TRIPLE-S MANAGEMENT CORP
Form 10-K
March 13, 2008

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

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2007

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

COMMISSION FILE NUMBER 0-49762
Triple-S Management Corporation

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

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

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

Securities registered pursuant to Section 12(g) of the Act: Class A common stock, $1.00 par value
Indicate by check mark if the registrant is well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES o NO þ
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. YES o NO þ
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES þ NO o
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer, accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o	Accelerated filer o	Non-accelerated filer þ	Smaller reporting company o

(Do not check if a smaller reporting company)
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act). o YES þ NO
The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are affiliates) as of June 30, 2007 was approximately $26,709,000. Aggregate market value was determined at par because at that time there was no established public trading market for TSM s common stock.

As of February 29, 2008, the registrant had 16,042,809 of its Class A common stock outstanding and 16,266,554 of is Class B common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive Proxy Statement to be delivered to shareholders in connection with the Annual Meeting of Shareholders to be held April 27, 2008 are incorporated by reference into Parts II and III of this Annual Report on Form 10-K.

Triple-S Management Corporation
FORM 10-K
For The Fiscal Year Ended December 31, 2007
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Part I

Item 1. Business.

General Description of Business and Recent Developments

Triple-S Management Corporation (Triple-S , TSM , the Company , the Corporation , we , us or our) is the la managed care company in Puerto Rico, serving approximately one million members across all regions, and holds a leading market position covering approximately 25% of the population. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico and have over 45 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial, Medicare and Puerto Rico Health Reform (similar to Medicaid) (the Reform) markets.

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

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

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

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

Industry Overview

Managed Care

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

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stand-alone basis, pursuant to Medicare Part D (also referred to as PDP stand-alone product). In addition, the government of the Commonwealth of Puerto Rico (the government of Puerto Rico) provides managed care coverage to the medically indigent population of Puerto Rico through the Reform program.

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

The Blue Cross Blue Shield Association (BCBSA) had 39 independent licensees as of December 31, 2007. We are licensed by BCBSA to use both the Blue Shield name and mark in Puerto Rico. Most of the BCBSA licensees have the right to use the Blue Shield and Blue Cross marks in their designated geographic territories. We are not licensed to use the Blue Cross mark in Puerto Rico. A different BCBSA licensee has the right to use the Blue Cross mark in Puerto Rico. The number of people enrolled in Blue Cross Blue Shield (BCBS) plans has been steadily increasing, from 65.2 million in 1994 to 100.2 million at December 31, 2007 which represents 33.0% of the U.S. population. The Blue Cross Blue Shield plans work cooperatively in a number of ways that create significant market advantages, especially when competing for very large, multi-state employer groups. For example, all Blue Cross Blue Shield plans participate in the BlueCard program, which effectively creates a national Blue network. Each plan is able to take advantage of other Blue Cross Blue Shield plans broad provider networks and negotiated provider reimbursement rates where a member covered by a policy in one state or territory lives or travels outside of the state or territory in which the policy under which he or she is covered is written. This program is referred to as BlueCard, and is a source of revenue for providing member services in Puerto Rico for individuals who are customers of other BCBS plans and at the same time provide us a significant network in the U.S. BlueCard also provides a significant competitive advantage to us because Puerto Ricans frequently travel to the continental United States.

Life Insurance

Total annual premiums in Puerto Rico in 2006 for the life insurance market approximate $700 million. The main products in the market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are through independent agents. In recent years banks have established general agencies to cross sell many life products, such as term life and credit life.

Property and Casualty Insurance Segment

The total property and casualty market in Puerto Rico in terms of gross premiums written for 2006 was approximately $1.8 billion. Property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi peril, fire and allied lines and other general liabilities. Approximately 70% of the market is written by the top six companies in terms of market share, and approximately 80% of the market is written by companies incorporated under the laws of, and which operate principally in, Puerto Rico.

It is estimated that the Puerto Rican property and casualty insurance market has between $80 billion and $90 billion of insured value, while the industry has capital and surplus of approximately $1.4 billion. As a result, the market is highly dependent on reinsurance and some local carriers have diversified their operations outside Puerto Rico, particularly to Florida.

Puerto Rico s Economy

The economy of Puerto Rico is closely linked to that of the mainland United States, as most of the external factors that affect the Puerto Rico economy (other than the price of oil) are determined by the policies and results of the United States. These external factors include exports, direct investment, the amount of federal transfer payments, the level of interest rates, the rate of inflation, and tourist expenditures. During the fiscal year ended June 30, 2006, approximately 83% of Puerto Rico s exports went to the United States mainland, which was also the source of approximately 51% of Puerto Rico s imports. In the past, the

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economy of Puerto Rico has generally followed economic trends in the overall United States economy. However, in recent years economic growth in Puerto Rico has lagged behind growth in the United States.

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

Preliminary figures for fiscal year 2006 show that gross product increased from $53.6 billion (in current dollars) for fiscal 2005 to $56.7 billion (in current dollars) for fiscal 2006. Real gross national product, however, is projected to decline by 1.4% for fiscal year 2007. Personal income, both aggregate and per capita, has increased consistently each fiscal year from 1985 to 2006. In fiscal year 2006, aggregate personal income was $50.9 billion and personal income per capita was $12,997. Personal income, however, is expected to decline by 1.2% in fiscal year 2007. Average total employment increased from 1,253,400 in fiscal 2006 to 1,262,900 for fiscal 2007. The average unemployment rate decreased from 11.7% in fiscal 2006 to 10.4% in fiscal 2007.

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

Products and Services

Managed Care

We offer a broad range of managed care products, including HMOs, PPOs, Medicare Supplement, Medicare Advantage and Medicare Part D. Managed care products represented 86.1%, 88.6% and 92.7% of our consolidated premiums earned, net for the years ended December 31, 2007, 2006 and 2005. We design our products to meet the needs and objectives of a wide range of customers, including employers, individuals and government entities. Our customers either contract with us to assume underwriting risk or self-funded underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members access to providers is subject to referral or preauthorization requirements.

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

We currently offer the following managed care plans:

Health Maintenance Organization (HMO). We offer HMO plans that provide our Reform and Medicare Advantage members with health care coverage for a fixed monthly premium in addition to applicable member co-payments. Health care services can include emergency care, inpatient hospital and physician

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care, outpatient medical services and supplemental services, such as dental, vision, behavioral and prescription drugs, among others. Members must select a primary care physician within the network to provide and assist in managing care, including referrals to specialists. During the third quarter of 2005, we launched Medicare Selecto, our Medicare Advantage product for dual eligibles (individuals that are eligible for both the Reform and Medicare Advantage), and in 2006 we launched a supplemental product sponsored by the government of Puerto Rico called Medicare Platino.

Preferred Provider Organization (PPO). We offer PPO managed care plans that provide our commercial and Medicare Advantage members and their dependent family members with health care coverage in exchange for a fixed monthly premium from our member or the member s employer. In addition, we provide our PPO members with access to a larger network of providers than our HMO. In contrast to our HMO product, we do not require our PPO members to select a primary care physician or to obtain a referral to utilize in-network specialists. We also provide coverage for PPO members who access providers outside of the network. Out-of-network benefits are generally subject to a higher deductible and coinsurance. We also offer national in-network coverage to our PPO members through the BlueCard program. As a PPO under the Medicare Advantage program, effective January 1, 2005 we launched Medicare Optimo, our PPO Medicare Advantage policy, under which we provide extended health coverage to Medicare beneficiaries.

BlueCard. For our members who purchase our PPO and some of our Medicare Advantage products, we offer the BlueCard program. The BlueCard program offers these members in-network benefits through the networks of the other Blue Cross Blue Shield plans in the 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 basic Medicare program does not cover, such as deductibles, coinsurance and specified losses that exceed the Federal program s maximum benefits.

