**We face risks related to litigation.**

In addition to the litigation risks discussed above in Risks Related to Our Capital Stock, we are, or may be in the future, a party to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we may be subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services. These could include:

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

We are a defendant in various lawsuits, some of which involve claims for substantial and/or indeterminate amounts and the outcome of which is unpredictable. While we are defending these suits vigorously, we will incur expenses in the defense of these suits. Any adverse judgment against us resulting in damage awards could have an adverse effect on our cash flows, results of operations and financial condition. See Item 3. Legal Proceedings on page 52 of our Annual Report on Form 10-K for the year ended December 31, 2012 incorporated by reference herein and note 13 to our unaudited consolidated financial statements included elsewhere in this prospectus supplement.

**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 loans and note purchase agreements may restrict our operations.**

We are a party to secured loans with two commercial banks for an aggregate amount of $30.7 million, for which we have outstanding balances of $17.3 and $13.4 million as of March 31, 2013, respectively. Also, we have an aggregate principal amount of $45.0 million of senior

unsecured notes outstanding, consisting of a $35.0 million aggregate principal amount of 6.60% notes due 2020 and a $10.0 million aggregate principal amount of 6.70% notes due 2021 (collectively, the notes). The secured term loans 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 loans 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

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outstanding debt obligations under our secured term loans or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the secured term loans, cease to make further extensions of credit. If the indebtedness under our secured term loans 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.

**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 or under-estimated 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;
- establish goodwill or other intangible assets as a result of a future business combination, which may be incorrectly valued or become non-recoverable;

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.

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**If our goodwill or intangible assets become impaired, it may adversely affect our financial condition and future results of operations.**

As of December 31, 2012 we had approximately $27.8 million and $26.9 million of goodwill and intangible assets recorded on our balance sheet, primarily related to the AH acquisition, that represent 2.7% of our total consolidated assets and 7.2% of our consolidated stockholders equity. If we make additional acquisitions it is likely that we will record additional goodwill and intangible assets on our consolidated balance sheet.

In accordance with applicable accounting standards, we periodically evaluate our goodwill and other intangible assets to determine the recoverability of their carrying values. Goodwill and other intangible assets with indefinite lives are tested for impairment at least annually. Impairment testing requires us to make assumptions and judgments regarding the estimated fair value of our reporting units, including goodwill and other intangible assets (with indefinite lives). 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 equity and other intangible assets with indefinite lives in future impairment tests, or if significant impairment indicators are noted relative to other intangible assets subject to amortization, we may be required to record significant impairment losses against future income. Factors that may be considered a change in circumstances, indicating that the carrying value of the goodwill or amortizable intangible assets may not be recoverable, include reduced future cash flow estimates and slower growth rates in the industry.

Any future evaluations requiring an impairment of our goodwill and other intangible assets could adversely affect our results of operations and stockholders equity in the period in which the impairment occurs. A material decrease in stockholders equity could, in turn, negatively impact our debt ratings or potentially impact our compliance with existing debt covenants

In addition, the estimated value of our reporting units may be impacted as a result of the implementation of various health care reform regulations. Such regulations could have significant effects on our future operations, which in turn could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets and result in significant impairment charges in future periods. See Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates Goodwill and Other Intangible Assets.

**Risks Related to Taxation**

**If we are 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 our shares of Class B common stock could be subject to adverse tax consequences.**

We do not expect that we 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 we will not be a RPII CFC in any taxable year. We do not intend to monitor whether we generate RPII or become a RPII CFC. If we were a RPII CFC in any taxable year, certain adverse tax consequences could apply to U.S. persons that own our shares of Class B common stock. See Material United States Federal Income Tax Considerations Related Person Insurance Income Rules.

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**If we are 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.**

Based on our current business assets and operations, we do not expect that we will be considered a passive foreign investment company (a PFIC ) for U.S. federal income tax purposes. However, because PFIC status depends upon the composition of our income and assets and the market value of our assets (including, among others, less than 25 percent owned equity investments) in each year, which may be uncertain and may vary substantially over time, there can be no assurance that we will not be considered a PFIC for any taxable year. Our belief that we are 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 we were treated as a PFIC for any taxable year, certain adverse consequences could apply to certain U.S. persons that own our shares of Class B common stock. See Material United States Federal Income Tax Considerations Passive Foreign Investment Company Rules.

## Risks Related 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. See 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.

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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, which in turn could impact the value of our business model and result in potential impairments of our goodwill and other intangible assets.

**The health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.**

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, on March 30, 2010 (collectively, the ACA ) provides comprehensive changes to the U.S. health care system, which are being phased in at various stages through 2018. The legislation imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes. If this federal premium tax is imposed as enacted, and if the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this new tax, our results of operations, financial position and liquidity may be materially adversely affected.

There are numerous outstanding steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities.

Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our business may be materially adversely affected.

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

Under recently promulgated CMS regulations to implement certain ACA requirements that became effective on June 1, 2012, CMS has the authority not to renew our contracts at the beginning of 2015 based solely on our Star Ratings if our ratings do not improve to three or more stars for at least one of the three contract years starting in 2013 and ending in 2015. See Business Regulation Federal Regulations. In addition, CMS has the existing authority to terminate any of our Medicare Advantage contracts or our Part D contract before 2014 if it determines that any of these plans has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage or Part D program. Any termination or non-renewal of our Medicare Advantage or Part D plans would have a material adverse effect on our business and financial results.

Beginning in 2012, Medicare Advantage plans with an overall Star Rating of three or more stars (out of five) are eligible for a quality bonus in their basic premium rates. Initially, quality bonuses were limited to the few plans that achieved 4 or more stars as their overall Star Rating, but CMS is using demonstration authority to

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expand the quality bonus to 3 star plans for a three year period through 2014. Also beginning in 2012, Medicare Advantage Star Ratings affect the rebate percentage available for plans to provide additional member benefits (plans with quality ratings of 3.5 stars or above will have their rebate percentage increased from a base rate of 50% to 65% or 70%). In all cases, these rebates percentages are lower than the previous percentage of 75%. Furthermore, CMS has informed plan sponsors nationwide of its intention to implement a series of initiatives beginning in 2012 to encourage beneficiaries to receive care through plans that receive Star Ratings of 3 stars or higher. These initiatives include: (i) permitting beneficiaries upon request to change during the 2012 contract year to a plan with a 3 Star Rating or higher rating if one is available in the beneficiary s area; (ii) notifying beneficiaries in low rated plans of their plan s low rating and advising them of their ability to elect another plan with a Star Rating of 3 or higher in 2013; (iii) limiting a low rated plan s ability to accept enrollments online through the Medicare Plan Finder; and (iv) limiting the scope and detail of information about low rated plans set forth in the CMS Medicare & You handbook.

TSS has a contract with CMS with regards to three Medicare Advantage plans and one stand-alone Part D plan. AH has a single plan covering both Part C and Part D services. TSS s HMO plan (which covers approximately 11,000 members) was rated in 2011 by CMS at 2 stars, and the other four plans (which cover approximately 109,000 members) were rated by CMS at 2.5 stars, out of a possible five stars. Two of the plans the TSS HMO plan and the AH plan have received Star Ratings of less than 3 stars for three or more consecutive years. As a consequence, CMS requested that we submit corrective action plans ( CAPs ) for these two plans by June 29, 2012 that set forth an achievable framework to improve the Star Ratings to 3 stars or higher. We timely submitted the required action plans. CMS recently issued its Star Ratings for 2013. One of our plans, the AH plan, increased their ratings to 3 stars. Our other four plans received Star Ratings of 2.5 stars, and three of these plans have received a Star Rating lower than three stars for each of the past three years. As a result, CMS informed TSS in October 2012 that it was going to issue notices to enrollees concerning these three plans alerting them of the plans low rating, encouraging them to explore higher rated plan options, and offering them the opportunity to move into higher quality plans during a special enrollment period in 2013.

Due to our plans 2012 Star Ratings, we are not eligible for full level quality bonuses or increased rebates in 2012 or 2013. The AH plan s 3 star rating for 2013 will qualify that plan for the quality bonus corresponding to that rating and rebate adjustment in 2014. The remaining plans will not be eligible for such bonuses or rebates in 2014. This situation could adversely affect the broadness of the benefits such plans can offer, and reduce their membership and profit margins.

From April 30, 2012 through May 4, 2012, the Medicare Advantage programs of TSS and AH were audited by CMS. This full performance audit review focused on our organization performance in Part D formulary and benefit administration, Part D coverage determinations, appeals and grievances, Part C organizational determinations, appeals and grievances, and dismissals, agent/broker oversight, Part C access to care, Part C and Part D enrollment, disenrollment, late enrollment penalty and compliance program effectiveness. On May 10, 2012, as part of these audits, CMS notified TSS that it was noncompliant with multiple CMS drug formulary administration requirements and beneficiary coverage determination, appeals and grievances requirements. On October 9, 2012, CMS imposed a $350,000 civil monetary penalty on TSS for the formulary and benefit administration violations discovered during the audit, as well as for noncompliance with CMS disenrollment requirements. The AH plan was not subject to any sanctions.

CMS conducted several validation studies to determine whether the immediate CAPs were effective in remedying the deficiencies discovered at TSS during the audit. On October 17, 2012 CMS notified TSS that it passed the second validation study for the CAP related to Part D coverage determinations, appeals and grievances. CMS validation of the formulary administration is ongoing. Also on October 17, 2012, CMS issued a draft report of its TSS and AH plan audits. The report contained various findings in all five plans. Our response to the report was issued on January 30, 2013.

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We made significant changes in our operations to ensure compliance with all applicable CMS requirements for our Medicare Advantage and Part D plans, including the engagement of additional pharmacy benefit management support, and the consolidation of all our plans under a single management team. We are devoting the resources and management attention we believe necessary to improve our Star ratings, but cannot warrant that we will be completely successful in increasing TSS to 3 stars or higher. Our failure to achieve Star Ratings of 3 or higher, or to otherwise improve our administration of these plans, would jeopardize our ability to attract and retain members in our Medicare Advantage and Part D plan, as well as our ability to continue to participate in these federal programs and to successfully bid for future CMS contracts in these programs.

In the course of a compliance assessment conducted in January 2013, our Medicare Advantage compliance department reviewed the files of twenty network providers in TSS s Medicare Advantage plan network and found that these files did not comply with TSS s policy for documenting the verification of provider credentials nor with the credentialing or re-credentialing documentation requirements mandated by CMS for Medicare Advantage plans. Upon learning of this issue, we voluntarily disclosed it to CMS and prepared a CAP to validate that the credentials of all of TSS s Medicare Advantage network providers have been verified and documented in compliance with CMS requirements.

CMS informed the Administration for Health Insurance of the government of Puerto Rico ( ASES ) of this credentialing issue and on February 25, 2013, ASES issued a notice of breach to TSS pursuant to our *miSalud* contract, requesting that we submit a written CAP for its approval and advising us that failure to comply with its request could result in the imposition of sanctions. On March 4, 2013, we timely submitted a CAP to ASES for its approval and, at ASES request, supplemented it on April 5, 2013. If we fail to implement an adequate CAP, ASES may impose sanctions, which could include liquidated damages or contract termination. Any penalty that ASES ultimately imposes could materially adversely affect our business, financial condition, operating results and cash flows.

We are currently implementing both our CAPs by reviewing the credentialing files of all of TSS s Medicare Advantage and *miSalud* medical providers. As part of this review, we have confirmed that the credentialing and re-credentialing procedures in place for American Health s Medicare Advantage plan substantially comply with CMS requirements. Because approximately 5,600, or 56%, of the providers in TSS s Medicare Advantage plan are also credentialed under American Health s Medicare Advantage plan, CMS has agreed to treat the credentialing and re-credentialing by American Health as satisfying such requirements for TSS s MA network as well. We expect to complete our CAPs by October 2013.

Although we believe this validation process is adequate, we can give no assurances as to how many of TSS s current Medicare Advantage or *miSalud* providers may have incomplete credentialing files and, in this event, whether we will be able to obtain sufficient information to satisfy CMS or ASES requirements with respect to each provider. However, we have confirmed that all providers of TSS s *miSalud* and MA network are duly licensed under Puerto Rico law and are not on the exclusion list of the Office of Inspector General ( OIG ). Therefore, we believe this credentialing issue does not pose a material risk to the health of our beneficiaries.

We are still in preliminary discussions with CMS regarding this issue, and understand they are considering several actions to take in response to TSS s credentialing shortfall. We believe these actions could range from a monetary fine, to a ban on certain marketing by TSS to a termination of TSS s Medicare Advantage contract with CMS. Although we believe our self-reporting of this issue and our initiative in correcting this problem may result in limitation of the penalty, any penalty that CMS ultimately imposes could materially adversely affect our business, financial condition, operating results and cash flows.

Beginning January 1, 2013, all of our Medicare Advantage plans are being managed by AH, so that all are internally managed under the same administrative oversight and infrastructure.

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**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 ( OCR ) of the U.S. Department of Health and Human Services ( HHS ), the U.S. Department of Justice ( DOJ ), the U.S. Department of Labor ( DOL ), and the OPM, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations. We may also become the subject of non-routine regulatory or other investigations or proceedings brought by these or other authorities, and our compliance with and interpretation of applicable laws and regulations may be challenged. In addition, our regulatory compliance may also be challenged by private citizens under the whistleblower provisions of applicable laws. The defense of any such challenge could result in substantial cost, diversion of resources, and a possible material adverse effect on our business.

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

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

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

**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.

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**If we fail to comply with applicable privacy and security laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, or if we fail to address emerging security threats or detect and prevent privacy and security incidents, our business, reputation, results of operations, financial position and cash flows could be materially and adversely affected.**

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. HIPAA also requires business associates as well as covered entities to comply with certain privacy and security requirements. Even though we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we still have limited oversight or control over their actions and practices.

Our facilities and systems and those of our third-party service providers may be vulnerable to privacy and security incidents; security attacks and breaches; acts of vandalism or theft; computer viruses; coordinated attacks by activist entities; emerging cybersecurity risks; misplaced or lost data; programming and/or human errors; or other similar events. Emerging and advanced security threats, including coordinated attacks, require additional layers of security which may disrupt or impact efficiency of operations.

Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain our ability to manage our business model. For example, final HHS regulations released in January 2013 implementing the ARRA amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows.

Noncompliance or findings of noncompliance with applicable laws, regulations or requirements, or the occurrence of any privacy or security breach involving the misappropriation, loss or other unauthorized disclosure of sensitive personal information, whether by us or by one of our third-party service providers, could have a material adverse effect on our reputation and business, including mandatory disclosure to the media, significant increases in the cost of managing and remediating privacy or security incidents and material fines, penalties and litigation awards, among other consequences, any of which could have a material and adverse effect on our results of operations, financial position and cash flows.