Prescription Drug Benefit Plans. Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D pursuant to our Medicare Advantage plans as well as on a stand-alone basis. Our PDP stand-alone product, called FarmaMed, was launched in 2006. In May 2005, we launched the Drug Discount Card for local government employees and individuals. As of December 31, 2007, we had enrolled approximately 18,000 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2008.

Government Services We serve as fiscal intermediary for the Medicare Part B program in Puerto Rico and the U.S. Virgin Islands, for which we receive reimbursement of all direct costs and allocated overhead expenses, based on an approved budget by CMS. This program is subject to change. See Regulation Fiscal Intermediary included in this Item.

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

Life Insurance

We offer a wide variety of life, accident and health and annuity products to all markets in Puerto Rico through our subsidiary Triple-S Vida, Inc. (TSV). Among these are group life and life individual insurance products. Life insurance premiums represented 5.9%, 5.7% and 1.2% of our consolidated premiums earned, net for the years ended December 31, 2007, 2006 and 2005. TSV markets in-home service life and

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supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases, credit and pre-need life products are marketed through independent agents. We are the principal company in Puerto Rico that offers guaranteed issue, funeral and cancer policies directly to people in their homes in the lower and middle income market segments. We also market our group life coverage through our managed care subsidiary s network of exclusive agents.

Property and Casualty Insurance

We offer a wide range of property and casualty insurance products through our subsidiary Seguros Triple-S, Inc. (STS). Property and casualty insurance premiums represented 6.4%, 5.9% and 6.3% of our consolidated premiums earned, net for the years ended December 31, 2007, 2006 and 2005. Our predominant lines of business are commercial multi-peril, commercial property mono-line policies, auto physical damage, auto liability and dwelling insurance. The segment s commercial lines target small to medium size accounts. We generate a majority of our dwelling business through our strong relationships with financial institutions. During the year ended December 31, 2007, we generated our premiums in the property and casualty insurance segment primarily from the following lines of business:

	Percentage of Total Segment Revenues for the Year Ended December 31, 2007
Line of Business	
Commercial multi-peril line of business	43%
Auto business	25
Dwelling and commercial property mono-line businesses	17
Other	15

Due to our geographical location, property and casualty insurance operations in Puerto Rico are subject to natural catastrophic activity, in particular hurricanes and earthquakes. As a result, local insurers, including us, rely on the international reinsurance market. The property and casualty insurance market is affected by the cost of reinsurance, which varies with the catastrophic experience. After 2005, the cost of reinsurance reported increases due to the severe catastrophic losses occurred in that year. The 2006 and 2007 years have been of lower severity on catastrophic events and accordingly, reinsurance rates are lower in 2008.

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Our policy is to enter into reinsurance agreements with reinsurers considered to be financially sound. Over 90% of our reinsurers have an A.M. Best rating of A- or better, or an equivalent rating from other rating agencies. During the year ended December 31, 2007, 40.5% of the premiums written in the property and casualty insurance segment were ceded to reinsurers. Although these reinsurance arrangements do not relieve us of our direct obligations to our insureds, we believe that the risk of our reinsurers not paying balances due to us is low.

Marketing and Distribution

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

Branding and Marketing

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

to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall

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company image. We believe these efforts support and further our competitive brand advantage. We will continue to utilize the Triple-S name and the Blue Shield mark for all managed care products and services in Puerto Rico.

Distribution

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

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

Life Insurance Segment. In our life insurance segment, we offer our insurance products through our own network of brokers and independent agents, as well as group life insurance coverage through our managed care network of agents. We place a majority of our premiums (57% and 47% during the years ended December 31, 2007 and 2006) through direct selling to customers in their homes. TSV employs over 500 full-time active agents and managers and utilized approximately 1,200 independent agents and brokers. We pay commissions on a monthly basis based on premiums paid. In addition, TSV has over 200 agents that are licensed to sell certain of our managed care products.

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is exclusively subscribed through 20 general agencies, including our insurance agency, Signature Insurance Agency, Inc. (SIA), where business is placed by independent insurance agents and brokers. SIA placed approximately 52% of our property and casualty insurance subsidiary, STS, total premium volume during each of the years ended December 31, 2007, 2006 and 2005, respectively. As of December 31, 2007, SIA was the third largest insurance agency in Puerto Rico in terms of premiums written. The general agencies contracted by our property and casualty insurance subsidiary remit premiums net of their respective commission.

Customers

Managed Care

We offer our products in the managed care segment to four distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2007:

	Enrollment at December 31, 2007	Percentage of Total Enrollment
Market Sector		
Commercial	574,251	58.8%
Reform	353,694	36.2
Medicare Advantage	49,245	5.0
Total	977,190	100.0%

Commercial Sector

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

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Corporate Accounts. Corporate accounts consist of small (2 to 50 employees) and large employers (over 50 employees). Employer groups may choose various funding options ranging from fully insured to self-funded financial arrangements or a combination of both. While self-funded clients participate in our managed care networks, the clients bear the claims risk, except to the extent that such self-funded clients maintain stop loss coverage, including with us.
U.S. Federal Government Employees. For more than 40 years, we have maintained our leadership in the provision of managed care to U.S. federal government employees in Puerto Rico. We provide our services to federal employees in Puerto Rico under the Federal Employees Health Benefits Program pursuant to a direct contract with the United States Office of Personnel Management (OPM). We are one of two companies in Puerto Rico that has such a contract with OPM. Every year, OPM allows other insurance companies to compete for this business, provided such companies comply with the applicable requirements for service providers. This contract is subject to termination in the event of noncompliance not corrected to the satisfaction of OPM.
Individual Accounts. We provide managed care services to individuals and their dependent family members who contract these services directly with us though our network of independent brokers. We provide individual and family contracts. We assume the risk of both medical and administrative costs in return for a monthly premium.
Local Government Employees. We provide managed care services to the local government employees of Puerto Rico through a government-sponsored program whereby the health plan assumes the risk of both medical and administrative costs for its members in return for a monthly premium. The government qualifies on an annual basis the managed care companies that participate in this program and sets the coverage, including benefits, co-payments and amount to be contributed by the government. Employees then select from one of the authorized companies and pays for the difference between the premium of the selected carrier and the amount contributed by the government.
Medicare Supplement. We offer Medicare Supplement products, which provide supplemental coverage for many of the medical expenses that the basic Medicare program does not cover, such as deductibles, coinsurance and specified losses that exceed the Federal program s maximum benefits.

Reform Sector

In 1994, the government of Puerto Rico privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into geographical areas and by December 31, 2001, the Reform had been fully implemented in each of these areas. Each of the eight geographical areas is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2007, the Reform provided healthcare coverage to over 1.5 million people. Mental health and drug abuse benefits are currently offered to Reform beneficiaries by behavioral healthcare companies and are therefore not part of the benefits covered by us.
The Reform program is similar to the Medicaid program, a joint federal and state health insurance program for medically indigent residents of the state. The Medicaid program is structured to provide states the flexibility to establish eligibility requirements, benefits provided, payment rates, and program administration rules, subject to general federal guidelines.
The government has adopted several measures to control the increase of Reform expenditures, which represented approximately 6.2% of total government expenditures during its fiscal year ended June 30, 2007, including closer and continuous scrutiny of participants (members) eligibility, decreasing the number of areas in order to take advantage of economies of scale and establishing disease management programs. In addition, the government of Puerto Rico began a pilot project in 2003 within one of the eight geographical areas under which it contracted services on an ASO basis with an Independent Practice Associations (IPA), instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us until October 31, 2006. All other areas that we currently serve remain with the fully-insured model; however, there can be no assurance that the government will not implement such a program in the future. If it is adopted in any areas served by us during the contract period, we would not generate premiums in the Reform business but instead

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administrative service fees. On the other hand, the government has expressed its intention to evaluate different alternatives of providing health services to Reform beneficiaries.