**The revised rate calculation system for Medicare Advantage, the payment system for the Medicare Part D, and changes in the methodology and payment policies used by CMS to establish rates could reduce our profitability and the benefits we offer our beneficiaries.**

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. For 2013, if the accepted bid is less than the benchmark, Medicare pays the plan its bid plus a rebate of 58.3% of the amount by which the benchmark exceeds the bid, if the star rating is 3.5 or 4 stars the rebate is 68.3% of the amount by which the benchmark exceeds the bid and if the star rating is 4.5 or 5 stars the rebate is 71.7% 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.

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CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability.

A number of legislative proposals, as well as 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 county benchmarks to Medicare fee for service expenditures, or other means. The CMS Advance Notice of Methodological Changes for Calendar Year 2014 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter, (the Advance Notice ) released on February 15, 2013, would have resulted in rate cuts in Puerto Rico that exceed the mandated ACA premium reductions. However, on April 1, 2013, when CMS issued the final notice of these new rates, it acknowledged certain differences between Puerto Rico and the mainland in Medicare enrollment, cost, and use patterns. As a result CMS modified the rate calculation methodology for Puerto Rico in a manner that mitigates, to some extent, the rate reductions that would have resulted from the changes announced in the Advance Notice. We are still reviewing the specifics of the new rates to determine the potential financial impact to Triple-S for 2014 and are unable to predict with certainty the impact on future revenues or profitability as a result of these changes.

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

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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 were 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 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 Medicare Modernization Act of 2003 (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 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 sometime after the disenrollment. 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.

**Medicare and Medicaid spending by the federal government could be decreased as part of the spending cuts associated with the debt ceiling.**

The Sequestration Transparency Act of 2012 (P.L. 112-155) requires President Obama to submit to Congress a report on the potential sequestration triggered by the failure of the Joint Selective Committee on Deficit Reduction to propose, and Congress to enact, a plan to reduce the deficit by $1.2 trillion, as required by the Budget Control Act of 2011. The sequestration resulted in cuts of 2% ($11.1 billion) to Medicare on March 1, 2013.

We cannot predict whether Congress will take any action to change the automatic spending cuts. Further, we cannot predict how states will react to any changes that occur at the federal level.

**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

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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 names and marks 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 OCR for the Primary and Security Rules, CMS for security and electronic transactions, the DOJ for criminal violations, and by States Attorneys General. In addition, CMS advised all Medicare Advantage plans, including TSS and AH, of CMS s 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.

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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 Omnibus Rule. 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 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 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.

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## USE OF PROCEEDS

The selling shareholders will receive all of the net proceeds from the sale of the Shares. We will not receive any proceeds from this offering.

## PRICE RANGE OF CLASS B COMMON STOCK

Our Class B common stock is quoted on the NYSE under the symbol GTS. The following table sets forth for the indicated periods the high and low sales prices per share for our Class B common stock on the NYSE:

| | Price Range | |
|---|---|---|
| | **High** | **Low** |
| **2013** | | |
| First Quarter | $ 19.61 | $ 17.03 |
| Second Quarter (through May 10) | 20.19 | 16.88 |
| **2012** | | |
| First Quarter | $ 24.99 | $ 19.79 |
| Second Quarter | 23.20 | 16.63 |
| Third Quarter | 21.60 | 17.50 |
| Fourth Quarter | 21.17 | 16.05 |
| **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 |

## DIVIDEND POLICY

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.

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## CAPITALIZATION

The following table sets forth our cash and cash equivalents and our capitalization as of March 31, 2013:

on an actual basis;

on an as adjusted basis to give effect to the Conversion (See Summary The Conversion ) and the purchase and retirement by us of Shares in the offering at a price of $ per Share.

The following table should be read in conjunction with the information under Management s Discussion and Analysis of Financial Condition and Results of Operations and our consolidated financial statements and related notes thereto included in this prospectus supplement.

| | March 31, 2013 | |
|---|---|---|
| | Actual | As Adjusted |
| | (unaudited, dollar amounts in thousands) | |
| Cash and cash equivalents | $ 62,595 | $ |
| Long-term borrowings | $ 100,778 | $ 100,778 |
| Shareholders equity | | |
| Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 9,042,809 at March 31, 2013 | $ 9,043 | $ 2,382 |
| Common Stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 19,398,839 at March 31, 2013 | 19,399 | |
| Additional paid-in capital | 145,278 | |
| Retained earnings | 556,999 | 556,999 |
| Accumulated other comprehensive income | 56,916 | 56,916 |
| Total Triple-S Management Corporation stockholders equity | 787,635 | |
| Non-controlling interest in consolidated subsidiary | 185 | 185 |
| Total shareholders equity | 787,820 | |
| **Total capitalization** | **$ 888,598** | **$** |

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## MANAGEMENT S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

*The following discussion and analysis ( MD&A ) of our financial condition and results of operations covers each of the three years ended December 31, 2012 and the three months ended March 31, 2013 and 2012. References to the terms we, our or us used throughout this MD&A, refer to TSM and unless the context otherwise requires, its direct and indirect subsidiaries. This analysis should be read in its entirety and in conjunction with the audited and unaudited consolidated financial statements, notes and tables included elsewhere in this prospectus supplement.*

### Overview

We are 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 Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plan ( PDP )) markets. In the Commercial market we are the largest provider of managed care products. We offer products to corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement. We also participate in *miSalud* (a government of Puerto Rico-funded managed care program for the medically indigent that is similar to the Medicaid program in the U.S.), by administering the provision of the physical health component in designated service regions in Puerto Rico. For the three months ended March 31, 2013, operating income generated under the Medicaid program represented 34% of our consolidated operating income. See Risk Factors Risks Related to Our Business We are dependent on a small number of government contracts to generate a significant amount of the revenues of our managed care business for more details of our Medicaid contract.

We have the exclusive right to use the BCBS names and marks throughout Puerto Rico and U.S. Virgin Islands. As of March 31, 2013 we serve approximately 1,675,000 members across all regions of Puerto Rico For the three months ended March 31, 2013, our managed care segment represented approximately 90% of our total consolidated premiums earned. 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 13.1% (in terms of direct premiums) during the year ended December 31, 2011. Our property and casualty segment had a market share of approximately 8.8% (in terms of direct premiums) during the year ended December 31, 2012.

We participate in the managed care market through our subsidiaries TSS and AH. TSS is a BCBSA licensee, which provides us with exclusive use of the BCBS names and marks throughout Puerto Rico and U.S. Virgin Islands. Also, as of January 1, 2013, AH was granted the license to use the names and marks of the BCBSA in Puerto Rico.

We participate in the life insurance market through our subsidiary, TSV and in the property and casualty insurance market through our subsidiary, TSP, each one representing approximately 6% and 4%, respectively, of our consolidated premiums earned, net for the three months ended March 31, 2013.

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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 for each segment presented in this prospectus supplement 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:

| | Three Months Ended March 31, | | Year Ended December 31, | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2012 | 2011 | 2010 |
| | (Dollar amounts in millions) | | | | |
| **Premiums earned, net:** | | | | | |
| Managed care | $ 493.9 | $ 495.8 | $ 2,033.5 | $ 1,846.4 | $ 1,700.3 |
| Life insurance | 31.8 | 30.0 | 124.7 | 113.0 | 105.8 |
| Property and casualty insurance | 24.9 | 22.2 | 97.7 | 97.6 | 99.2 |
| Intersegment premiums earned | (0.6) | (0.7) | (2.5) | (2.5) | (4.2) |
| Consolidated premiums earned, net | $ 550.0 | $ 547.3 | $ 2,253.4 | $ 2,054.5 | $ 1,901.1 |
| **Administrative service fees** | | | | | |
| Managed care | $ 28.1 | $ 28.7 | $ 114.8 | $ 43.0 | $ 43.2 |
| Inter segment administrative service fees | (1.0) | (1.2) | (4.7) | (4.5) | (3.6) |
| Consolidated administrative service fees | $ 27.1 | $ 27.5 | $ 110.1 | $ 38.5 | $ 39.6 |
| **Operating income:** | | | | | |
| Managed care | $ 20.5 | $ 7.4 | $ 47.0 | $ 53.0 | $ 63.8 |
| Life insurance | 4.0 | 4.4 | 16.7 | 17.7 | 17.3 |
| Property and casualty insurance | 0.4 | (1.4) | 6.8 | 4.5 | 3.6 |
| Inter segment and other | (2.2) | (1.5) | (0.9) | 2.1 | 3.3 |
| Consolidated operating income | $ 22.7 | $ 8.9 | $ 69.6 | $ 77.3 | $ 88.0 |

**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

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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.

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 ASO contracts, including claims administration, billing, access to our provider networks and membership services. Effective November 1, 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 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 to a significant extent 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 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,

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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.

## Membership

Our results of operations 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 1, 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, 2012 and 2011, the Medicare membership attributable to AH was 50,883 and 47,522, respectively.

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

| | As of March 31, | | As of December 31, | | |
|---|---|---|---|---|---|
| | **2013** | **2012** | **2012** | **2011** | **2010** |
| Commercial(1) | 686,706 | 707,768 | 703,072 | 711,508 | 725,328 |
| Medicare(2) | 113,821 | 120,007 | 122,741 | 113,431 | 63,553 |
| Medicaid(3) | 874,169 | 876,230 | 895,301 | 858,757 | |
| Total | 1,674,696 | 1,704,005 | 1,721,114 | 1,683,696 | 788,881 |

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

## Recent Developments

### Puerto Rico s Economy

Puerto Rico s economy is currently in a recession that began in the fourth quarter of fiscal year 2006, during which the real gross national product grew by only 0.5%. For fiscal years 2007, 2008, 2009, 2010 and 2011 the real gross national product contracted by 1.2%, 2.9%, 3.8%, 3.4%, and 1.5% respectively. The Puerto Rico Planning Board (the Planning Board ) currently projects an increase of 0.9% in real gross national product for fiscal year 2012 and an increase of 1.1% in real gross national product for fiscal year 2013.

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In fiscal year 2011, aggregate personal income was $59.4 billion and personal income per capita was $15,995. From fiscal year 2000 to fiscal year 2011, total employment decreased at an average annual rate of 0.6%, from 1,150,291 to 1,077,006. A reduction in total employment began in the fourth quarter of fiscal year 2006 and has continued consistently through fiscal year 2011 due to the current recession and fiscal adjustment measures. During fiscal year 2012, the unemployment rate dropped below 15% for the first time since 2009.

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 recent years economic growth in Puerto Rico has not been consistent with the performance of the United States economy.

The dominant sectors of the Puerto Rico economy in terms of production and income are manufacturing and services. 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.

Since 2000, the Government of Puerto Rico (the Government ) has faced a number of fiscal challenges, including a continued imbalance between its general fund revenues and expenditures, reaching its highest level in fiscal year 2009 with a deficit of $3.3 billion. Deficits were generally bridged through the use of non-recurring measures, such as borrowings, postponing payments to suppliers, and other one-time measures such as the use of derivatives and borrowings collateralized with government-owned real estate.

Recurrent budget deficits have substantially increased the amount of public sector debt. The total outstanding public sector debt amounted to $69.3 billion as of March 31, 2012. Gross National Product as of the end of fiscal year 2011 (from July 1, 2010 to June 30, 2011) was $64.1 billion, resulting in a debt/GNP ratio of 108%. Another obligation of the Government is an unfunded liability of the government public pension funds, which have funded ratios below 10%. The Government Employees Retirement System ( ERS ), the biggest of these public pension funds, announced in November 2012 that the total unfunded liability of all funds amounts to $37.3 billion.

In December 2012, Moody s downgraded Puerto Rico General Obligation debt from Baa1 to Baa3, combined with a negative outlook. In March 2013, Standard & Poor s downgraded Puerto Rico General Obligation debt to BBB-, combined with a negative outlook. In March 2013, Fitch also downgraded Puerto Rico General Obligation debt to BBB-, combined with a negative outlook. Most related Puerto Rico credits have also been downgraded over the same time period.

The rating agencies cite continued financial deterioration of Puerto Rico, continued weak economic growth forecasts, high and growing debt levels, and a high level of retirement liabilities. The lowest investment grade rating combined with a negative outlook by all rating agencies, reflects the challenge Puerto Rico will face attempting to address the underfunded pension systems from an already weak financial and economic position. We depend on Government contracts for a significant amount of our consolidated revenues. If the Government is unable to fund payment on these contracts, our results of operations would be materially affected.

In recent years, the Government has been focused on implementing measures to achieve fiscal balance, restore economic growth, finding solutions for its underfunded pension system and thereby safeguarding the investment-grade ratings of its bonds. Measures taken include (1) a reduction in the amount of Governmental employees, (2) tax reform, (3) privatization of the airport and certain highways through public-private partnerships, and, more recently, (4) a pension reform reducing benefits and increasing retirement age. To address the economic situation in Puerto Rico the Government may take other revenue raising measures, such as amending current taxation law, including sales tax and the implementation of a tax on insurance premiums, which could have a material adverse effect on our business, financial condition and results of operations.

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**Managed Care Medicaid Business**

The ASO contract with ASES, under which we provide services to the medically indigent population in five designated regions, expires on June 30, 2013, the end of the Government s fiscal year. As of the date of this prospectus supplement, ASES has not issued a request for proposals for the continuation of these services during its 2013-2014 fiscal year. However, ASES s Executive Director recently made a public statement indicating that the contracts for the administration of the Medicaid program, which includes ours, will be extended. He also indicated that the only amendments will be of a procedural nature, with no change in coverage for beneficiaries. He did not indicate until when the contract will be extended.

## Results of Operations

**Consolidated Operating Results**

The following table sets forth our consolidated operating results for the three months ended March 31, 2013 and 2012 and the years ended December 31, 2012, 2011 and 2010. Further details of the results of operations of each reportable segment are included in the analysis of operating results for the respective segments.

| | Three Months Ended March 31, | | Years ended December 31, | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2012 | 2011 | 2010 |
| | (Dollar amounts in millions) | | | | |
| Revenues: | | | | | |
| Premiums earned, net | $ 550.0 | $ 547.3 | $ 2,253.4 | $ 2,054.5 | $ 1,901.1 |
| Administrative s service fees | 27.1 | 27.5 | 110.1 | 38.5 | 39.6 |
| Net investment income | 11.3 | 11.2 | 46.8 | 48.2 | 49.1 |
| Other operating revenues | 1.2 | 1.0 | 4.3 | | |
| Total operating revenues | 589.6 | 587.0 | 2,414.6 | 2,141.2 | 1,989.8 |
| Net realized investment gains | 1.9 | 1.7 | 5.2 | 18.6 | 2.5 |
| Net unrealized investment gain (loss) on trading securities | | | | (7.3) | 5.4 |
| Other income, net | 0.5 | 1.1 | 2.2 | 0.7 | 0.9 |
| Total revenues | 592.0 | 589.8 | 2,422.0 | 2,153.2 | 1,998.6 |
| Benefits and expenses: | | | | | |
| Claims incurred | 452.0 | 475.6 | 1,919.8 | 1,716.3 | 1,596.8 |
| Operating expenses | 114.9 | 102.5 | 425.2 | 347.6 | 305.0 |
| Total operating costs | 566.9 | 578.1 | 2,345.0 | 2,063.9 | 1,901.8 |
| Interest expense | 2.4 | 2.6 | 10.6 | 10.8 | 12.6 |
| Total benefits and expenses | 569.3 | 580.7 | 2,355.6 | 2,074.7 | 1,914.4 |
| Income before taxes | 22.7 | 9.1 | 66.4 | 78.5 | 84.2 |
| Income tax expense | 5.5 | 1.6 | 12.5 | 20.5 | 17.4 |
| Net income | 17.2 | 7.5 | 53.9 | 58.0 | 66.8 |
| Net loss attributable to non-controlling interest | | | (0.1) | | |
| Net income attributable to TSM | $ 17.2 | $ 7.5 | $ 54.0 | $ 58.0 | $ 66.8 |

**Three Months Ended March 31, 2013 Compared to Three Months Ended March 31, 2012**

***Operating Revenues***

Consolidated premiums earned, net for the three months ended March 31, 2013 increased by $2.7 million or 0.5%, to $550.0 million when compared to the three months ended March 31, 2012. This increase is the net result

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of increases in the premiums earned, net of the Life Insurance and the Property and Casualty Insurance segments of $1.8 million and $2.7 million, respectively, offset in part by a $1.9 million decrease in Managed Care premiums mostly driven by a lower member month enrollment across all sectors.

The consolidated administrative service fees of $27.1 million decreased by $0.4 million, or 1.5%, when compared to prior period.

***Net Realized Investment Gains***

Consolidated net realized investment gains of $1.9 million during the 2013 period are the result of net realized gains, mainly from the sale of debt and equity securities.

***Claims Incurred***

Consolidated claims incurred decreased by $23.6 million, or 5.0%, to $452.0 million during the three months ended March 31, 2013 when compared to the claims incurred during the three months ended March 31, 2012, mostly in the Medicare and Commercial businesses of the Managed Care segment. Medical claims incurred in Managed Care decreased mostly as a result of lower utilization and cost trends as well as to the effect of favorable prior period reserve developments, mostly driven by better than expected utilization trends. The lower member month enrollment in this segment also contributed to the decreased claims incurred. The consolidated loss ratio decreased by 470 basis points to 82.2%.

***Operating Expenses***

Consolidated operating expenses during the three months ended March 31, 2013 increased by $12.4 million, or 12.1%, to $114.9 million as compared to the operating expenses during the three months ended March 31, 2012. For the three months ended March 31, 2013, the consolidated operating expense ratio increased by 210 basis points to 19.9%. The higher operating expenses and operating expenses ratio are mainly related to special technology initiatives, expenses related to the reorganization of the Medicare business, higher payroll and related expenses mostly as a result of recruitment of additional Medicare sales force, and an increase in professional services related to our CMS star ratings efforts.

***Income Tax Expense***

Consolidated income tax expense during the three months ended March 31, 2013 increased by $3.9 million, to $5.5 million, as compared to the income tax expense for the three months ended March 31, 2012. The effective tax rate increased by 660 basis points to 24.2%. The higher effective tax rate is the result of the increase in the taxable income of the Managed Care segment, which operates at a higher effective tax rate.

**Year ended December 31, 2012 compared with the year ended December 31, 2011**

***Operating Revenues***

Consolidated premiums earned, net increased by $198.9 million, or 9.7%, to $2.3 billion during the year ended December 31, 2012 compared to the year ended December 31, 2011. The increase was mostly the result of the higher member month enrollment in the Medicare and Commercial business, attributed to the new members acquired from AH on February 2011 and organic growth, as well as to the receipt of higher risk score adjustments from CMS in 2012 as compared to 2011.

The increase in the administrative service fees of the Managed Care segment of $71.6 million, or 186.0%, to $110.1 million 2012 is attributed to a higher amount of self-insured contracts after resuming our participation in the Medicaid sector.

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Consolidated net investment income decreased by $1.4 million, or 2.9%, to $46.8 million during the year ended December 31, 2012 mostly as the result of lower yields in fixed income investments acquired during the period.

Other operating revenues of $4.3 million are related to the operations of the health clinic we acquired during the first quarter of 2012.

***Net Realized Investment Gains***

Consolidated net realized investment gains of $5.2 million during the year ended December 31, 2012 are the result of net realized gains from the sale of debt and equity securities available for sale, as part of asset/liability management and tax planning strategies.

***Other Income, Net***

The $1.5 million increase in the consolidated other income primarily results from a lower loss on derivative instruments in 2012. The derivative instruments we held matured during the second quarter of 2012.

***Claims Incurred***

Consolidated claims incurred during the year ended December 31, 2012 increased by $203.5 million, or 11.9%, to $1.9 billion when compared to the claims incurred during the year ended December 31, 2011, mostly due to claims incurred in the Managed Care segment. The increased claims incurred of the Managed Care segment result from higher utilization and cost trends, particularly in the Medicare business. The Life and Property and Casualty segments also experienced increases in claims incurred. The consolidated loss ratio increased by 170 basis points to 85.2%.

***Operating Expenses***

Consolidated operating expenses during the year ended December 31, 2012 increased by $77.6 million, or 22.3%, to $425.2 million as compared to the operating expenses during the year ended December 31, 2011. For the year ended December 31, 2012, the consolidated operating expense ratio increased by 140 basis points to 18.0%, primarily reflecting the higher amount of self-insured contracts after resuming our participation in the Medicaid sector effective November 1, 2011, plus higher expenses in external consultants partly related to the MA business planning and integration.

***Income Tax Expense***

Consolidated income tax expense during the year ended December 31, 2012 decreased by $8.0 million, or 39.0%, to $12.5 million as compared to the income tax expense during the year ended December 31, 2011. The effective tax rate decreased by 730 basis points, to 18.8%, during the year ended December 31, 2012. The consolidated income tax expense for the year ended December 31, 2011 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, that reduced the maximum corporate tax rate from 39% to approximately 30%.

**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.

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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%.

***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 a 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 enactment of the new Puerto Rico tax reform, which was effective January 2011 that reduced the maximum corporate tax rate from 39% to approximately 30%. Partially offsetting the effect of this adjustment to net deferred tax assets, is a reduction in the taxable income of the Managed Care segment, which operates at a higher effective tax rate, and the use of tax credits in the 2011 period.

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**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 three months ended March 31, 2013, the Commercial sector represented 42.4% and 9.3% 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 three months ended March 31, 2013 represented 47.3% and 46.3%, respectively, of our consolidated earned premiums, net and operating income, respectively. The operating income of the Medicaid sector represented 33.9% of the consolidated operating income for the three months ended March 31, 2013.

| | Three month ended March 31, | | Years ended December 31, | | |
|---|---|---|---|---|---|
| **(Dollar amounts in millions)** | **2013** | **2012** | **2012** | **2011** | **2010** |
| **Operating revenues:** | | | | | |
| Medical premiums earned, net: | | | | | |
| Commercial | $ 233.6 | $ 241.6 | $ 960.0 | $ 947.1 | $ 947.1 |
| Medicare | 260.3 | 254.2 | 1,073.5 | 896.6 | 468.4 |
| Medicaid | | | | 2.7 | 284.8 |
| Medical premiums earned, net | 493.9 | 495.8 | 2,033.5 | 1,846.4 | 1,700.3 |
| Administrative service fees | 28.1 | 28.7 | 114.8 | 43.0 | 43.2 |
| Net investment income | 3.9 | 3.9 | 16.4 | 17.5 | 19.8 |
| Total operating revenues | 525.9 | 528.4 | 2,164.7 | 1,906.9 | 1,763.3 |
| Medical operating costs : | | | | | |
| Medical claims incurred | 423.1 | 448.5 | 1,806.4 | 1,610.5 | 1,497.8 |
| Medical operating expenses | 82.3 | 72.5 | 311.3 | 243.4 | 201.7 |
| Total medical operating costs | 505.4 | 521.0 | 2,117.7 | 1,853.9 | 1,699.5 |
| **Medical operating income** | **$ 20.5** | **$ 7.4** | **$ 47.0** | **$ 53.0** | **$ 63.8** |
| **Additional data:** | | | | | |
| **Member months enrollment:** | | | | | |
| Commercial: | | | | | |
| Fully-insured | 1,395,023 | 1,467,148 | 5,817,009 | 5,806,053 | 5,982,094 |
| Self-funded | 667,176 | 659,500 | 2,681,962 | 2,744,431 | 2,966,291 |
| Total Commercial member months | 2,062,199 | 2,126,648 | 8,498,971 | 8,550,484 | 8,948,385 |
| Medicaid: | | | | | |
| Fully-insured | | | | | 3,078,288 |
| Self-funded | 2,650,618 | 2,612,958 | 10,562,571 | 1,718,888 | 1,782,426 |
| Total Medicaid member months | 2,650,618 | 2,612,958 | 10,562,571 | 1,718,888 | 4,860,714 |
| Medicare: | | | | | |
| Medicare Advantage | 322,758 | 329,944 | 1,354,301 | 1,132,634 | 670,250 |
| Stand-alone PDP | 24,073 | 25,271 | 101,675 | 105,987 | 112,297 |
| Total Medicare member months | 346,831 | 355,215 | 1,455,976 | 1,238,621 | 782,547 |
| **Total member months** | **5,059,648** | **5,094,821** | **20,517,518** | **11,507,993** | **14,591,646** |
| Medical loss ratio | 85.7% | 90.5% | 88.8% | 87.2% | 88.1% |
| Operating expense ratio | 15.8% | 13.8% | 14.5% | 12.9% | 11.6% |

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**Three Months Ended March 31, 2013 Compared to Three Months Ended March 31, 2012**

***Medical Operating Revenues***

Medical premiums earned for the three months ended March 31, 2013 decreased by $1.9 million, or 0.4%, to $493.9 million when compared to the medical premiums earned during the three months ended March 31, 2012. This decrease is principally the result of the following:

- Medical premiums generated by the Commercial business decreased by $8.0 million, or 3.3%, to $233.6 million during the three months ended March 31, 2013. This fluctuation is primarily the result of a decrease in member month enrollment by 72,125, or 4.9%, mainly in our rated groups and local government employees sector products, mostly due to the non-renewal of one large commercial account.

- Medical premiums generated by the Medicare business increased during the three months ended March 31, 2013 by $6.1 million to $260.3 million while member month enrollment decreased by 8,384, or 2.4%, year over year, mostly resulting from changes in product design for 2013. Increased premiums mostly result from higher risk score estimates in 2013.

Administrative service fees remained in line with prior period, with a slight decrease of $0.6 million, or 2.1%, to $28.1 million during the three months ended March 31, 2013.

***Medical Claims Incurred***

Medical claims incurred during the three months ended March 31, 2013 decreased by $25.4 million, or 5.7%, to $423.1 million when compared to the three months ended March 31, 2012, reflecting favorable prior period reserve developments and reduced current period claims. The medical loss ratio ( MLR ) of the segment decreased 480 basis points during the 2013 period, to 85.7%. These fluctuations are primarily attributed to the effect of the following:

- The medical claims incurred of the Medicare business decreased by $15.0 million, or 6.5%, during the 2013 period and its MLR decreased by 790 basis points, to 83.1%. The lower member month enrollment in this sector contributed to the decrease in claims incurred. The MLR excluding prior period reserve developments and risk-score adjustments in the 2013 and 2012 periods presents a decrease of 330 basis points, reflecting lower cost and utilization trends. The decrease also reflects improved drug costs after the new Pharmacy Benefit Manager ( PBM ) contract and the impact of changes in 2013 product design.

- The medical claims incurred of the Commercial business decreased by $10.4 million, or 4.8%, during the 2013 period mostly due to the lower fully-insured member month enrollment. The Commercial MLR was 88.4%, which is 140 basis points lower than the MLR for the prior year. Excluding the effect of favorable prior period reserve developments in 2013 and 2012, the MLR would have increased by 40 basis points.

These cost and utilization trends are not necessarily indicative of the trends we may experience in future periods. In particular, the medical claims incurred in the first quarter of 2013 may have been affected by the occurrence of the Easter holidays in March, as utilization typically declines during these holidays. Furthermore, as explained in note 6 to the unaudited consolidated financial statements included elsewhere in this prospectus supplement, prior period reserve developments generally result from cost and utilization trends that differ from those expected. The medical claims incurred during the first quarter of 2013 consider the effect of such differences. See Critical Accounting Estimates Claim Liabilities.

***Medical Operating Expenses***

Medical operating expenses for the three months ended March 31, 2013 increased by $9.8 million, or 13.5%, to $82.3 million when compared to the three months ended March 31, 2012. The operating expense ratio increased by 200 basis points, from 13.8% in 2012 to 15.8% in 2013. This increase is mainly related to on-going special project initiatives related to TSS s core system upgrade to QNXT 5.0, expenses related to the on-going reorganization of the MA business, higher payroll and related expenses mostly as a result of recruitment of additional MA sales force, and in increase in professional services related to our CMS star ratings efforts.

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**Year ended December 31, 2012 compared with the year ended December 31, 2011**

***Medical Operating Revenues***

Medical premiums earned for the year ended December 31, 2012 increased by $187.1 million, or 10.1%, to $2.0 billion when compared to the medical premiums earned during the year ended December 31, 2011. This increase is principally the result of the following:

- Medical premiums generated by the Medicare business increased by $176.9 million, or 19.7%, to $1.1 billion. This fluctuation is the result of an overall increase in the member months enrollment of this business by 217,355, or 17.5%, when compared with the same period in 2011. Increase in member months enrollment was mainly attributed to increased sales across all our Medicare products, as well as to the effect of presenting the members acquired from AH for the full year in 2012 and only for eleven months in 2011. This fluctuation also results from the receipt of higher risk score adjustments from CMS in 2012 as compared to 2011. The 2012 and 2011 periods include the net effect of approximately $12.6 million and $1.9 million, respectively, related to CMS final risk scores adjustments corresponding to prior periods.