The government of Puerto Rico has also implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in Medicare Advantage programs, such as the deductibles and co-payments of prescription drug benefits. Many qualified Reform participants began moving to the government-sponsored plan in January 2006, and approximately 61,000 of such participants did so in the year ended December 31, 2006. During the year ended December 31, 2007, approximately 3,400 participants from areas served by us moved to the government-sponsored plan.

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

Medicare

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

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

Life Insurance

Our life insurance customers consist primarily of individuals, which hold approximately 340,000 policies, and insure approximately 1,900 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.

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Underwriting and Pricing

Managed Care

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

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

We have been able to maintain relatively high retention rates in the corporate accounts sector of our managed care business and since 2003 have maintained our overall market share. The retention rate in our corporate accounts, which is the percentage of existing business retained in the renewal process, has been over 90% in the last four years.

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

Life Insurance

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

Property and Casualty Insurance

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

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

Quality Initiatives and Medical Management

We utilize a broad range of focused traditional cost containment and advanced care management processes across various product lines. We continue to enhance our management strategies, which seek to control

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

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

We have designed a comprehensive Quality Improvement Program (QIP). This program is designed with a strong emphasis on continuous improvement of clinical and service indicators, such as Health Employment Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures. Our QIP also includes a Physician Incentive Program (PIP) which is directed to support corporate quality initiatives, such as participation of members on chronic care improvement programs.

Information Systems

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

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

In addition, we have selected Quality Care Solutions, Inc. to assess and implement new core business applications for our managed care segment. We completed this assessment in the fourth quarter of 2007 and plan to convert our managed care system over time by line of business, with the first line of business expected to be converted in the first half of 2009. We expect the managed care conversion process to be completed by 2012 at a total cost of approximately $64.0 million.

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

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Provider Arrangements

Approximately 98% of member services are provided through one of our contracted provider networks and the remaining 2% of member services are provided by out-of-network providers. Our relationships with managed care providers, physicians, hospitals, other facilities and ancillary managed care providers are guided by standards established by applicable regulatory authorities for network development, reimbursement and contract methodologies. As of December 31, 2007, we had provider contracts with 4,433 primary care physicians, 3,071 specialists and 63 hospitals.

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

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

In the Reform sector, we have a network of IPAs which provide managed care services to our Reform beneficiaries in exchange for a capitation fee. The IPA assumes the costs of certain primary care services provided and referred by its primary care physicians (PCPs), including procedures and in-patient services not related to risks assumed by us. We retain the risk associated with services provided to beneficiaries under this arrangement, such as: neonatal, obstetrical, AIDS, cancer, cardiovascular and dental services, among others.

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

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

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

Services are provided to our members through our network providers with whom we contract directly. Members seeking medical treatment outside of Puerto Rico are served by providers in these areas through the BlueCard program, a third-party national provider network.

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

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

Competition

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

Managed Care

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

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

Competitors in the managed care segment include national and local managed care plans. We currently have approximately 977,000 members enrolled in our managed care segment at December 31, 2007, representing approximately 25% of the population of Puerto Rico. Our market share in terms of premiums written in Puerto Rico was estimated at over 25% for the year ended December 31, 2006. We offer a variety of managed care products, and are the leader by market share in almost every sector, as measured by the share of premiums written. Our nearest competitor is Medical Card Systems Inc., which had a market share of approximately 22% as of December 31, 2006. Our other largest competitors in the managed care segment are Aveta Inc. (or MMM Healthcare) and Humana Inc.

Life Insurance

We are the leading provider of life insurance products in Puerto Rico. In the life insurance segment, we are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines, in particular from Cooperativa de Seguros de Vida de Puerto Rico and National Life Insurance Company. In the ordinary life sector, our main competitors are National Life Insurance Company and Americo Financial Life and Annuity Insurance Company. In group life insurance, our main competitors are Hartford Life, Inc., Universal Life Insurance Company and Metropolitan Life Insurance Company. In the cancer sector, our main competitors are National Life Insurance Company, Trans-Oceanic Life Insurance Company, Universal Life Insurance Company and American Family Insurance.

Property & Casualty Insurance

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

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In 2006, we were the fourth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 9%. Our nearest competitors in the property and casualty insurance market in Puerto Rico in 2006 were National Insurance Company and Integrand Assurance Company. The market leaders in the property and casualty insurance market in Puerto Rico in 2006 were Universal Insurance Group, Cooperativa de Seguros Múltiples de Puerto Rico and MAPFRE Corporation.

Blue Shield License

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

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

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

- failure to maintain our total adjusted capital at 200% of Health Risk-Based Capital Authorized Control Level, as defined by the National Association of Insurance Commissioners (NAIC) Risk Based Capital (RBC) model act;
- failure to maintain liquidity of greater than one month of underwritten claims and administrative expenses, as defined by the BCBA, for two consecutive quarters;
- failure to satisfy state-mandated statutory net worth requirements;
- impending financial insolvency; and
- a change of control not otherwise approved by the BCBSA or a violation of the BCBSA voting and ownership limitations on our capital stock.

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

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

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

Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the Blue Shield name and mark. The annual BCBSA fee for the year

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2008 is $997,476. During the years ended December 31, 2007 and, 2006, we paid fees to the BCBSA in the amount of $921,636 and $964,956, respectively. The BCBSA is a national trade association of 39 Blue Cross Blue Shield licensees (also known as Member Plans), the primary function of which is to promote and preserve the integrity of the Blue Cross Blue Shield names and marks, as well as to provide certain coordination among the Member Plans. Each Blue Cross Blue Shield Member Plan is an independent legal organization and is not responsible for obligations of other Blue Cross Blue Shield Association Member Plans. With a few limited exceptions, we have no right to market products and services using the Blue Shield names and marks outside our Blue Shield licensed territory.

We do not have the authority to use the Blue Cross name and marks in Puerto Rico.

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

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 degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. For additional information regarding the calculation of claim liabilities, see Item 7 Management s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Policies and Estimates Claim Liabilities .

Investments

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

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

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

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

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

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Trademarks

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

Regulation

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

grant, suspend and revoke licenses to transact business;

regulate many aspects of the products and services we offer;

assess fines, penalties and/or sanctions;

monitor our solvency and adequacy of our financial reserves; and

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

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

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

local government plans and initiatives;

Reform and Medicare reform legislation; and

Increase government concerns regarding fraud and abuse.

The U.S. Congress is continuing to develop legislation efforts directed toward patient protection, including proposed laws that could expose insurance companies to economic damages, and in some cases punitive damages, for making a determination denying benefits or for delaying members receipt of benefits as well as for other coverage determinations. Similar legislation has been proposed in Puerto Rico. Given the political process, it is not possible to determine whether any federal and/or local legislation or regulation will be enacted in 2008 or what form any such legislation might take. Other legislative or regulatory changes that may affect us are described below. While certain of these measures could adversely affect us, at this time we cannot predict the extent of this impact.

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

licensure;

policy forms, including plan design and disclosures;

premium rates and rating methodologies;

underwriting rules and procedures;

benefit mandates;

eligibility requirements;

security of electronically transmitted individually identifiable health information;

geographic service areas;

market conduct;

utilization review;

payment of claims, including timeliness and accuracy of payment;

special rules in contracts to administer government programs;

transactions with affiliated entities;

limitations on the ability to pay dividends;

rates of payment to providers of care;

transactions resulting in a change of control;

member rights and responsibilities;

fraud and abuse;

sales and marketing activities;

quality assurance procedures;

privacy of medical and other information and permitted disclosures;

rates of payment to providers of care; · surcharges on payments to providers;

provider contract forms;

delegation of financial risk and other financial arrangements in rates paid to providers of care;

agent licensing;

financial condition (including reserves);

reinsurance;

issuance of new shares of capital stock;

corporate governance; and

permissible investments.