- Medical premiums generated by the Commercial business increased by $12.9 million, or 1.4%, to $960.0 million during the year ended December 31, 2012 as compared to the year ended December 31, 2011. This is the result of higher average premium rates per member of approximately 1.2% and an increase in member months enrollment by 10,956, or 0.2%.

Administrative service fees increased by $71.8 million, or 167.0%, to $114.8 million during the year ended December 31, 2012. This fluctuation primarily results from the member months enrollment related to the *miSalud* program, which we resumed servicing effective November 1, 2011.

***Medical Claims Incurred***

Medical claims incurred during the year ended December 31, 2012 increased by $195.9 million, or 12.2%, to $1.8 billion, when compared to the year ended December 31, 2011. The MLR of the segment experienced an increase of 160 basis points during the 2012 period, to 88.8%. These fluctuations are primarily attributed to the effect of the following:

- The medical claims incurred of the Medicare business increased by $151.2 million during the 2012 period primarily due to the increase in member months enrollment in 2012 attributed to increased sales, as well as to the effect of presenting the members acquired from AH for the full period in 2012 and only for eleven months in 2011. The Medicare MLR was 88.8%, which is 60 basis points lower than the MLR for the prior year. Excluding the effect of risk-score premium adjustments and prior period reserve developments in the 2012 and 2011 periods, the MLR increased by 270 basis points, mostly as the result of higher utilization and cost trends in AH, particularly in pharmacy services.

- The medical claims incurred of the Commercial business increased by $39.4 million during the 2012 period and its MLR increased by 300 basis points. Excluding effect of prior period reserve developments in the 2012 and 2011 periods, the MLR of this business presents an increase of 120 basis points in 2012 mostly as the result of moderate premium rate increases and higher utilization trends, particularly in hospital admissions and surgical procedures.

- The medical claims incurred of the Medicaid business increased by $5.3 million during 2012 compared to prior year mostly because of a favorable prior period reserve development recognized in the 2011 period, after the termination of the Medicaid fully-insured contracts that was effective September 30, 2010.

***Medical Operating Expenses***

Medical operating expenses for the year ended December 31, 2012 increased by $67.9 million, or 27.9%, to $311.3 million when compared to the year ended December 31, 2011, primarily resulting from the higher

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member months enrollment in 2012. The operating expense ratio increased by 160 basis points, from 12.9% in 2011 to 14.5% in 2012, reflecting a higher amount of self-insured contracts after resuming our participation in the Medicaid sector in November 2011.

**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 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.

Medicare 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 claim 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 an 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 presented 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.

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***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.

**Life Insurance Operating Results**

| | Three month ended March 31, | | Years ended December 31, | | |
|---|---|---|---|---|---|
| **(Dollar amounts in millions)** | **2013** | **2012** | **2012** | **2011** | **2010** |
| **Operating revenues:** | | | | | |
| Premiums earned, net: | | | | | |
| Premiums earned | $ 33.8 | $ 32.0 | $ 132.7 | $ 118.8 | $ 111.4 |
| Premiums earned ceded | (2.0) | (2.0) | (8.0) | (5.8) | (5.6) |
| Premiums earned, net | 31.8 | 30.0 | 124.7 | 113.0 | 105.8 |
| Net investment income | 5.3 | 4.9 | 20.8 | 18.5 | 17.1 |
| Total operating revenues | 37.1 | 34.9 | 145.5 | 131.5 | 122.9 |
| **Operating costs:** | | | | | |
| Policy benefits and claims incurred | 16.8 | 14.8 | 66.4 | 57.5 | 49.8 |
| Underwriting and other expenses | 16.3 | 15.7 | 62.4 | 56.3 | 55.8 |
| Total operating costs | 33.1 | 30.5 | 128.8 | 113.8 | 105.6 |
| Operating income | $ 4.0 | $ 4.4 | $ 16.7 | $ 17.7 | $ 17.3 |
| **Additional data:** | | | | | |
| Loss ratio | 52.8% | 49.3% | 53.2% | 50.9% | 47.1% |
| Operating expense ratio | 51.3% | 52.3% | 50.0% | 49.8% | 52.7% |

**Three Months Ended March 31, 2013 Compared to Three Months Ended March 31, 2012**

***Operating Revenues***

Premiums earned, net for the three months ended March 31, 2013 increased by $1.8 million, or 6.0% to $31.8 million when compared to the three months ended March 31, 2012 as a result of overall business growth. Such increase is mostly related to new sales in the Individual Life and Cancer business, which presented a combined year over year increase of $1.8 million, or 6.3%.

***Policy Benefits and Claims Incurred***

Policy benefits and claims incurred for the three months ended March 31, 2013 increased by $2.0 million, or 13.5%, to $16.8 million when compared to the three months ended March 31, 2012. This is the result of a higher amount of claims received in the 2013 period, particularly in the individual life and cancer products. As a result, the loss ratio for the period increased from 49.3% in 2012 to 52.8% in 2013, or 350 basis points.

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***Underwriting and Other Expenses***

Underwriting and other expenses for the three month period ended March 31, 2013 increased $0.6 million, or 3.8%, to $16.3 million when compared to the three months ended March 31, 2012, mostly related to a lower amount of expenses capitalized as Deferred Policy Acquisition Costs. The operating expenses ratio decreased by 100 basis points from 52.3% in 2012 to 51.3% in 2013 as a result of the increase in volume of business during the three months ended March 31, 2013 as compared to the three months period ended March 31, 2012.

**Year ended December 31, 2012 compared with the year ended December 31, 2011**

***Operating Revenues***

Premiums earned, net for the segment increased by $11.7 million, or 10.4%, to $124.7 million during the year ended December 31, 2012 as compared to the year ended December 31, 2011, primarily as the result of higher sales in the Cancer, Individual Life and Group Life lines of business during the period.

***Policy Benefits and Claims Incurred***

Policy benefits and claims incurred increased by $8.9 million, or 15.5%, to $66.4 million during the year ended December 31, 2012. This fluctuation is primarily the result of higher claims received for 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 and improved persistency on the Individual Life business. The loss ratio for the period increased from 50.9% in 2011 to 53.2% in 2012, or 230 basis points.

***Underwriting and Other Expenses***

Underwriting and other expenses for the segment increased by $6.1 million, or 10.8%, to $62.4 million during the year ended December 31, 2012 primarily the related to higher commissions as a result of the higher volume of business of this segment. Expense control and the growth in premiums during this period resulted in a slightly higher operating expense ratio, which increased by 20 basis points, from 49.8% in 2011 to 50.0% in 2012.

**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 Cancer and Individual Life lines of business.

***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 a 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 of the higher 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.

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**Property and Casualty Insurance Operating Results**

| (Dollar amounts in millions) | Three month ended March 31, 2013 | Three month ended March 31, 2012 | Years ended December 31, 2012 | Years ended December 31, 2011 | Years ended December 31, 2010 |
|---|---|---|---|---|---|
| **Operating revenues:** | | | | | |
| Premiums earned, net: | | | | | |
| Premiums written | $ 31.0 | $ 33.8 | $ 162.7 | $ 152.9 | $ 159.2 |
| Premiums ceded | (13.2) | (14.2) | (63.5) | (63.0) | (63.7) |
| Change in unearned premiums | 7.1 | 2.6 | (1.5) | 7.7 | 3.7 |
| Premiums earned, net | 24.9 | 22.2 | 97.7 | 97.6 | 99.2 |
| Net investment income | 2.0 | 2.2 | 8.9 | 9.5 | 10.1 |
| Total operating revenues | 26.9 | 24.4 | 106.6 | 107.1 | 109.3 |
| **Operating costs:** | | | | | |
| Claims incurred | 12.7 | 12.8 | 49.3 | 48.2 | 49.2 |
| Underwriting and other expenses | 13.8 | 13.0 | 50.5 | 54.4 | 56.5 |
| Total operating costs | 26.5 | 25.8 | 99.8 | 102.6 | 105.7 |
| Operating income (loss) | $ 0.4 | $ (1.4) | $ 6.8 | $ 4.5 | $ 3.6 |
| **Additional data:** | | | | | |
| Loss ratio | 51.0% | 57.7% | 50.5% | 49.4% | 49.6% |
| Operating expense ratio | 55.4% | 58.6% | 51.7% | 55.7% | 57.0% |

**Three Months Ended March 31, 2013 Compared to Three Months Ended March 31, 2012**

***Operating Revenues***

Total premiums written during the three months ended March 31, 2013 decreased by $2.8 million, or 8.3%, to $31.0 million, mostly resulting from lower sales of Dwelling insurance products.

Premiums ceded to reinsurers during the three months ended March 31, 2013 decreased by $1.0 million, or 7.0%, to $13.2 million. The ratio of premiums ceded to premiums written increased by 60 basis points, from 42.0% in 2012 to 42.6% in 2013, mostly resulting from a change in the mix of business subscribed during 2013.

The change in unearned premiums presented an increase of $4.5 million, to $7.1 million during the three months ended March 31, 2013, primarily as the result of the lower volume of premiums written in 2013.

***Claims Incurred***

Claims incurred during the three months ended March 31, 2013 decreased by $0.1 million, or 0.8%, to $12.7 million. The loss ratio decreased by 670 basis points, to 51.0% during this period as a result of a favorable loss experience, mostly in the Commercial Auto line of business.

***Underwriting and Other Expenses***

Underwriting and other operating expenses for the three months ended March 31, 2013 increased by $0.8 million, or 6.2%, to $13.8 million, primarily due to a higher net commission expense resulting from an increase in the amortization of deferred policy acquisition costs. The operating expense ratio decreased by 320 basis points during the same period, to 55.4% in 2013.

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**Year ended December 31, 2012 compared with the year ended December 31, 2011**

***Operating Revenues***

Total premiums written during the year ended December 31, 2012 increased by $9.8 million, or 6.4%, to $162.7 million, mostly related to higher volume in the Commercial Auto, Commercial Liability, Commercial Package, and Commercial Property insurance products after the acquisition of several government and municipality accounts. In addition, this segment reported increased sales in the Personal Package insurance products. Nonetheless, the commercial business remains under soft market conditions with strong competition.

Premiums ceded to reinsurers during the year ended December 31, 2012 increased by approximately $0.5 million, or 0.8%, to $63.5 million. The ratio of premiums ceded to premiums written decreased by 220 basis points, to 39.0% in 2012. This fluctuation was primarily the result of a change in the mix of business subscribed during 2012.

The change in unearned premiums presented a decrease of $9.2 million, to $1.5 million during the year ended December 31, 2012, primarily as the result of the higher volume of premiums written during this period.

***Claims Incurred***

Claims incurred during the year ended December 31, 2012 increased by $1.1 million, or 2.3%, to $49.3 million. The loss ratio increased by 110 basis points, to 50.5% in 2012, as a result of unfavorable loss experience in the Commercial Auto and General Liability line of business, primarily resulting from the receipt of several large auto liability claims that together had the effect of increasing 2012 claims incurred by approximately $2.3 million, offset in part by a decrease in the claims related to the Dwelling line of business.

***Underwriting and Other Expenses***

Underwriting and other operating expenses for the year ended December 31, 2012 decreased by $3.9 million, or 7.2%, to $50.5 million. The operating expense ratio decreased by 400 percentage points during the same period, to 51.7% in 2012. This decrease is primarily due to a lower net commission expense and decreases in other operating expenses.

**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 in the Dwelling and Commercial Property Mono-line and Commercial Auto insurance products; offset in part by higher sales of Commercial Multi-peril products. Soft market conditions also prevailed in 2011, 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%.

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

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result of a favorable loss experience in the Commercial Auto line of business resulting from lower claim amounts in the claims reported in 2011; 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 the lower premiums written; 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 55.7% in 2011.

**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:

| | Three Months Ended March 31, | | Years ended December 31, | | |
|---|---|---|---|---|---|
| | 2013 | 2012 | 2012 | 2011 | 2010 |
| | (dollar amounts in millions) | | | | |
| Sources of cash: | | | | | |
| Net cash provided by operating activities | $ 31.2 | $ 74.2 | $ 109.7 | $ 162.5 | $ 37.7 |
| Proceeds from annuity contracts | 3.0 | 6.5 | 39.7 | 31.8 | 10.7 |
| Proceeds from exercise stock options | | 0.3 | 0.3 | 0.2 | |
| Net proceeds from borrowings | | | 30.0 | | 40.6 |
| Other | 20.4 | 5.6 | | 4.4 | 0.2 |
| Total sources of cash | 54.6 | 86.6 | 179.7 | 198.9 | 89.2 |
| Uses of cash: | | | | | |
| Net purchases of investment securities | (52.3) | (15.2) | (91.1) | (13.6) | (23.7) |
| Cash settlements of stock options | | | | (2.4) | |
| Capital expenditures | (6.1) | (2.8) | (12.1) | (16.3) | (19.2) |
| Payments of long-term borrowings | (0.5) | (0.5) | (26.9) | (51.6) | (26.4) |
| Payments of short-term borrowings | (21.5) | | | (15.6) | |
| Surrenders of annuity contracts | (1.2) | (1.7) | (7.1) | (6.6) | (9.1) |
| Repurchase and retirement of common stock | | | (2.3) | (11.3) | (6.2) |
| Acquisition of business , net of cash of $0.8 in the three months ended March 31, 2012 and the year ended December 31, 2012 and $29.4 in the year ended December 31, 2011 | | (2.7) | (2.7) | (54.7) | |
| Other | | | (19.8) | | |
| Total uses of cash | (81.6) | (22.9) | (162.0) | (172.1) | (84.6) |
| Net increase in cash and cash equivalents | $ (27.0) | $ 63.7 | $ 17.7 | $ 26.8 | $ 4.6 |

**Three Months Ended March 31, 2013 Compared to Three Months Ended March 31, 2012**

Cash flow from operating activities decreased by $43.0 million for the three months ended March 31, 2013 as compared to the three months ended March 31, 2012, principally due to a decrease in premium collections by $63.5 million. The lower premium collections primarily result from the collection in March 2012 of approximately $80 million related to the CMS April 2012 premiums, which advance collection did not occur

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during the current period, and the Managed Care Segment decreased membership enrollment. This fluctuation is offset in part by the effect of a decrease in claims paid by $10.2 million, cash paid to suppliers and employees by $4.7 million, and the income taxes paid, by $4.6 million.

During the three months ended March 31, 2013 we received $3.0 million in policyholder deposits, this represents a decrease $3.5 million when compared to the prior year and is the result of lower sales of annuity products.

The increase in other sources of cash is attributed to changes in the amount of outstanding checks over bank balances in the 2013 period.

Net acquisition of investment securities were $37.1 million higher during the three months ended March 31, 2013 as compared to the three months ended March 31, 2012, primarily resulting from the investment of excess cash flows from operations.

Net capital expenditures increased by $3.3 million for the three months ended March 31, 2013, as compared to the three months ended March 31, 2012, principally due to special projects initiatives related to information technology.

Net payments of short-term borrowings increased by $21.5 million during the three months ended March 31, 2013, addressing timing differences between cash receipts and disbursements.

On January 18, 2012, we acquired a controlling stake in a health clinic in Puerto Rico at a cost of $2.7 million, net of $0.8 million of cash acquired. There was no acquisition of business during the three months ended March 31, 2013.

**Year ended December 31, 2012 compared to year ended December 31, 2011**

Cash flows from operating activities decreased by $52.8 million for the year ended December 31, 2012 as compared to the year ended December 31, 2011, principally due to the effect of higher claims paid and cash paid to suppliers and employees by $163.1 million and $39.5 million, respectively, offset in part by higher premiums collections by $195.3 million. The increase in premiums collected is principally the result of the higher Managed Care membership enrollment. The increase in claim payments mostly results from the higher enrollment and increased utilization trends in the Managed Care segment. The 2011 operating cash flows include $50.3 million of net proceeds from the trading portfolio, which was sold during that year.

During the year ended December 31, 2012 we received $39.7 million in policyholder deposits. This represents an increase of $7.9 million when compared to the prior year and is the result of new annuity products that are more attractive to prospective policyholders.

Net proceeds from short-term borrowings increased by $30.0 million during the year ended December 31, 2012, addressing timing differences between cash receipts and disbursements.

Net purchases of investment securities were $91.1 million during the year ended December 31, 2012, $77.5 million higher than last year, primarily resulting from the investment of excess cash flows from operations.

In the 2011 period we cash-settled 432,567 stock options for $2.4 million, its fair value on settlement date. No cash settlement of stock options occurred during the year ended December 31, 2012.

Capital expenditures are $4.2 million lower during the year ended December 31, 2012 primarily as a result of the completion of the Managed Care new core system implementation during the third quarter of this year.

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Payments of long-term borrowings of $26.9 million during the year ended December 31, 2012 are primarily the result of a $25.0 million prepayment of one of our senior unsecured notes. The $24.7 million decrease in payments of long-term debt is due to the prepayment of another senior unsecured note of $50.0 million during the year ended December 31, 2011.

On September 29, 2010 we announced the commencement of a $30.0 million share repurchase program (the 2010 stock repurchase program ). During the year ended December 31, 2012 we paid approximately $2.3 million under the 2010 share repurchase program.

On January 18, 2012, we acquired a controlling stake in a health clinic in Puerto Rico at a cost of $2.7 million, net of $0.8 million of cash acquired. On February 7, 2011, we acquired AH at a cost of $54.0 million, net of $30.1 million of cash acquired.

The increase in other uses of cash is attributed to changes in the amount of outstanding checks over bank balances in the 2012 period.

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

Cash flows from operating activities increased by $124.8 million during 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 this 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.

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.

We paid approximately $11.3 million under the 2010 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.

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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.

**Share Repurchase Program**

On September 29, 2010, we announced the immediate commencement of the 2010 stock repurchase program. The program is conducted using available cash through open-market purchases and privately-negotiated transactions of Class B shares only, in accordance with Rules 10b-18 and 10b5-1 under the Exchange Act, as amended. During the year ended December 31, 2012 we repurchased and retired 136,222 shares at an average per share price of $16.86, for an aggregate cost of $2.3 million. We did not repurchase any shares in the three months ended March 31, 2013. On March 23, 2013, we discontinued our 2010 stock repurchase program.

**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 March 31, 2013, we had $235.0 million of available credit under these facilities. There are $8.5 million outstanding short-term borrowings under these facilities as of March 31, 2013.

As of March 31, 2013, we had the following long-term borrowings:

On January 31, 2006, we issued and sold $35.0 million of our 6.7% senior unsecured notes 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. On September 10, 2012 we repaid $25.0 million of the principal of these senior unsecured notes.

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

On November 1, 2010, we entered into a $25.0 million arrangement to sell securities under repurchase agreements that matures in November 2015. This repurchase agreement pays interest on a quarterly basis 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 March 31, 2013 investment securities available for sale with fair value of $36.9 million (face value of $34.9 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 March 31, 2013, 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 March 31, 2013, this secured loan had an outstanding balance of $17.3 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 that are customary for this type of facility, including, but

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not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of March 31, 2013 we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the outstanding balance.

As part of the acquisition transaction of the controlling stake in a health clinic, we assumed a term loan with balance of $13.4 million as of March 31, 2013. The loan requires monthly payments of $0.1 million, including principal and interest, is due on December 23, 2014 with a final payment of $12.9 million and bears interest at an annual rate of 4.75%

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

**Planned Capital Expenditures**

In February 2012 the Company began a corporate project to implement a new Enterprise Resource Planning (ERP) system. Total costs for the project are expected to amount approximately $13.0 million. We expect to incur costs of approximately $6.0 million during 2013. We estimate that approximately $3.9 million of the costs to be incurred in 2013 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 our operating cash flows.

Federal regulations require that we begin using a new set of standardized diagnostic codes, known as ICD-10, by October 2014, which will require a significant information technology investment. In order to become ICD-10 compliant, we need to upgrade the version of TSS s core business application that we previously implemented in the third quarter of 2012. We expect to begin this upgrade during the second quarter of 2013 and have completed the migration of our membership on time to comply with the current ICD-10 deadline. The estimated cost of the core business application upgrade and ICD-10 compliance efforts is approximately $6.0 million.

**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, 2012, we had $95.9 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, 2012, our policyholder deposits had a carrying amount of $111.7 million.

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Other long-term liabilities Due to the indeterminate nature of their cash outflows, $136.3 million of other long-term liabilities are not reflected in the following table, including $82.0 million of liability for pension benefits, $32.9 million in deferred tax liabilities, and $21.4 million in liabilities to the Federal Employees Health Benefits Plan Program.

| | | Contractual obligations by year | | | | | |
|---|---|---|---|---|---|---|---|
| | Total | 2013 | 2014 | 2015 | 2016 | 2017 | Thereafter |
| | (Dollar amounts in millions) | | | | | | |
| Short-term borrowings | $ 30.0 | $ 30.0 | $ | $ | $ | $ | |
| Long-term borrowings(1) | 129.9 | 6.3 | 19.1 | 30.3 | 4.8 | 4.8 | 64.6 |
| Operating leases | 25.1 | 5.8 | 5.2 | 4.2 | 3.8 | 2.3 | 3.8 |
| Purchase obligations(2) | 167.0 | 144.1 | 13.2 | 8.8 | 0.3 | 0.3 | 0.3 |
| Claim liabilities(3) | 377.9 | 284.6 | 61.5 | 7.3 | 8.3 | 5.8 | 10.4 |
| Estimated obligation for future policy benefits(4) | 301.8 | 54.0 | 52.5 | 51.3 | 49.8 | 48.1 | 46.1 |
| | $ 1,031.7 | $ 524.8 | $ 151.5 | $ 101.9 | $ 67.0 | $ 61.3 | $ 125.2 |

(1) As of December 31, 2012, 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 loans 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, 2012. 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 Financing and Financing Capacity for additional information.

(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 $7.0 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, 2012. 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 $39.1 million of reserves had been ceded at December 31, 2012.

(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

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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, 2012 and are gross of any reinsurance recoverable. The $301.8 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $276.6 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual experience and the assumptions used in the estimation of these payments.

**Off-Balance Sheet Arrangements**

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

**Restriction on Certain Payments by the Corporation s Subsidiaries**

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance. 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 RBC reports following the National Association of Insurance Commissioners ( NAIC ) 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, 2012, 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, 2012, both TSM and TSS estimated RBC ratio was above the minimum BCBSA RBC requirement of 200% and the 375% of RBC level required by the BCBSA to avoid monitoring. Effective January 1, 2013 AH began offering BCBSA branded products, as a smaller controlled affiliate AH is in compliance with the minimum BCBSA requirement of 100% RBC.

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**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. See Item 3. Legal Proceedings on page 52 of our Annual Report on Form 10-K for the year ended December 31, 2012 incorporated by reference herein and note 13 to our unaudited consolidated financial statements included elsewhere in this prospectus supplement. 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.

***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, 2012, 2011 and 2010, 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 2012, 2011 and 2010, 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 2012, 2011 and 2010, the Association distributed the Company a dividend based on the good experience of the business amounting to $1.2 million in 2012 and $1.3 million in 2011 and 2010.

**Critical Accounting Estimates**

Our consolidated financial statements and accompanying notes included in this prospectus supplement 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

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general, management s estimates are based on historical experience and various other assumptions it believes to be reasonable under the circumstances. The following is an explanation of our accounting policies considered most significant by management. These accounting policies require us to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information is known. Actual results could differ materially from those estimates.

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

**Claim Liabilities**

Claim liabilities by segment as of March 31, 2013 were as follows:

| | (Dollars amounts in millions) |
|---|---|
| Managed Care | $ 281.5 |
| Property and casualty insurance | 89.1 |
| Life insurance | 43.5 |
| Consolidated | $ 414.1 |

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 March 31, 2013, claim liabilities for the managed care segment amounted to $281.5 million and represented 68.0% of our total consolidated claim liabilities and 21.7% of our total consolidated liabilities.

Claim liabilities are determined employing actuarial methods that are commonly used by managed care actuaries and meet Actuarial Standards of Practice, which require that the claim liabilities be adequate under moderately adverse circumstances. The segment determines the amount of the liability by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project a best estimate of claim liabilities. Under this process, historical claims incurred dates are compared to actual dates of claims payment. This information is analyzed to create completion or development factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the

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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 91% of the claims are paid within three months after the last day of the month in which they were incurred and about 4% 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.

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.

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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, 2012 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

| Completion Factor(1) (Decrease) Increase (Dollar amounts in millions) | | Claims Trend Factor(2) (Decrease) Increase (Dollar amounts in millions) | |
|---|---|---|---|
| **In completion factor** | **In unpaid claim liabilities** | **In claims trend factor** | **In unpaid claim liabilities** |
| -0.6% | $10.5 | 0.75% | $10.8 |
| -0.4% | $7.0 | 0.50% | $7.3 |
| -0.2% | $3.5 | 0.25% | $3.6 |
| 0.2% | ($3.5) | -0.25% | ($3.6) |
| 0.4% | ($6.9) | -0.50% | ($7.3) |
| 0.6% | ($10.4) | -0.75% | ($10.8) |

(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.

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.

| | Years ended December 31, | | | |
|---|---|---|---|---|
| | **2012** | **2011** | **2010** | **2009** |
| | | (Dollar amounts in millions) | | |
| Total incurred claims: | | | | |
| As reported(1) | $ 1,811.0 | $ 1,612.1 | $ 1,503.3 | $ 1,512.1 |
| On a retrospective basis | 1,787.8 | 1,607.5 | 1,495.6 | 1,506.5 |
| Variance | $ 23.2 | $ 4.6 | $ 7.7 | $ 5.6 |
| Variance to total incurred claims as reported | 1.3% | 0.3% | 0.5% | 0.4% |

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

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Management expects that substantially all of the development of the 2012 estimate of medical claims payable will be known during 2013 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.

In the Commercial business 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.

***Life Insurance Segment***

At March 31, 2013, claim liabilities for the life insurance segment amounted to $43.5 million and represented 10.5% of total consolidated claim liabilities and 3.3% 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. The estimate of claim liabilities for this segment is based on the amount of benefits contractually determined for reported claims, and on estimates based on past experience modified for current trends, for unreported claims. This estimate relies on observations of ultimate loss experience for similar historical events.

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.

***Property and Casualty Insurance Segment***

At March 31, 2013, claim liabilities for the property and casualty insurance segment amounted to $89.1 million and represented 21.5% of the total consolidated claim liabilities and 6.9% 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.

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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, 2012, the actuarial reserve range determined by the actuaries was from $87 million to $97 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 $5.8 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 4.90% 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.

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.

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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 to sell or the likelihood of a required sale prior to recovery, (4) the recoverability of principal and interest for fixed maturity securities, or cost for equity securities, and (5) other factors, as applicable. This

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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.

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 year ended December 31, 2012, there were no realized losses associated with other-than-temporary impairments, as compared to the $0.3 million and $3.0 million recognized in 2011 and 2010, respectively, on fixed income, equity securities and perpetual preferred stocks classified as available for sale. As of December 31, 2012, the investment in securities of $1.3 billion is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $934.9 million, or 73.4%, 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 $339.6 million, or 26.6%, are corporate fixed income securities, equity securities and mutual funds. The gross unrealized gains and losses as of December 31, 2012 of the available-for-sale and held-to-maturity portfolios amounted to $121.3 million and $0.4 million, respectively.

The impairment analysis as of December 31, 2012 indicated that 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

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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.

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, 2012 and 2011 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 $24.4 million and $23.9 million as of December 31, 2012 and 2011, 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 and other intangible assets at December 31, 2012 were $27.8 million and $22.9 million, respectively. At December 31, 2011 the consolidated goodwill and other intangible assets were $25.4 million and $33.3 million, respectively. The goodwill and other intangible assets balance for both years were primarily related to AH. At December 31, 2012 the AH goodwill and other intangible assets were $25.0 million and $18.9 million, respectively. At December 31, 2011 the AH goodwill and other intangible assets were $25.0 million and $26.0 million, respectively.

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.

As required by FASB guidance, we completed our annual impairment tests of existing goodwill during the fourth quarter of 2012 and 2011. These tests involve the use of estimates related to the fair value of the reporting

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unit and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or other changes in our business occur. The result of the impairment test performed in 2012 indicated that the fair value of the reporting unit exceeded its carrying value by approximately 6%.

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 premiums, expected claims, MLR, operating expenses and net income derived from our internal planning process and historical trends. 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. It assumes the effective implementation of measures to contain the utilization and cost trends. Events or changes in circumstances, including a decrease in membership, an increase in MLR and/or operating expenses, could result in goodwill impairment.

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.