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

Puerto Rico Insurance Laws

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

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

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

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

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

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

Privacy of Financial and Health Information

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

Managed Care Provider Services

Puerto Rico law requires that managed care providers cover and provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialized services. In addition, the Office of the Solicitor for the Beneficiaries of the Reform is authorized to review and supervise the operations of entities contracted by the Commonwealth of Puerto Rico to provide services under the Reform. The Solicitor may investigate and adjudicate claims filed by beneficiaries of the Reform against the various service providers contracted by the Commonwealth of Puerto Rico. See Business Customers Medicare Supplement Reform Sector included in this Item for more information.

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Capital and Reserve Requirements

In addition to the capital and reserve requirements set forth below, the Commissioner of Insurance requires our managed care subsidiary to maintain minimum capital of $1.0 million, our life insurance subsidiary to maintain minimum capital of $2.5 million and our property and casualty insurance subsidiary to maintain minimum capital of $3.0 million. In addition, our managed care subsidiary is subject to the capital and surplus licensure requirements of the BCBSA.

The capital and surplus requirements of the BCBSA are based on the National Association of Insurance Commissioners (NAIC) RBC Model Act. These capital and surplus requirements are intended to assess capital adequacy taking into account the risk characteristics of an insurer s investments and products. The RBC Model Act set forth the formula for calculating the risk-based capital requirements, which are designed to take into account risks, insurance risks, interest rate risks and other relevant risks with respect to an individual insurance company s business. The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company s risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the company s total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The company action level is triggered if a company s total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital. At the company action level, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. A company whose total adjusted capital is between 250% and 200% of its risk-based capital is subject to a trend test. The trend test calculates the greater of any decrease in the margin (i.e., the amount in dollars by which a company s adjusted capital exceeds it risk-based capital) between the current year and the prior year and between the current year and the average of the past three years, and assumes that the decrease could occur again in the coming year. If a similar decrease in margin in the coming year would result in a risk-based capital ratio of less than 190%, then company action level regulatory action will occur. The regulatory action level is triggered if a company s total adjusted capital is less than 150% but greater than or equal to 100% of its risk-based capital. At the regulatory action level, the regulatory authority will perform a special examination of the company and issue an order specifying corrective actions that must be followed. The authorized control level is triggered if a company s total adjusted capital is less than 100% but greater than or equal to 70% of its risk-based capital, at which level the regulatory authority may take any action it deems necessary, including placing the company under regulatory control. The mandatory control level is triggered if a company s total adjusted capital is less than 70% of its risk-based capital, at which level the regulatory authority must place the company under its control.

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

In addition to its catastrophic reinsurance coverage, STS is required by local regulatory authorities to establish and maintain a trust fund (the Trust) to protect us from our dual exposure to hurricanes and earthquakes. The Trust is intended to be used as our first layer of catastrophe protection whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust are determined by a rate (1% in 2007 and 2006), imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2007 and 2006, we had $29.1 million and $27.1 million, respectively, invested in securities deposited in the Trust. The income generated by investment securities deposited in the Trust becomes part

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of the Trust fund balance. For additional details see note 16 of the audited consolidated financial statements.

Dividend Restrictions

Puerto Rico insurance laws also restrict insurance companies ability to pay dividends, as they provide that such companies can only pay cash dividends from their available surplus funds derived from realized net profits and cannot pay dividends with funds derived from loans. Any violation of these provisions would subject us to a penalty under these laws.

Puerto Rico insurance laws are not directly applicable to us, as a holding company, since we are not an insurance company. However, we, together with our insurance subsidiaries, 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.

Guaranty Fund Assessments

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

Federal Regulation

The Medicare Program and Medicare Advantage

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

The Medicare program, created in 1965, offers both hospital insurance, known as Medicare Part A, and medical insurance, known as Medicare Part B. In general, Medicare Part A covers hospital care and some nursing home, hospice and home care. Although there is no monthly premium for Medicare Part A, beneficiaries are responsible for significant deductibles and co-payments. All United States citizens eligible for Medicare are automatically enrolled in Medicare Part A when they turn 65. Enrollment in Medicare Part B is voluntary. In general, Medicare Part B covers outpatient hospital care, physician services, laboratory services, durable medical equipment, and some other preventive tests and services. Beneficiaries that enroll in Medicare Part B pay a monthly premium that is usually withheld from their Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied a $131 deductible. To fill the gaps in traditional fee-for-service Medicare coverage, individuals often purchase Medicare supplement products, commonly known as Medigap , to cover deductibles, co-payments, and coinsurance.

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

As an alternative to the traditional fee-for-service Medicare program, in geographic areas where a managed care plan has contracted with CMS pursuant to the Medicare Advantage program, Medicare beneficiaries may choose to receive benefits from a managed care plan. The current Medicare managed care program was established in 1997 when Congress created a Medicare Part C, formerly known as Medicare+Choice and now known as Medicare Advantage. Pursuant to Medicare Part C, Medicare Advantage plans contract with CMS to provide benefits at least comparable to those offered under the traditional fee-for-service Medicare program in exchange for a fixed monthly premium payment per member from CMS. The

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monthly premium varies based on the county in which the member resides, as adjusted to reflect the member s demographics and the plans risk scores. Individuals who elect to participate in the Medicare Advantage program often receive greater benefits than traditional fee-for-service Medicare beneficiaries including, in some Medicare Advantage plans including ours, additional preventive services, and dental and vision benefits. Medicare Advantage plans typically have lower deductibles and co-payments than traditional fee-for-service Medicare, and plan members do not need to purchase supplemental Medigap policies. In exchange for these enhanced benefits, members are generally required to use only the services and provider network provided by the Medicare Advantage plan. Most Medicare Advantage plans have no additional premiums. In some geographic areas, however, and for plans with open access to providers, members may be required to pay a monthly premium.

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

The 2003 Medicare Modernization Act

Overview. In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, which is known as the Medicare Modernization Act, or MMA. The MMA increased the amounts payable to Medicare Advantage plans such as ours, expanded Medicare beneficiary healthcare options by, among other things, creating a transitional temporary prescription drug discount card program for 2004 and 2005 and added a Medicare Part D prescription drug benefit beginning in 2006. In 2007, we reaffirmed our commitment to Medicare beneficiaries by again offering the Part D prescription drug benefit as further described below.

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

Prescription Drug Benefit. As part of the MMA, every Medicare recipient is able to select a prescription drug plan through Medicare Part D. Medicare Part D replaced the Medicaid Prescription Drug Coverage for beneficiaries eligible for participation under both the Medicare and Medicaid programs, or dual-eligibles. The Medicare Part D prescription drug benefit is largely subsidized by the federal government and is additionally supported by risk-sharing with the federal government through risk corridors designed to limit the profits or losses of the drug plans and reinsurance for catastrophic drug costs, as described below. The government subsidy is based on the national weighted

average monthly bid for this coverage,

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adjusted for member demographics and risk factor payments. The beneficiary will be responsible for the difference between the government subsidy and his or her plan s bid, together with the amount of his or her plan s supplemental premium (before rebate allocations), subject to the co-pays, deductibles and late enrollment penalties, if applicable, described below. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries.

The Medicare Part D benefits are available to Medicare Advantage plan enrollees as well as Medicare fee-for-service enrollees. Medicare Advantage plan enrollees who elect to participate may pay a monthly premium for this Medicare Part D prescription drug benefit (MA-PD) while fee-for-service beneficiaries will be able to purchase a stand-alone prescription drug plan (PDP) from a list of CMS-approved PDPs available in their area. Any Medicare Advantage Member enrolling in a stand-alone PDP, however, will automatically be disenrolled from the Medicare Advantage plan altogether, thereby resuming traditional fee-for-service Medicare. Under the standard Part D drug coverage for 2008, beneficiaries enrolled in a stand-alone PDP will pay a $275 deductible, co-insurance payments equal to 25% of the drug costs between $275 and the initial annual coverage limit of $2,510 and all drug costs between $2,510 and $5,452, which is commonly referred to as the Part D doughnut hole . After the beneficiary has incurred $4,050 in out-of-pocket drug expenses, the MMA provides catastrophic stop loss coverage that will cover approximately 95% of the beneficiaries remaining out-of-pocket drug costs for that year. MA-PDs are not required to mirror these limits, but are required to provide, at a minimum, coverage that is actuarially equivalent to the standard drug coverage delineated in the MMA. The deductible, co-pay and coverage amounts will be adjusted by CMS on an annual basis. Each Medicare Advantage plan will be required to offer a Part D drug prescription plan as part of its benefits. We currently offer prescription drug benefits through our Medicare Advantage plans and also offer a stand-alone PDP. Among the options in Medicare Advantage, we offer two MA-PD plans with no initial deductible, one of which has generic coverage with a $5 co-payment during the doughnut hole period. On the PDP side, we currently offer three plans, two of which have no initial deductible and one of which has generic coverage with a $5 co-payment during the doughnut hole period.

Dual-Eligible Beneficiaries. A dual-eligible beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Reform, because of economic status. Health plans that serve dual-eligible beneficiaries receive a higher premium from CMS and the government of Puerto Rico for dual-eligible members. Currently, CMS pays an additional premium, generally ranging from 30% to 45% more per member per month, for a dually-eligible beneficiary. This additional premium is based upon the estimated incremental cost CMS incurs, on average, to care for dual-eligible beneficiaries. The government of Puerto Rico has implemented a plan to allow dual-eligibles enrolled in the Reform to move from the Reform program to a Medicare Advantage plan under which the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. All qualified Reform participants were eligible to move to the government-sponsored plan beginning in January 2006, and as of December 31, 2006 approximately 61,000 such participants from areas served by us did so. As of December 31, 2007 approximately 3,400 additional participants from areas served by us moved to the government-sponsored plan. 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, as of January 1, 2006 dual-eligible individuals receive their drug coverage from the Medicare program rather than the Reform program. Companies offering stand-alone PDPs with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within the applicable region.

Bidding Process. Although Medicare Advantage plans will continue to be paid on a capitated, or PMPM, basis, as of January 1, 2006 CMS uses a new rate calculation system for Medicare Advantage plans. The new system is based on a competitive bidding process that allows the federal government to share in any cost savings achieved by Medicare Advantage plans. In general, the statutory payment rate for each county, which is primarily based on CMS s estimated per beneficiary fee-for-service expenses, was relabeled as the benchmark amount, or bidding target, and local Medicare Advantage plans will annually submit bids that reflect the costs they expect to incur in providing the base Medicare Part A and Part B benefits in their applicable service areas. If the bid is less than the benchmark for that

year, Medicare will pay the plan its

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

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

Annual Enrollment and Lock-in. Prior to the MMA, Medicare beneficiaries were permitted to enroll in a Medicare managed care plan or change plans at any point during the year. As of January 1, 2006, Medicare beneficiaries have defined enrollment periods, similar to commercial plans, in which they can select a Medicare Advantage plan, stand-alone PDP, or traditional fee-for-service Medicare. The initial enrollment period for 2008 of Medicare Advantage plans began November 15, 2007 and will end on March 31, 2008 for a MA-PD or stand-alone PDP. The enrollment period for PDPs began on November 15, 2008 and ended on December 31, 2007. Enrollment on or prior to December 31 will be effective as of January 1 of the following year and enrollment on or after January 1 and within the enrollment period will be effective as of the first day of the month following the date on which the enrollment occurred. After these defined enrollment periods end, generally only seniors turning 65 during the year, Medicare beneficiaries who permanently relocate to another service area, dual-eligible beneficiaries and others who qualify for special needs plans and employer group retirees will be permitted to enroll in or change health plans during that plan year. Eligible beneficiaries who fail to timely enroll in a Part D plan will be subject to the penalties described above if they later decide to enroll in a Part D plan. The new annual lock-in created by the MMA will change the way we and other managed care companies market our services to and enroll Medicare beneficiaries in ways we cannot yet fully predict. The recently adopted Tax Relief and Health Care Act of 2006 allows Medicare beneficiaries to enroll throughout the year only in Medicare Advantage plans that do not offer Part D prescription drug coverage. In one of our products we do offer such coverage, thus in that particular product we can only enroll new Medicare Advantage members between November 15 and December 31 each year. We offer another product which does not offer the Part D prescription drug coverage and that is open for enrollment during the entire year. New eligibles can enroll at any time during the year at the date of eligibility. In addition, we can enroll MA members from other carriers through March 31st of the next calendar year. Dual-eligibles are allowed to enroll throughout the year.

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

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

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

HIPAA and Gramm-Leach-Bliley Act

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

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

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

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

Employee Retirement Income Security Act of 1974

The provision of services to certain employee welfare benefit plans is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA) a complex set of laws and regulations subject to interpretation and enforcement by the Internal Revenue Service and the Department of Labor (DOL). ERISA regulates certain aspects of the relationships between us, the employers who maintain employee welfare benefit plans subject to ERISA and participants in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans.

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We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA. Plans subject to ERISA can also be subject to state laws and the question of whether ERISA preempts a state law has been, and will continue to be, interpreted by many courts.

Other Government Programs

We participate in the Health Reform of the government of Puerto Rico (the Reform) to provide health coverage to medically indigent citizens in Puerto Rico. See Business Customers Reform Sector .

Legislative and Regulatory Initiatives

The Commissioner of Insurance is currently evaluating the adoption of Rule No. 83, titled Norms and Procedures to Regulate Insurance and Health Maintenance Holding Company Systems and the Criteria to Evaluate the Change of Control . The most recent draft of Rule No. 83 contains certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. Rule No. 83 would generally require insurance companies and HMOs within an insurance holding company system to register with the Commissioner of Insurance if they are domiciled in the Commonwealth 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 would require prior notice, reporting and regulatory approval of certain material transactions and intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other restrictions, Rule No. 83 would restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, Rule No. 83 would restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. According to Rule No. 83, 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, without (i) filing the appropriate documentation with the Commissioner of Insurance and (ii) obtaining the prior approval of the Commissioner of Insurance. This requirement is similar to that contained in the Insurance Code and referred to under Regulation Puerto Rico Insurance Laws .

In addition, on August 1, 2007, the U.S. House of Representatives passed the Children s Health and Medicare Protection Act of 2007 (H.R. 3162), which, among other things, would amend the Social Security Act to improve the federal government s children s health insurance program and make other changes under the Medicare and Medicaid programs. H.R. 3162 includes provisions that would gradually reduce Medicare Advantage payments over a four-year period to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program by 2011. The proposed reductions in Medicare Advantage rates are the result of hearings by the health subcommittee of the House Ways and Means Committee regarding recommendations contained in MedPac s annual report to Congress on Medicare payment policy dated March 1, 2007. Among other things, MedPac reported that the federal government s spending on care for beneficiaries in a private Medicare Advantage plan is on average 12% higher than spending on care for beneficiaries through the traditional Medicare program. MedPac recommended a gradual reduction in Medicare Advantage rates to ensure that payment rates between Medicare Advantage plans and the traditional Medicare program are equalized. H.R. 3162 was referred to the Senate on September 4, 2007 for consideration; however, Congress did not enact H.R. 3162. Instead, Congress enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007 in order to protect physician payment reductions through June 30, 2008. This legislation did not include any payment reductions to Medicare Advantage plans, but it included several provisions affecting Medicare Advantage plans, including: (i) extended the statutory authority to allow existing special needs plans (SNPs) to continue to operate through December 31, 2009: (ii) placed a moratorium on approval of new SNPs: and (iii) removed $1.5 billion from the stabilization fund for regional preferred provider organizations in 2012, which would have no impact on plans in Puerto Rico. Congress is expected to enact a Medicare bill this year in order to prevent further physician payment reductions. As of the date of this Annual Report on Form 10-K, the U.S. Congress has not enacted H.R. 3162, nor has the U.S. Senate passed any other bill that includes the MedPac recommendations from 2007 for gradual reductions in Medicare Advantage payments. In its annual report to Congress dated March 1, 2008, MedPac found that projected Medicare Advantage payments had increased, and continued to support financial neutrality between payment rates for fee-for-service and Medicare Advantage programs. Also, MedPac recommended

changes to SNPs, including requiring a contract with states to coordinate Medicaid benefits. We cannot provide assurances if, when or to what degree Congress may enact H.R. 3162 or similar legislation, including the MedPac recommendations, but any reduction in Medicare Advantage rates could have a material adverse effect on our revenue, financial position, results of operations or cash flow.