**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 included elsewhere in this prospectus supplement.

**Recently Issued Accounting Standards**

In October 2010 the FASB issued guidance to address diversity in practice regarding the interpretation of which costs relating to the acquisition of new or renewal insurance contracts qualify for deferral. This guidance specifies that the following costs incurred in the acquisition of new and renewal contracts should be capitalized: (1) Incremental direct costs of contract acquisition. Incremental direct costs are those costs that result directly from and are essential to the contract transaction and would not have been incurred by the insurance entity had the contract transaction not occurred. (2) Certain costs related directly to the following acquisition activities performed by the insurer for the contract: a. Underwriting, b. Policy issuance and processing, c. Medical and inspection, and d. Sales force contract selling. Advertising costs should be included in deferred acquisition costs only if the capitalization criteria in the direct-response advertising guidance in Subtopic 340-20, Other Assets and Deferred Costs Capitalized Advertising Costs, are met. This guidance is effective for fiscal years and interim periods within those fiscal years, beginning on or after December 15, 2011. The Corporation adopted this guidance in January 1, 2012; there was no significant impact on our financial position or results of operations as a result of the adoption.

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

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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 required reclassification adjustments from accumulated other comprehensive income to be measured and presented by income statement line item in net income and also in other comprehensive income on the face of the financial statement. The Corporation adopted this guidance in January 1, 2012 electing to present the components of comprehensive income in two separate but consecutive financial statements.

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. The Corporation adopted this guidance in January 1, 2012, with no significant impact on our financial position or results of operations as a result of the adoption. However, we have added disclosure requirements related to fair value measurements in Note 7, Fair Value Measurements.

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 August 27, 2012 and October 1, 2012, the FASB issued guidance to make generally non-substantive technical corrections to certain codification topics, remove inconsistencies and outdated provisions, clarify the FASB s intent and amend or delete various SEC paragraphs. In particular, the updates consist of:

- Technical corrections and amendments as part of the FASB s standing agenda to review and improve the Accounting Standards Codification;
- Conforming amendments related to fair value measurements, in accordance with Topic 820;
- Reflect the issuance of the SEC s Staff Accounting Bulletin No. 114, Revisions and Rescissions of Portions of the Interpretative Guidance Included in the Codification of Staff Accounting Bulletins; and
- Reflect the issuance of the SEC Final Rulemaking Release No. 33-9250, Technical Amendments to Commission Rules and Forms Related to the FASB s Accounting Standards Codification.

We adopted this guidance on January 1, 2013, there was no significant impact on our financial position or results of operations as a result of the adoption.

On February 5, 2013 the FASB issued guidance to improve the transparency of reporting reclassifications out of accumulated other comprehensive income. In particular, the guidance requires an entity to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income in the same

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reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. This guidance applies to all entities that issue financial statements that are presented in conformity with GAAP and that report items of other comprehensive income. We adopted this guidance on January 1, 2013, there was no 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 could have a material impact on Company s our financial position, operating results or financials statement disclosures.

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## BUSINESS

### General Description of Business and Recent Developments

We are one of the most significant players in the managed care industry in Puerto Rico, serving approximately 1,675,000 members across all regions as of March 31, 2013, with an estimated 28% market share in terms of premiums written in Puerto Rico for the year ended December 31, 2012. We have the exclusive right to use the BCBS names and marks throughout Puerto Rico and the U.S. Virgin Islands and over 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial and Medicare markets. 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. Until September 30, 2010 we provided managed care services to the HIP and beginning on November 1, 2011 we resumed our participation in this sector as an ASO provider for *miSalud*.

We also offer complementary products and services, including life insurance, accident and disability insurance and property and casualty insurance. We are one of 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.

In the year ended December 31, 2012, we generated total operating revenues of approximately $2.4 billion, of which approximately 90% was derived from our managed care businesses and 10% from our life insurance and property and casualty insurance businesses. In the three months ended March 31, 2013, we generated total operating revenues of approximately $589.6 million, of which approximately 89% was derived from our managed care businesses and 11% from our life insurance and property and casualty insurance businesses.

In January 2012, we acquired a controlling interest in a health clinic in Puerto Rico, which we expect to provide additional opportunities to our Managed Care segment.

On February 7, 2011, TSS completed the acquisition of 100% of the outstanding capital stock of Socios Mayores en Salud Holdings, Inc., the indirect parent company of 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, and was funded with unrestricted cash. The consolidated results of operations and financial condition of the Corporation included in this prospectus supplement 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 Exchange Act.

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 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 HMOs and PPOs. Through the introduction of these alternatives the managed care industry has attempted to contain the cost of health care

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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 ( PCPs ) to coordinate their care and approve any specialist or other services.

The government of the United States of America (the U.S. government or federal government ) provides hospital and medical insurance benefits to eligible people aged 65 and over as well as certain other qualified persons through the Medicare program, including the Medicare Advantage program. The federal government also offers prescription drug benefits to Medicare eligibles, both as part of the Medicare Advantage program and on a stand-alone basis, pursuant to 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 BCBSA to use the BCBS names and marks in Puerto Rico and the U.S. Virgin Islands. The BCBSA had 38 independent licensees as of December 31, 2012. BCBS membership stood at approximately 100 million members at December 31, 2012, which represents approximately 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 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 year ended December 31, 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 December 31, 2012 was approximately $1.9 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

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lines of business in Puerto Rico are personal and commercial auto, commercial multi-peril, fire and allied lines and other general liabilities. Approximately 67% of the market is written by the top six companies in terms of market share, and approximately 88% of the market is written by companies incorporated under the laws of, and which operate principally in Puerto Rico.

The Puerto Rican property and casualty insurance market is highly dependent on reinsurance.

**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. 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 in past years, the continuous contraction of the manufacturing sector, and budgetary pressures on government finances have triggered a general contraction in the economy. See Management s Discussion and Analysis of Financial Condition and Results of Operations Puerto Rico s Economy

**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, Medicare Part D and Medicaid plans. Managed care products represented approximately 90% of our consolidated premiums earned, net for each of the years ended December 31, 2012, 2011 and 2010. 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:

*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.

*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

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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, 2012, we had enrolled approximately 25,224 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2013.

*ASO.* 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 *miSalud*. 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 TSV. Life insurance premiums represented approximately 6% of our consolidated premiums earned, net for each of the years ended December 31, 2012, 2011 and 2010. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases 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 TSP. Property and casualty insurance premiums represented approximately 4% of our consolidated premiums earned, net for each of the years ended December 31, 2012, 2011 and 2010. 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.

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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. Nearly 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, 2012, 39% 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 insured, 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 BCBS 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 BCBS 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 other Managed Care subsidiary AH. AH, which began selling BCBS branded products effective January 1, 2013, will continue using its own name.

### Sales and Marketing

We employ a wide variety of sales and marketing activities. Such activities are closely regulated by the CMS and the OPM of the HHS, the Commissioner of Insurance 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 are sold entirely through independent agents who exclusively sell our individual products, and Medicare Advantage and group products are sold through our 339 person internal sales force as well as our approximately 155 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.

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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 57% for both 2012 and 2011) 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 1,300 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.

*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, 2012, 2011 and 2010 TSIA placed approximately 58%, 52% and 49% of TSP s total premium volume, respectively. The general agencies contracted by TSP remit premiums net of their respective commission.

## Customers

### Managed Care

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at March 31, 2013:

| Market Sector | Enrollment | Percentage of Total Enrollment |
|---|---|---|
| Commercial | 686,706 | 41.0% |
| Medicare | 113,821 | 6.8 |
| Medicaid | 874,169 | 52.2 |
| Total | 1,674,696 | 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 OPM and through the Federal Employee Program of the BCBSA. 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.

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*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 of Puerto Rico employees 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.

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 Medicare Part D, a prescription drug program. 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, 2012, this program provided healthcare coverage to over 1.6 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.

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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 the ASES. See 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 510,000 policies. We also insure approximately 1,700 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.

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 2012 our corporate accounts retention factor is 97%.

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

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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 and reinsurance capacity. 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.

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.

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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 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 continued into the third quarter of 2012, when we completed the full migration of TSS s commercial membership. Total external costs for the entire project amounted to approximately $56.0 million.

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

Federal regulations require that we begin using a new set of standardized diagnostic codes, known as ICD-10, by October 2014, which will require a significant information technology investment. In order to become ICD-10 compliant, we need to upgrade the version of TSS s core business application that we previously implemented in the third quarter of 2012. We expect to begin this upgrade during the second quarter of 2013 and have completed the migration of our membership on time to comply with the current ICD-10 deadline. The estimated cost of the core business application upgrade and ICD-10 compliance efforts is approximately $6.0 million.

Since our goal is to manage all Medicare enrollments in one core business application we are currently evaluating a transition to either TSS s new core, business application or to the core business application currently in use by AH. We continue to manage the Medicaid enrollment in TSS s legacy core system and we expect to continue to do so until we complete the upgrade of TSS s new core business application.

**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, 2012, we had provider contracts with approximately 4,823 primary care physicians, 3,276 specialists and 64 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.

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We seek to ensure that providers in our networks are paid in a timely manner, and we provide means and procedures for claims adjustments and dispute resolution. We also provide a dedicated service center for our providers. We seek to maintain broad provider networks to ensure member choice while implementing effective management programs designed to improve the quality of care received by our members.

We promote the use of electronic claims billing by our providers. Approximately 91% 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 78% and 81% in 2012 and 2011, 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 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.

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**Managed Care**

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

We believe that our competitive strengths, including our leading presence in Puerto Rico, our BCBS 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, 2012 we had approximately 1,721,000 members enrolled in our managed care segment. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 28% for the year ended December 31, 2012. 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 2011, we were the second largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 13%. 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 17%, and our main competitor is AFLAC (sector leader).

**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 year ended December 31, 2012, we were the fifth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 9%. Our nearest competitor in the property and casualty insurance market in Puerto Rico was 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 Group, and Cooperativa de Seguros Múltiples de Puerto Rico.

**Blue Cross and Blue Shield License**

TSM has license agreements with BCBSA that permit TSM the exclusive use of the BCBS names and marks for the sale, marketing and administration of managed care plans and related services in Puerto Rico and the U.S. Virgin Islands. Also, TSS has a license with BCBSA to use the BCBS names and marks in Puerto Rico and the U.S. Virgin Islands. Also, as of January 1, 2013, AH has a license with BCBSA to use the names and marks of the BCBS on its Medicare Advantage products. We believe that the BCBS names and marks are

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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 names and marks.

Upon the occurrence of any event causing the termination of our license agreements, we would cease to have the right to use the BCBS names and marks in Puerto Rico and the U.S. Virgin Islands. We also would no longer have access to the networks of providers of the different plans that are members of the Association nor the 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 names and marks in Puerto Rico and the U.S. Virgin Islands to another entity, which could have a material adverse effect on our business, financial condition and results of operations. See Risk Factors Risks Related to Our Business The termination or modification of our license agreements to use the BCBS names and marks could have a material adverse effect on our business, financial condition and results of operations.

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

- failure to maintain our total adjusted capital at or above 200% of Health Risk-Based Capital ( HRBC ) Authorized Control Level ( ACL ) as defined by the NAIC for the Primary Licensee (TSM) and the Larger BCBS Controlled Affiliate (TSS) and 100% HRBC ACL for the Smaller BCBS Controlled Affiliate (AH);

- 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 license 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 BCBS names and marks. 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 BCBS names and marks is already present. Currently, the BCBS names and marks are licensed to other entities in all markets of the continental United States, Hawaii, and Alaska. We also 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, TSM guarantees TSS contractual and financial obligations to their respective customers. Also, TSS guarantees AH s contractual and financial obligations to

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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 names and marks. The annual BCBSA fee for the year 2013 is $2,126,347. During the years ended December 31, 2012 and 2011, we paid fees to the BCBSA in the amount of $1,224,344 and $1,769,143, respectively. The BCBSA is a national trade association of 38 independent Primary Licensees (Plans), including TSM, the primary function of which is to promote and preserve the integrity of the BCBS names and marks, as well as to provide certain coordination among the Member Plans. Each Member Plan is an independent legal organization and is not responsible for obligations of other BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the BCBS names and marks outside our BCBS licensed territory.

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

**Claim Liabilities**

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

**Investments**

Our investment portfolio consists mainly of investment grade fixed income and a smaller portion is held in equity securities. The investment portfolio is conservative, diversified across and within asset classes, and has the following objectives, in order of importance: capital preservation, liquidity, income generation and capital appreciation. The interest rate risk of both our investments and liabilities and regularly evaluated.

The investment portfolio is centrally managed by investment professionals and decisions are taken based on the guidelines and limitations described in the Statement of Investment Policy and Guidelines (SIPG) and the Puerto Rico Insurance Code. The SIPG is established by the Investment and Financing Committee of the Board of Directors (the Investment and Financing Committee ). The Investment and Financing Committee establishes guidelines to ensure the SIPG is adhered to and any exception must be reported to the Investment and Financing Committee.

The investment portfolio is internally managed by an internal investment group, which 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 external investment managers through the use of mutual funds.

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**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 BCBS names and marks 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 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 ASES, which administers *miSalud* including the dual-eligible beneficiaries program. Federal regulatory agencies that oversee our operations include HHS directly and through its OIG, its OCR and CMS, the DOJ, the DOL, and the OPM. These government agencies have the right to:

- grant, suspend and revoke licenses to transact business;
- regulate many aspects of the products and services we offer, including through the review and approval of health insurance rates in the individual and small group markets;
- assess fines, penalties and/or sanctions;
- 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 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

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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, MCO, 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, we are currently evaluating the effect of this Final Rule 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, (iii) eliminating the use of gender as a ratings factor and (iv) 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;

Provisions that reduce premium payments to Medicare Advantage health plans and that tie such premium to the local Medicare fee for service costs. The adjustment began in 2012 and is being phased in over 5 to 7 years;

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 *miSalud* 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.

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

- licensure;
- policy forms, including plan design and disclosures;
- premium rates and rating methodologies;
- underwriting rules and procedures;
- benefit mandates;
- eligibility requirements;
- security of electronically transmitted individually identifiable health information;
- geographic service areas;
- market conduct;
- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- 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;
- permissible investments; and
- guaranteed issue and renewability.

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

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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 insured, 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.

The provisions regarding health insurance in the Puerto Rico Insurance Code are being revised in phases. The first and second phases of these revisions were enacted on August 29, 2011 and August 23, 2012, respectively. The main objective of the revisions to the Insurance Code is to update the regulatory framework applicable to health insurance and harmonize local provisions with recently approved federal legislation. The revised chapters of the Insurance Code that were recently adopted contain general provisions, such as handling of prescription medicines, availability of health insurance for small and medium-sized companies, prohibition of discretionary clauses in insurance contracts, complaint procedures of health organizations, external reviews, quality improvement programs, utilization review and provider credentialing, among others.

**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, our managed care subsidiaries must periodically inform our clients of our privacy policies, and in the case of our property and casualty and life insurance subsidiaries, 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.

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**Managed Care Provider Services**

Participating managed care providers of the dual-eligible sector of the population, administered by ASES, are required to provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialty 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 Customers Medicare Supplement and Medicare Advantage Sector 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 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, 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 ACL 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.

As of December 31, 2012, our insurance subsidiaries met and exceeded the minimum capital requirements of the Commissioner of Insurance and the BCBSA, as applicable. Because AH began offering BCBS branded products in January 2013, it will now also be required to comply with BCBSA minimum capital requirements.

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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 2011, 2010 and 2009), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2012 and 2011, we had $39.0 million and $37.6 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 18 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. See 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 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. There are approximately 50 million Medicare beneficiaries.

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 ($1,184 deductible for a hospital stay of up to 60 days in 2013).

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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 ($147 in 2013). Beneficiaries who enroll in Medicare Part B pay a monthly premium ($104.90 for 2013) 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 $147 deductible. Beneficiaries who report 2011 income above $85,000 a year ($170,000 filing jointly) are legally responsible to cover a larger portion of the cost of their coverage. These premium adjustments range from $42.00 to $230.80 a month for Medicare Part B.

Part C, also known as Medicare Advantage, allows beneficiaries to enroll in private health plans and receive Medicare-covered benefits. Currently, about 13 million Medicare beneficiaries are enrolled nationally in a Medicare Advantage plan. Under the ACA, payments to Medicare Advantage plans are being reduced over time, and bonus payments are paid to plans based on quality ratings. Beginning in 2014, plans will be required to maintain a MLR of at least 85 percent. The Part C premium varies by plan.

Part D is the voluntary, subsidized outpatient prescription drug benefit created under the MMA Part D includes subsidies for beneficiaries with low incomes that do not apply to Puerto Rico. Part D is offered through private plans that contract with Medicare, including stand-alone prescription drug plans and Medicare Advantage prescription drug plans. The Part D premium varies by plan.

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,, currently known as Medicare Advantage 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.

On April 12, 2012, CMS issued a final rule (the 2012 Final Rule ), effective June 1, 2012, to implement certain changes to the Medicare Advantage and Part D programs mandated by ACA, including strengthening CMS s ability to remove poor performers from the Medicare Advantage and Part D programs beginning in 2015. Under the 2012 Final Rule, beginning with Medicare contract year 2015, CMS will have the authority to terminate its contract with any Medicare Advantage or Part D plan for substantial contract non-compliance, or refuse to renew such plan, if the plan fails to achieve an overall Star Rating of three stars (out of five) for any consecutive three (3) year period. Although CMS has issued annual Star Ratings for Part D plans since 2007 and for Medicare Advantage plans since 2008, CMS will use Star Ratings issued for Medicare contract years 2013 and beyond in implementing the 2012 Final Rule. Thus, contract year 2015 will be the first year in which CMS will have the authority under the 2012 Final Rule to terminate a Medicare Advantage or Part D plan from participation in the federal program based on a plan s ratings for contract years 2013, 2014 and 2015. CMS issues Star Ratings on a prospective basis, typically in the fall preceding the contract year. The 2012 Final Rule provides CMS the authority to use the lower Star Ratings as a means to invoke its existing authority under

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Section 1857(c)(2) of the Social Security Act to terminate a contract when CMS determines that the Medicare Advantage or Part D plan has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage or Part D program.

***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 in 2012, decreases in benchmarks are to be phased-in over 2 to 6 years. The benchmarks 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. When a joint committee of Congress established to develop debt reduction legislation failed to cut at least $1.5 trillion over the coming 10 years, an automatic process of across-the-board cuts ( sequestration ) split equally between defense and non-defense programs was triggered. Under the sequestration, automatic spending cuts became effective beginning March 1, 2013. This resulted in cuts of 2% ($11.1 billion) to Medicare. Medicaid programs are not subject to automatic spending cuts.

***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. 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.

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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 55%. FMAPs are adjusted based on a 3 year cycle. Generally, during economic recessions such as the one that began 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.

The ACA expands Medicaid to an eligibility floor of 138% of the federal poverty level ( FPL ) beginning in 2014. Last year s U.S. Supreme Court decision regarding health care reform limited the federal government s ability to enforce Medicaid expansion meaning that the issue of Medicaid expansion is effectively left to each individual state. States (including Puerto Rico) are in the process of deciding whether to expand their Medicaid programs.

***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)

Under ACA, 15 states (not including Puerto Rico) have been awarded contracts to support the design of demonstration projects that aim to improve the coordination of care for people with Medicare and Medicaid

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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 fiscal year ended September 30, 2012, recoveries from civil health care matters brought under the False Claims Act were approximately $5.0 billion nationally.

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

Health care entities, such as TSS, are subject to laws, including the Health Insurance Portability and Accountability Act of 1996 ( HIPAA ), the Health Information Technology for Economic and Clinical Health Act ( HITECH ), and the Gramm-Leach-Bliley Act, that require the protection of certain health and other information. 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 pursuant to the HIPAA Administrative Simplification provisions and HITECH impose a number of additional obligations on issuers of health insurance coverage and health benefit plan sponsors. These requirements apply to self-funded group plans, health insurers and HMOs, health care clearinghouses and health care providers who transmit health information electronically (collectively, covered entities ) and their business associates that access, maintain, create, and/or receive individually identifiable health information (collectively business associates ). These regulations also establish significant criminal penalties and civil sanctions for non-compliance.

HHS also sets standards relating to the privacy of individually identifiable health information. In general, these regulations restrict how covered entities and business associates may use and disclose medical records and other individually identifiable health information 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, the Secretary of HHS, and in certain cases the media, in the event of a breach of unsecured individually identifiable health information. Our managed care subsidiaries are 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 or more active user IDs and passwords and not the result of a third party intrusion into 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.

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. Additionally, on January 17, 2013, the Secretary of HHS promulgated a final rule (the Omnibus Rule ), clarifying certain aspects of the Stimulus pertaining to HIPAA and bolstering both the Privacy Rule and the Security Rule. We have updated our internal policies and operations to comply with the Stimulus pertaining to HIPAA, and we will modify our policies and operations as necessary to comply with the Omnibus Rule in advance of the compliance deadlines contained therein. In the fall of 2010, CMS notified all Medicare Advantage plans, including our Managed Care subsidiaries 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 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 April 9, 2012, HHS announced the postponement of the original October 2012 compliance deadline to October 2014.

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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 United States Internal Revenue Service (the IRS ) and the 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 subsidiaries. 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.

***Federal Initiatives***

The constitutionality of ACA was challenged by at least 26 states, including Florida, Michigan and Virginia. On June 28, 2012, the U.S. Supreme Court upheld most of the Affordable Care Act. The Court upheld the individual mandate, the single most controversial and essential provision of the ACA which requires individuals (absent certain exceptions) to be covered by insurance by 2014. The Supreme Court also upheld, but limited, the Medicaid expansion provision of the ACA by holding that if a state declines to participate in the expansion, it cannot constitutionally be deprived of the federal Medicaid funding that it had previously received.

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Notwithstanding, 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 Market Proposed Rules

The ACA mandates significant changes to the rules regarding private health insurance to facilitate competition for market efficiency, promote prevention and wellness, increase pooling of risk, and prohibit discrimination for pre-existing conditions and/or health statues. On November 26, 2012, HHS released three proposed rules specifically related to health insurance market reforms, essential benefits, and standards for wellness programs by employers who sponsor group health plans. The market reform proposed rules concerns the sale, pricing, and renewability of health insurance. These rules apply to the individual and small group health insurance markets (whether or not in the health insurance exchanges). The rule does not generally apply to grandfathered health plans. The essential benefits proposed rule establishes the standards for covered benefits under private health insurance coverage. Under the rule, states have the ability to select a benchmark plan from ten popular private health plans. Popularity is based on enrollment figures for the plans. Should a state not select a plan, the default becomes the largest small group health plan. A covered benefit under the benchmark plan will be considered an essential health benefit. Under the ACA, health plans that are not grandfathered in the individual and small group market are required to cover essential health benefits. While essential benefits are not specifically defined, the ACA outlines 10 categories of benefits that are required to be covered by plans, including: a) emergency services; b) ambulatory patient services; c) hospitalization; and d) preventive and wellness services and chronic disease management. The wellness proposed rule amends an earlier regulation regarding the design and implementation of wellness programs offered by employers in group health plans. Among other things, the propose rule would modify existing regulations to increase the maximum reward allowable under reasonably designed programs from 20 to 30 percent, and would further increase the maximum reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. We are assessing the impact these proposed rules, if adopted as drafted, will have on our individual and small group business.

**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 28 to the audited consolidated financial statements for the years ended December 31, 2012, 2011 and 2010 and in note 3 to the unaudited consolidated financial statements for the periods ended March 31, 2013 and 2012.

**Employees**

As of December 31, 2012, we had approximately 3,320 full-time employees and 420 temporary employees. TSS has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 43.3% of our managed care subsidiary s approximately 1,220 regular employees. The collective bargaining agreement expires on July 31, 2016. The Corporation considers its relations with employees to be good.

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## PRINCIPAL SHAREHOLDERS

As of February 26, 2013, we had outstanding 9,042,809 shares of Class A common stock and 19,321,944 shares of Class B common stock. The following table sets forth certain information with respect to the beneficial ownership of our shares of Class A common stock and our Class B common stock, on a fully-diluted basis, as of February 26, 3013, for:

- each shareholder known by us to be the beneficial owner of more than 5% of our outstanding common shares;
- each of our directors; and
- each of our named executive officers.

Beneficial ownership is determined in accordance with the rules of the SEC and includes voting or investment power with respect to the securities. Common shares that may be acquired by an individual or group within 60 days of February 26, 2013, pursuant to the exercise of options or warrants, are deemed to be outstanding for the purpose of computing the percentage ownership of such individual or group, but are not deemed to be outstanding for the purpose of computing the percentage ownership of any other person shown in the table.

Except as indicated in footnotes to this table, we believe that the shareholders named in this table have sole voting and investment power with respect to all common shares shown to be beneficially owned by them, based on information provided to us by such shareholders. Unless otherwise indicated, the address for each director and executive officer listed is: Triple-S Management Corporation, 1441 F.D. Roosevelt Avenue, San Juan, Puerto Rico 00920.

| | Class A Shares | | Class B Shares | |
|---|---|---|---|---|
| **Name and Addresses of Beneficial Owner** | **Shares Beneficially Owned** | **% of Class(1)** | **Shares Beneficially Owned** | **% of Class(1)** |
| **Directors** | | | | |
| Luis A. Clavell-Rodríguez(2) | 17,218 | * | 29,010 | * |
| David H. Chafey, Jr. | | * | | * |
| Carmen Ana Culpeper-Ramírez | | * | 10,028 | * |
| Cari M. Dominguez | | * | 2,495 | * |
| Antonio F. Faría-Soto | | * | 12,162 | * |
| Manuel Figueroa-Collazo | | * | 15,628 | * |
| Joseph A. Frick | | * | | * |
| Jorge L. Fuentes-Benejam | | * | 8,828 | * |
| Juan E. Rodríguez-Díaz | | * | 12,828 | * |
| Jesús R. Sánchez-Colón(3) | 6,064 | * | 13,584 | * |
| Adamina Soto-Martínez | | * | 12,128 | * |
| Francisco Toñarely-Barreto | | * | 4,179 | * |
| **Named Executive Officers** | | | | |
| Ramón M. Ruiz-Comas(4) | | * | 275,057 | 1.42% |
| Amílcar L. Jordán-Pérez | | * | 2,489 | * |
| Arturo Carrión-Crespo | | * | 49,506 | * |
| Pablo Almodóvar-Scalley | | * | 23,861 | * |
| Socorro Rivas-Rodríguez | | * | 87,148 | * |
| Eva G. Salgado-Micheo | | * | 58,060 | * |
| Liliana Rivera-Corcino | | * | 1,215 | * |
| **All our directors, nominees and executive officers as a group (25 persons)** | 23,282 | * | 634,029 | 3.28% |

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| Name and Addresses of Beneficial Owner | Class A Shares Shares Beneficially Owned | % of Class(1) | Class B Shares Shares Beneficially Owned | % of Class(1) |
|---|---|---|---|---|
| **Five Percent Shareholders** | | | | |
| FMR LLC(5) | | | 1,972,134 | 10.21% |
| T. Rowe Price Associates, Inc.(6) | | | 1,788,360 | 9.26 |
| Dimensional Fund Advisors LP(7) | | | 1,485,474 | 7.69 |
| North Run Advisors, LLC(8) | | | 1,334,842 | 6.91 |
| BlackRock, Inc.(9) | | | 1,017,589 | 5.27 |

* Less than 1% of outstanding common stock of such class.

(1) Based on 9,042,809 Class A shares and 19,321,944 Class B shares outstanding as of February 26, 2013.

(2) Mr. Clavell-Rodríguez will be participating in the Conversion and the offering, pursuant to which 12,513 of his Class A shares will be converted and sold in the offering and 4,705 will be converted and retained (assuming full exercise of the over-allotment option).

(3) Includes 5,051 Class A shares and 2,769 Class B shares owned by the spouse of Dr. Sánchez-Colón, with respect to which he has shared voting and dispositive powers. Dr. Sánchez-Colón will be participating in the Conversion and the offering, pursuant to which 736 of his Class A shares will be converted and sold in the offering and 277 will be converted and retained (assuming full exercise of the over-allotment option).

(4) Mr. Ruiz-Comas is the president and chief executive officer. Pursuant to our articles of incorporation and our bylaws, the president is a member of our Board while acting in such capacity.

(5) Based solely on a Schedule 13G/A filed by FMR LLC on February 14, 2013 reporting the above stock ownership as of December 31, 2012. FMR LLC reports that it has sole voting power with respect to 14,400 Class B shares and sole dispositive power with respect to 1,972,134 Class B shares. Fidelity Management & Research Company ( Fidelity ), a wholly-owned subsidiary of FMR LLC, reports that it is the beneficial owner of 1,957,734 Class B shares of the outstanding Class B shares. Fidelity Low-Priced Stock Fund reports that it is the beneficial owner of 1,957,734 Class B shares of the outstanding Class B shares. Edward C. Johnson 3d has sole voting power with respect to 14,400 Class B shares and sole power to dispose of 14,400 Class B shares. Pyramis Global Advisors, LLC, an indirect wholly-owned subsidiary of FMR LLC, is the beneficial owner of 14,400 Class B shares of the outstanding Class B shares.

(6) Based solely on a Schedule 13G/A filed by T. Rowe Price Associates, Inc. ( Price Associates ) on February 11, 2013 reporting the above stock ownership as of December 31, 2012. Price Associates reports that it has sole voting power with respect to 613,310 Class B shares and sole dispositive power with respect to 1,788,360 Class B shares. These securities are owned by various individual and institutional investors which Price Associates serves as investment advisor with the power to direct investments and/or sole power to vote the securities. For the purposes of the reporting requirements of the Exchange Act, Price Associates is deemed to be a beneficial owner of such securities; however, Price Associates expressly disclaims that it is, in fact, the beneficial owner of such securities.