Financial Information About Segments

Operating revenues (with intersegment premiums/service revenues shown separately), operating income and total assets attributable to the reportable segments are set forth in note 26 to the audited consolidated financial statements for the years ended December 31, 2007, 2006 and 2005.

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Employees

As of January 31, 2008, we had 2,274 full-time employees and 256 temporary employees. Our managed care subsidiary has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 46% of our managed care subsidiary s 785 regular employees. The collective bargaining agreement expires on July 31, 2012. The Corporation considers its relations with employees to be good.

Available Information

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

Special Note Regarding Forward-Looking Statements

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

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

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

trends in health care costs and utilization rates;

ability to secure sufficient premium rate increases;

competitor pricing below market trends of increasing costs;

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re-estimates of our policy and contract liabilities;

changes in government regulation of managed care, life insurance or property and casualty insurance;

significant acquisitions or divestitures by major competitors;

introduction and use of new prescription drugs and technologies;

a downgrade in our financial strength ratings;

litigation or legislation targeted at managed care, life insurance or property and casualty insurance companies;

ability to contract with providers consistent with past practice;

ability to successfully implement our disease management and utilization management programs;

volatility in the securities markets and investment losses and defaults;

general economic downturns, major disasters and epidemics.

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

Item 1A. Risk Factors

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

Risks Relating to our Capital Stock

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

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

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Notwithstanding the fact that TSI 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 TSI 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 TSI were required to issue a significant number of shares in respect of these agreements, the interest of our existing shareholders would be substantially diluted. As of the date of this Annual Report on Form 10-K, only one judicial claim to enforce any of these agreements has been commenced. Additionally, we have received inquiries with respect to over 600 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 Puerto Rico counsel that, on the basis of a reasoned analysis, while the matter is not free from doubt and there are no applicable controlling precedents, we should prevail in any litigation of these claims because, among other defenses, the condition precedent to SSS s obligations under the share acquisition agreements never occurred, and any obligation it may, or we may be deemed to, have had under the share acquisition agreements should be understood to have expired prior to our corporate reorganization, which took effect in 1999, although the share acquisition agreements do not expressly provide for any expiration.

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

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

For much of our history, we and our predecessor entity have restricted the ownership or transferability of our shares, including by reserving to us or our predecessor a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, we and our predecessor, consistent with the requirements of our and our predecessor s bylaws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, former shareholders heirs who were not eligible to own or be transferred shares because they were not physicians or dentists at the time of their purported inheritance (non-medical heirs), may claim an entitlement to our shares or to damages with respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 former shareholders whose non-medical heirs may claim to have inherited up to 10,500,000 shares after giving effect to the 3,000-for-one stock split. As of the date of this Annual Report on Form 10-K, one judicial claim seeking the return of or compensation for 16 shares (prior to giving effect to the 3,000-for-one stock split) had been brought by the non-medical heirs of a former shareholder whose shares were repurchased upon his death. These heirs purport to represent as a class all non-medical heirs of deceased shareholders whose shares we repurchased. In addition, we have received inquiries from non-medical heirs with respect to over 600 shares (or 1,800,000 shares after giving effect to the 3,000-for-one stock split).

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

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

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

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

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

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

Sales of a substantial number of shares of our common stock in the public market, or the perception that large sales could occur, could cause the market price of our Class B common stock to decline. Either of these limits our future ability to raise capital through an offering of equity securities. There are 16,266,554 shares of Class B common stock and 16,042,809 shares of Class A common stock outstanding as of December 31, 2007. Approximately 71.3% of our Class A common stock will be subject to contractual lockup restrictions for one year following our initial public offering. Thereafter, such shares will become freely tradable without restriction or further registration under the Securities Act by persons other than our affiliates within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the New York Stock Exchange (NYSE) and will not be fungible with our listed shares of Class B common stock. In addition, at any time after the first anniversary of our initial public offering, our board of directors may, at its sole discretion and after considering relevant factors, including market conditions at the time, cause up to approximately half of our shares of Class A common stock to be converted to shares of Class B common stock, including in connection with an underwritten public secondary offering, subject to limitations. In addition, at any time following the fifth anniversary of our initial public offering, or such earlier date after the first anniversary of the initial public offering as all claims with respect to which anti-dilution protections are afforded to shares of Class B common stock have been resolved, all or any portion of our shares of Class A common stock may at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock.

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Risks Related to Our Business

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

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

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

In addition to the challenge of managing managed care costs, we face pressure to contain premium rates. Our customers may move to a competitor at policy renewal to obtain more favorable premiums. Future Medicare and Reform premium rate levels may be affected by continuing government efforts to contain medical expense or other federal budgetary constraints. In particular, the government of Puerto Rico has adopted several measures to control Reform expenditures, such as closer and continuous scrutiny of participants eligibility, redesign of benefits, co-payments, deductibles, and requiring the establishment of disease management programs. Changes in the Medicare and Reform programs, including with respect to funding, may lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits, or reductions in the number of persons enrolled in or eligible for Medicare and the Reform. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

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

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

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changes; our exit from a specific market; reductions in workforce by existing customers; negative publicity and news coverage; failure to maintain the Blue Shield license; and any general economic downturn that results in business failures.

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

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

Reform: We participate in the government of Puerto Rico Health Reform Program to provide health coverage to medically indigent citizens in Puerto Rico. Our results of operations have depended to a significant extent on our participation in the Reform program. During each of the years ended December 31, 2007, 2006 and 2005, the Reform program has accounted for 21.7%, 30.2% and 37.0%, respectively , of our consolidated premiums earned, net. During the 2007 period, we were the sole Reform provider in two of the eight Reform regions in Puerto Rico. During the 2006 and 2005 periods, we were the sole Reform provider in three Reform regions. Since we obtained our first Reform contract in 1995, we have been the sole provider for two to three regions each year. The contract for each geographical area is subject to termination in the event of any non-compliance by the insurance company which is not corrected or cured to the satisfaction of the government entity overseeing the Reform, or on 90 days prior written notice in the event that the government determines that there is an insufficiency of funds to finance the Reform. These contracts have one-year terms and expire on June 30 of each year. Upon the expiration of the contract for a geographical area, the government of the Commonwealth of Puerto Rico usually commences an open bidding process for such area. In October 2006, we were informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company effective November 1, 2006. During each of the years ended December 31, 2006 and 2005, this region accounted for 10.7% and 14.6% of our consolidated premiums earned, net, respectively, and 7.3% and 10.3% of our consolidated operating income, respectively. We intend to continue to participate in the Reform program, but we may not be able to retain the right to service a particular geographical area in which we currently operate after the expiration of our current or any future contracts.

Medicare: We provide services through our Medicare Advantage health plans pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if any of these contracts are terminated, our business would be materially impaired. During each of the years ended December 31, 2007, 2006 and 2005, contracts with CMS represented 16.9% 11.3% and 2.5% of our consolidated premiums earned, net, respectively, and 39.4%, 46.0% and -1.2% of our consolidated operating income, respectively. The Medicare business may in the future represent a greater percentage of our results.

Commercial: Our managed care subsidiary is a qualified contractor to provide managed care coverage to federal government employees within Puerto Rico. Such coverage is provided pursuant to a contract with the U.S. Office of Personnel Management (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, 2007, 2006 and 2005 premiums generated under this contract represented 8.0%, 7.5% and 8.2% of our consolidated premiums earned, net, respectively, and 1.2%, 1.1% and 2.4% of our consolidated operating income, respectively.

If any of these contracts is terminated for any reason, including by reason of any noncompliance by us, or not renewed or replaced by a comparable contract, our premiums would be materially adversely affected. The further loss or non-renewal of either of our Reform contracts could have a material adverse effect on our operating results and could result in the downsizing of certain personnel, the cancellation of lease agreements of certain premises and of certain contracts, and severance payments, among others.

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

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than administrative services only (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. In addition, the government of Puerto Rico began a pilot project in 2003 in one of the eight geographical areas under which it contracted services on an ASO basis for certain members instead of contracting on a fully insured basis. This project was subsequently extended to the Metro-North region, which was served by us until October 31, 2006. There can be no assurance that the government will not implement such a program in areas served by us. As of December 31, 2007, 83.5% of our managed care customers had fully insured arrangements and 16.5% had ASO arrangements, as compared to approximately 83.9% and 16.1%, respectively, as of December 31, 2006. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

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

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

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

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

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

Upon any event causing termination of the license agreements, we would no longer have the right to use the Blue Shield name and mark in Puerto Rico. Furthermore, the BCBSA would be free to issue a license to use the Blue Shield name and mark in Puerto Rico to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership

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limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Accordingly, termination of the license agreements could have a material adverse effect on our business, financial condition and results of operations.

In addition, the BCBSA requires us to comply with certain specified levels of 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 license.

Upon termination of a license agreement, the BCBSA would impose a Re-establishment Fee upon us, which would allow the BCBSA to re-establish a Blue Shield presence in the vacated service area with another managed care company. The fee is currently $86.18 per licensed enrollee. If the re-establishment fee were applied to our total Blue Shield enrollees as of December 31, 2007, we would be assessed approximately $84.2 million by the BCBSA.

See Item 1 Business Blue Shield License for more information.

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

Reinsurance is the practice of transferring part of an insurance company s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. In the year ended December 31, 2007, 40.4%, or $69.1 million, of the premiums written in the property and casualty insurance segment and 9.0%, or $8.8 million, of the premiums written in the life insurance segment were ceded to reinsurers. In the year ended December 31, 2006, 41.3%, or $65.7 million, of the premiums written in the property and casualty insurance segment and 10.6%, or $9.7 million, of the premiums written in the life insurance segment were ceded to reinsurers. The availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or to obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

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

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

We are subject to loss and credit risk with respect to the reinsurers with whom we deal because buying reinsurance does not relieve us of our liability to policyholders. In accordance with general industry practices, our property and casualty and life insurance subsidiaries annually purchase reinsurance to lessen the impact of large unforeseen losses and mitigate sudden and unpredictable changes in our net income and shareholders equity. Reinsurance contracts do not relieve us from our obligations to policyholders. In the event that all or any of the reinsurance companies are unable to meet their obligations under existing reinsurance agreements or pay on a timely basis, we will continue to be liable to our policyholders notwithstanding such defaults or delays. If our reinsurers are not capable of fulfilling their financial obligations to us, our insurance losses would increase, which would negatively affect our financial condition and results of operations.

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

Ratings assigned by A.M. Best are an important factor influencing the competitive position of the property and casualty insurance companies in Puerto Rico. In July 2006, as a result of the additional indebtedness we incurred in connection with the acquisition of GA Life, A.M. Best maintained our property and casualty

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

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

Managed Care

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of managed care companies. In addition, the managed care market in Puerto Rico, other than the Medicare Advantage market, is mature. According to the U.S. Census Bureau, Puerto Rico s population grew by 0.4% between July 2004 and 2005, less than half the national population rate growth of 0.9% during the same period. As a result, in order to increase our profitability we must increase our membership in the new Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically. In Puerto Rico, several new managed care plans and other entities were awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans and entered that market in 2006 and 2007. We anticipate that these other plans will aggressively market their benefits to our current and our prospective members. Although we believe that we market an attractive offering, there are no assurances that we will be able to compete successfully with these other plans for new members, or that our current members will not choose to terminate their relationship with us and enroll in these other plans. The recently adopted Tax Relief and Health Care Act of 2006 allows Medicare beneficiaries to enroll throughout the year only in Medicare Advantage plans that do not offer Part D prescription drug coverage. Since we do offer such coverage, we can only enroll new Medicare Advantage members between November 15 and December 31 each year, thus placing us at a competitive disadvantage.

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. In addition, our rights under the BCBSA license only extend to the use of the Blue Shield mark in Puerto Rico. The exclusive right to use the Blue Cross mark in Puerto Rico is currently held by a relatively small company. If a large competitor were to acquire that right in the future, that could have a material adverse impact on our business.

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

Complementary Products

The property and casualty insurance market in Puerto Rico is extremely competitive. Due to the relatively low level of economic growth in Puerto Rico, there are few new sources of business in this segment. As a result, property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. We also face heavy competition in the life and disability insurance market.

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

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

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 requirements could subject us to regulatory action . These regulations, among other things, require insurance companies to maintain certain levels of capital which range by type of insurance from $1.0 million to $3.0 million, thereby restricting the amount of earnings that can be distributed. Our subsidiaries ability to make any payments to us will also depend on their earnings, the terms of their indebtedness, if any, business and other legal restrictions. Furthermore, our subsidiaries are not obligated to make funds available to us, and creditors of our subsidiaries have a superior claim to such subsidiaries assets. Our subsidiaries may not be able to pay dividends or otherwise contribute or distribute funds to us in an amount sufficient for us to meet our financial obligations. In addition, from time to time, we 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 Blue Shield name and mark could have a material adverse effect on our business, financial condition and results of operations .

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

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

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

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

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

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

- identify profitable new geographic markets to enter;
- operate in new geographic areas, as we have very limited experience operating outside Puerto Rico;
- obtain licenses in new geographic areas in which we wish to market and sell our products;
- successfully implement our underwriting, pricing, claims management and product strategies over a larger operating region;
- properly design and price new and existing products and programs and reinsurance facilities for markets in which we have no direct experience;
- identify, train and retain qualified employees;
- identify, recruit and integrate new independent agencies and brokers and expand the range of Triple-S products carried by our existing agents and brokers;
- develop a network of physicians, hospitals and other managed care providers that meets our requirements and those of applicable regulators; and
- augment our internal monitoring and control systems as we expand our business.

We also may encounter difficulties in the implementation of our growth strategies. For instance, our BCBSA license entitles us to use the Blue Shield name only in Puerto Rico. We currently are not able to use the Blue Shield name in areas outside Puerto Rico. In addition, we may enter into markets or product lines in which we have little or no prior experience. For example, we plan to expand our operations outside Puerto Rico and to expand our property and casualty insurance segment through the establishment of an auto preferred rate insurance company, which will write personal auto policies at discounted rates.

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

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

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

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

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

We have exposure to market risk in our investment activities. The market values of our investments vary from time to time depending on economic and market conditions. Fixed maturity securities expose us to interest rate risk. Equity securities expose us to equity price risk. Interest rates are highly sensitive to many factors, including governmental monetary policies and domestic and international economic and political conditions. These and other factors also affect the equity securities owned by us. The outlook of

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our investment portfolio depends on the future direction of interest rates, fluctuations in the equity securities market and in the amount of cash flows available for investment. For additional information, see Management s Discussion and Analysis of Financial Condition and Results of Operations Quantitative and Qualitative Disclosures About Market Risk for an analysis of our exposure to interest and equity price risks and the procedures in place to manage these risks. Our investment portfolios may lose money in future periods, which could have a material adverse effect on our financial condition.

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, real estate and equity investments, amongst 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, and, in some instances, we may be required to sell those investments.

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

Substantially all of our business activity is with insureds located throughout Puerto Rico, and as such, we are subject to the risks associated with the Puerto Rico economy. Preliminary reports on the performance of the Puerto Rico economy for fiscal year 2006 indicate that real gross national product increased 0.7% and the forecast for fiscal year 2007 projects a decline of 1.4%. The major factors affecting the economy are, among others, high oil prices, the slowdown of economic activity in the United States, the continuing economic uncertainty generated by the budgetary deficiency affecting the government of Puerto Rico and the effects on the economy of a recently implemented sales tax.