(7) Based solely on a Schedule 13G/A filed by Dimensional Fund Advisors LP ( Dimensional ) on February 11, 2013 reporting the above stock ownership as of December 31, 2012. Dimensional reports that it has sole voting power with respect to 1,462,407 Class B shares and sole dispositive power with respect to 1,485,474 Class B shares. These securities are owned by certain funds which Dimensional serves as investment advisor, sub-adviser and/or manager. For the purposes of the reporting requirements of the Exchange Act, Dimensional is deemed to be a beneficial owner of such securities; however, Dimensional expressly disclaims that it is, in fact, the beneficial owner of such securities.

(8) Based solely on a Schedule 13G/A filed by North Run Capital, LP, North Run GP, LP, North Run Advisors, LLC, Todd B. Hammer and Thomas B. Ellis on February 10, 2012 reporting the above stock ownership as of December 31, 2011. Each of North Run Capital, LP, North Run GP, LP, North Run Advisors, LLC, Todd B. Hammer and Thomas B. Ellis reports that it has shared voting power with respect to 1,334,842 Class B shares and shared dispositive power with respect to 1,334,842 Class B shares.

(9) Based solely on a Schedule 13G/A filed by BlackRock, Inc. on February 11, 2013 reporting the above stock ownership as of December 31, 2012. BlackRock, Inc. reports that it has sole voting power with respect to 1,017,589 Class B shares and sole dispositive power with respect to 1,017,589 Class B shares.

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## SELLING SHAREHOLDERS

The table attached hereto as Annex A contains information with respect to the beneficial ownership of our common stock by the selling shareholders immediately prior to the completion of this offering and as adjusted to reflect the sale of the Shares pursuant to this offering, including the sale of Shares pursuant to the over-allotment option. Before this offering, on a pro forma basis after giving effect to the Conversion, the selling shareholders beneficially owned an aggregate of 7,675,554 shares of Class B common stock, or 29.5% of the outstanding Class B common stock as of March 31, 2013 and 47,752 shares of Class A common stock, or 2.0% of the outstanding Class A common stock as of March 31, 2013. The selling shareholders are selling an aggregate of 6,210,423 shares of Class B common stock in this offering, assuming the full exercise of the over-allotment option. After this offering, the selling shareholders will beneficially own an aggregate of 1,443,949 shares of Class B common stock, or 5.6% of the outstanding Class B common stock after this offering, assuming the full exercise of the over-allotment option. To our knowledge, each selling shareholder has sole voting and investment power with respect to its shares of common stock listed.

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## SHARES ELIGIBLE FOR FUTURE SALE

Future sales of substantial amounts of our Class B common stock, including shares issued upon the exercise of outstanding options or warrants, in the public market could adversely affect market prices prevailing from time to time. Furthermore, because only a limited number of shares will be available for sale by the selling shareholders shortly after this offering due to existing contractual and legal restrictions on resale as described below, there may be sales of substantial amounts of our Class B common stock in the public market after the restrictions lapse. This may adversely affect the prevailing market price and our ability to raise equity capital in the future.

Upon completion of this offering, including giving effect to the Conversion and the purchase by us of Shares, we will have shares of Class B common stock outstanding assuming no exercise of any options and warrants outstanding as of March 31, 2013. We expect all of these shares will be freely transferable without restriction or registration under the Securities Act, except for any shares purchased by one of our existing affiliates, as that term is defined in Rule 144 under the Securities Act, and as set forth in the following sentence. Subject to certain exceptions described under the caption Underwriting, in connection with this offering, we, our directors and executive officers and the selling shareholders have agreed not to offer, sell or agree to sell, directly or indirectly, any shares of our Class B common stock without permission of Credit Suisse Securities (USA) LLC for a period of 180 days from the date of this prospectus. Following this offering, 2,866,621 Class B shares (2,056,566 Class B shares if the underwriters exercise their over-allotment option in full), representing shares converted as part of the Conversion and not sold in the offering and other Class B shares owned by our directors and executive officers and the selling shareholders, will be subject to this lock-up. Class B shares are not held by our directors, officers or selling shareholders and will not be subject to this lock-up. When the lock-up period expires, we and our locked-up shareholders will be able to sell our Class B shares in the public market, subject to prior registration or qualification for an exemption from registration including, the case of shares held by affiliates, compliance with the volume limitation, manner of sale and notice provisions of Rule 144. However, if this offering is not consummated by December 31, 2013, this lock-up will be released.

### Rule 144

In general, under Rule 144 as currently in effect, an affiliate who has beneficially owned restricted shares of our common stock for at least six months would be entitled to sell within any three-month period beginning 90 days after the date of this prospectus a number of shares that does not exceed the greater of either of the following:

- 1% of the number of shares of common stock then outstanding, which will equal approximately shares immediately after this offering; and
- the average weekly reported volume of trading of our common stock during the four calendar weeks preceding the filing of a notice on Form 144 with respect to the sale.

In addition, any sales by affiliates under Rule 144 are also limited by manner of sale provisions and notice requirements and the availability of current public information about us.

The volume limitation, manner of sale and notice provisions described above will not apply to sales by non-affiliates. For purposes of Rule 144, a non-affiliate is any person or entity who is not our affiliate at the time of sale and has not been our affiliate during the preceding three months. A non-affiliate who has beneficially owned restricted shares of our common stock for six months may rely on Rule 144 provided that certain public information regarding us is available. However, a non-affiliate who has beneficially owned the restricted shares proposed to be sold for at least one year will not be subject to any restrictions under Rule 144.

We are unable to estimate the number of shares that will be sold under Rule 144 since this will depend on the market price for our Class B common stock, the personal circumstances of the stockholder and other factors.

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**Stock Options**

On May 20, 2008, we filed a registration statement on Form S-8 under the Securities Act covering an aggregate of 4,700,000 shares of Class B common stock issuable pursuant to our 2007 Incentive Plan. These shares are available for sale in the open market, subject to Rule 144 volume limitation, manner of sale and notice provisions applicable to affiliates, vesting restrictions with us or the contractual restrictions described above.

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## MATERIAL UNITED STATES FEDERAL INCOME TAX CONSIDERATIONS

### U.S. Federal Income Tax Considerations

The following is a discussion of the material U.S. federal income tax considerations relevant to the acquisition, ownership and disposition of shares of Class B common stock by U.S. Holders, as defined below, but it does not purport to be a comprehensive description of all of the tax considerations that may be relevant to a particular person s decision to acquire such securities. The discussion applies only if you hold shares of Class B common stock as a capital asset for tax purposes and it does not describe all of the tax consequences that may be relevant in light of a U.S. Holder s particular circumstances, including alternative minimum tax consequences, the potential application of the Medicare contribution tax, and tax consequences applicable to U.S. Holders subject to special rules, such as:

- certain financial institutions;
- regulated investment companies and real estate investment trusts;
- insurance companies;
- dealers and traders who use a mark-to-market method of tax accounting;
- persons holding shares of Class B common stock as part of a hedging transaction, straddle, wash sale, conversion transaction or other integrated transaction or persons entering into a constructive sale with respect to shares of Class B common stock;
- persons whose functional currency for U.S. federal income tax purposes is not the U.S. dollar;
- partnerships or other entities classified as partnerships for U.S. federal income tax purposes;
- persons holding shares in connection with a trade or business conducted outside of the United States;
- certain former residents of the United States; or
- tax-exempt entities, including an individual retirement account or Roth IRA.

If an entity that is classified as a partnership for U.S. federal income tax purposes holds shares of Class B common stock, the U.S. federal income tax treatment of a partner will generally depend on the status of the partner and the activities of the partnership. Partnerships holding shares of Class B common stock and partners in such partnerships should consult their tax advisers as to the particular U.S. federal income tax consequences of holding and disposing of the shares of Class B common stock.

This discussion is based on the Internal Revenue Code of 1986, as amended (the Code ), administrative pronouncements, judicial decisions and final, temporary and proposed Treasury regulations, all as of the date of this offering, any of which is subject to change, possibly with retroactive effect.

A U.S. Holder is a holder who, for U.S. federal income tax purposes, is a beneficial owner of shares of Class B common stock and is:

a citizen or individual resident of the United States;

a corporation, or other entity taxable as a corporation, created or organized in or under the laws of the United States, any state therein or the District of Columbia; or

an estate or trust the income of which is subject to U.S. federal income taxation regardless of its source.

The term U.S. Holder does not include individual Puerto Rico residents who are not citizens or residents of the United States, nor does it include Puerto Rico corporations or other Puerto Rico entities taxable as corporations. As used herein, the term Puerto Rico U.S. Holder means an individual U.S. Holder who is a bona fide resident of Puerto Rico during the entire taxable year (or, in some cases, a portion thereof) within the meaning of Section 933 of the Code.

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You should consult your own tax advisor concerning the U.S. federal, state, local and foreign tax consequences of purchasing, owning and disposing of shares of Class B common stock based on your particular circumstances.

**Taxation of Distributions**

Subject to the controlled foreign corporation rules, related person insurance income rules and passive foreign investment company rules, each described below, distributions paid on shares of Class B common stock, other than certain pro rata distributions of shares of Class B common stock (including any distributions of shares of Class B common stock in respect of anti-dilution rights, as discussed below), will be treated as a dividend to the extent paid out of the Company s current or accumulated earnings and profits (as determined under U.S. federal income tax principles). Subject to applicable limitations and the discussion below concerning Puerto Rico U.S. Holders, dividends paid to non-corporate U.S. Holders will be taxable at the preferential rates applicable to long-term capital gain. U.S. Holders should consult their own tax advisors regarding the implications of these rules in their particular circumstances. The amount of a dividend will include any amounts withheld by the Company or its paying agent in respect of Puerto Rico taxes. Because the Company does not currently, and does not expect to, conduct significant operations in the United States, the amount of the dividend generally will be treated as foreign-source dividend income and will not be eligible for the dividends received deduction generally allowed to U.S. corporations under the Code.

Subject to applicable limitations that may vary depending upon your circumstances and provided that you are not a Puerto Rico U.S. Holder, any Puerto Rico taxes withheld from dividends on shares of Class B common stock will be creditable against your U.S. federal income tax liability. The limitation on foreign taxes eligible for credit is calculated separately with respect to specific classes of income. The rules governing foreign tax credits are complex and, therefore, you should consult your own tax advisors regarding the availability of foreign tax credits in your particular circumstances. Instead of claiming a credit, U.S. Holders may, at their election, deduct such otherwise creditable Puerto Rico taxes in computing their taxable income, subject to generally applicable limitations under U.S. federal income tax law. An election to deduct foreign taxes instead of claiming foreign tax credits applies to all taxes paid or accrued in the taxable year to foreign countries and possessions of the United States.

A Puerto Rico U.S. Holder generally will be exempt from U.S. federal income taxation with respect to dividends paid on shares of Class B common stock. However, in the event the Company expands its operations outside of Puerto Rico, and depending on the extent of such operations, dividends paid on shares of Class B common stock to a Puerto Rico U.S. Holder may not be eligible for the exemption. Such holders should consult their own tax advisors concerning their status as a Puerto Rico U.S. Holder, the availability of the exemption from U.S. federal income tax on dividends in their particular circumstances and certain limitations on deductions and credits that may otherwise be available under U.S. federal income tax law.

**Distributions in Respect of Anti-Dilution Rights**

Distributions of shares of Class B common stock, other than cash in lieu of fractional shares of Class B common stock, received as a distribution in respect of anti-dilution rights (as discussed above under Description of Capital Stock Anti-Dilution Rights ) generally will not be subject to U.S. federal income tax on the date of distribution. In the event of such a pro rata distribution, a U.S. Holder s tax basis in the newly distributed shares of Class B common stock (including any fractional shares) (the New Shares ) and the shares of Class B common stock held before the distribution (the Old Shares ) will be determined by allocating such holder s basis in the Old Shares between the Old Shares and the New Shares in proportion to the fair market values of each on the date of distribution. A U.S. Holder will have the same holding period for the New Shares as it had for the Old Shares. With respect to any cash received in lieu of fractional shares of Class B common stock, a U.S. Holder will realize gain or loss on an amount equal to the difference between the amount of cash received and the

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U.S. Holder s tax basis in the fractional shares of Class B common stock, determined in the manner discussed above. Any gain or loss will be subject to U.S. federal income tax as described below under Sale or Other Disposition of Class B Shares.

**Sale or Other Disposition of Class B Shares**

Subject to the controlled foreign corporation rules, related person insurance income rules and passive foreign investment company rules, each described below, and subject to the discussion below concerning Puerto Rico U.S. Holders, for U.S. federal income tax purposes, gain or loss realized on the sale or other disposition of shares of Class B common stock will be capital gain or loss, and will be long-term capital gain or loss if the U.S. Holder held the shares of Class B common stock for more than one year. The amount of a U.S. Holder s gain or loss will be equal to the difference between the U.S. Holder s tax basis in the shares of Class B common stock disposed of and the amount realized on the disposition, in each case as determined in U.S. dollars. This gain or loss generally will be U.S.-source gain or loss for foreign tax credit purposes, except for a Puerto Rico U.S. Holder.

If any gain from the sale or other disposition of shares of Class B common stock is subject to Puerto Rico tax, you may not be able to credit such taxes against your U.S. federal income tax liability under the U.S. foreign tax credit limitations of the Code because such gain generally would be U.S.-source income. However, such tax may be credited against tax due on other income derived from foreign sources (subject to applicable limitations).

Gain realized by a Puerto Rico U.S. Holder on the sale or other disposition of shares of Class B common stock generally will be exempt from U.S. federal income taxation and will be treated as Puerto Rico-source income for U.S. federal income tax purposes. Such holders should consult their own tax advisors concerning their status as Puerto Rico U.S. Holders, the availability of the exemption from tax on gain from the sale or other disposition of shares of Class B common stock in their particular circumstances and certain limitations on deductions and credits that may otherwise be available under U.S. federal income tax law.

**Controlled Foreign Corporation Rules**

A foreign corporation generally is considered a controlled foreign corporation (a CFC ) for U.S. federal income tax purposes if 10% U.S. Shareholders (as defined below) directly, indirectly or constructively own more than 50% of such company s shares by vote or value. In addition, for purposes of taking into account certain insurance income, the term CFC also generally includes a foreign insurance company in which 10% U.S. Shareholders directly, indirectly or constructively own more than 25% of such company s shares by vote or value. A