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

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

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

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

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

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs. If we are unable to maintain or expand our systems, we could suffer from, among other things, operational disruptions, such as the inability to pay claims or to make claims payments

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on a timely basis, loss of members, difficulty in attracting new members, regulatory problems and increases in administrative expenses. We recently completed a system conversion process related to our property and casualty insurance business. We started the implementation of this system in April 2005 and put in service it on October 1, 2006 at an estimated cost of $4.0 million. In addition, we recently selected Quality Care Solutions, Inc., a wholly owned subsidiary of Trizzetto, Inc, to assess and implement new core business applications for our managed care segment. We completed an initial assessement during 2007, with the first line of business expected to be converted during late 2009. We expect the managed care conversion process to be completed by 2011, at a total cost of approximately $64.0 million. If we are unsuccessful in implementing these improvements in a timely manner or if these improvements do not meet our customers requirements, we may not be able to recoup these costs and expenses and effectively compete in our industry.

Our business requires the secure transmission of confidential information over public networks. Advances in computer capabilities, new discoveries in the field of cryptography or other event or developments could result in compromises or breaches of our security system and patient data stored in our information systems. Anyone who circumvents our security measures could misappropriate our confidential information or cause interruptions in services or operations. The Internet is a public network and data is sent over this network from many sources. In the past, computer viruses or software programs that disable or impair computers have been distributed and have rapidly spread over the Internet. Computer viruses could be introduced into our systems, or those of our providers or regulators, which could disrupt our operations, or make our systems inaccessible to our providers or regulators. We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. Our security measures may be inadequate to prevent security breaches, and our business operations would be adversely affected by cancellation of contracts and loss of members if they are not prevented.

We face risks related to litigation.

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

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

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

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

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

Covenants in our secured term loan and note purchase agreements may restrict our operations.

We are a party to a secured loan with a commercial bank for an aggregate amount of $41.0 million, for which we had an outstanding balance of $25.9 million as of December31, 2007. Also, we have an aggregate principal amount of $145.0 million of senior unsecured notes outstanding, consisting of $50.0 million aggregate principal amount of 6.30% notes due 2019, $60.0 million aggregate principal amount of 6.60% notes due 2020 and $35.0 million aggregate principal amount of 6.70% notes due 2021 (collectively, the notes). The secured term loan and the note purchase agreements governing the notes contain covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These covenants could restrict our operations. In addition, if we fail to make any required payment under our secured term loan or note purchase agreements governing the notes or to comply with any of the covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our secured term loan or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the secured term loan, cease to make further extensions of credit. If the indebtedness under our secured term loan or note purchase agreements is accelerated, we may be unable to repay or 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 expect to pursue acquisitions in the future.

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

- disruption of on-going business operations, distraction of management, diversion of resources and difficulty in maintaining current business standards, controls and procedures;

- difficulty in integrating information technology of acquired entity and unanticipated expenses related to such integration;

- difficulty in the integration of the new company s accounting, financial reporting, management, information, human resources and other administrative systems and the lack of control if such integration is delayed or not implemented;

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difficulty in the implementation of controls, procedures and policies appropriate for filers with the SEC at companies that prior to acquisition lacked such controls, policies and procedures;

potential unknown liabilities associated with the acquired company;

failure of acquired businesses to achieve anticipated revenues, earnings or cash flow;

dilutive issuances of equity securities and incurrence of additional debt to finance acquisitions;

other acquisition-related expenses, including amortization of intangible assets and write-offs; and

competition with other firms, some of which may have greater financial and other resources, to acquire attractive companies.

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

We could be subject to possible regulatory actions in connection with alleged illegal political contributions.

Miguel Vázquez-Deynes, who was president and chief executive officer of the Company from January 1990 to April 2002, prior to the time that we became an SEC registrant, stated during a radio interview in October 2007 that he had testified to a federal grand jury to having caused the Company to effect illegal political contributions totaling over $100,000 between 1996 and 2000. Mr. Vázquez-Deynes has stated publicly that the payments in question were made to Puerto Rico public relations firms for the purpose of concealing the fact that they exceeded the amounts permitted by applicable Puerto Rico election laws. Mr. Vázquez-Deynes testimony was given in connection with an ongoing investigation by the U.S. Attorney s Office for the District of Puerto Rico into illegal political contributions in Puerto Rico. The Puerto Rico Legislative Assembly and the Puerto Rico Department of Justice have subsequently launched separate investigations into the matters described by Mr. Vázquez-Deynes. The Company is cooperating fully with all requests made of it in connection with these investigations.

There may be, or could in the future be, other investigations by governmental authorities relating to these matters. The current and any such future investigations could result in actions against us or certain of our current or former employees. These actions could result in fines, penalties, sanctions, injunctions against future conduct, third party litigation or other actions that could have a material adverse effect on our business, financial condition, share price and reputation, including by impairing government contracts and adversely affecting our ability to obtain future contracts and participate in governmental payor programs.

Following the airing of Mr. Vázquez s allegations, the Company s board of directors hired outside counsel from Clifford Chance US, LLP, a law firm that had no prior relationship with the Company, to conduct an internal investigation into these allegations. The investigation was completed in February 2008 and concluded that any misconduct was limited to the matters alleged by Mr. Vázquez-Deynes and limited to the period when he was an officer of the Company. No current officer or director of the Company was found to have acted improperly. Our internal controls today are substantially more comprehensive than those in place during the period when these events took place and we believe these controls reduce the possibility of any similar event occurring in the future. Although we cannot predict the outcome of the government investigations described above, management does not currently believe that they will result in actions having a material adverse effect on the Company.

Risks Relating to Taxation

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

The Company does not expect that it will be considered a controlled foreign corporation under the related person insurance income rules (a RPII CFC) for U.S. federal income tax purposes. However, because RPII CFC status depends in part upon the correlation between an insurance company s shareholders and such company s insurance customers and the extent of such company s insurance business outside its country of incorporation, there can be no assurance that the Company will not be a RPII CFC in any taxable year. The

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Company does not intend to monitor whether or not it generates RPII or becomes an RPII CFC. If the Company were a RPII CFC in any taxable year, certain adverse tax consequences could apply to U.S. persons that own the Company s shares of Class B common stock.

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

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

Risks Relating to the Regulation of Our Industry

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

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

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

local government plans and initiatives;

legislation to revise Medicare and the Reform; and

increased governmental concern regarding fraud and abuse.

The U.S. Congress is developing legislation aimed at patient protection, including proposed laws that could expose insurance companies to damages, and in some cases punitive damages, for certain coverage determinations including the denial of benefits or delay in providing benefits to members. Similar legislation has been proposed in Puerto Rico. Congressional committees are currently considering MedPac recommendations to lower Medicare Advantage rates to ensure financial neutrality with the traditional Medicare program.

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 could have a material adverse effect on the profitability or marketability of our business, financial condition and results of operations.

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

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

An adverse review, audit or an investigation 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, the Reform 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.

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

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

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

Effective January 1, 2006, a revised rate calculation system based on a competitive bidding process was instituted for Medicare Advantage managed care plans, including our *Medicare Selecto* and *Medicare Optimo* plans. The statutory payment rate was relabeled as the benchmark amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. If the accepted bid is less than the benchmark, Medicare pays the plan its bid plus a rebate of 75% of the amount by which the benchmark exceeds the bid. However, these rebates can only be used to enhance benefits or

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lower premiums and co-pays for plan members. If the bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid and the benchmark, which could affect our ability to attract enrollees. CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability.

Furthermore, the Deficit Reduction Act of 2005, or the DRA, signed by the President of the United States on February 8, 2006, directs CMS to conduct an analysis of fee-for-service provider (a provider who receives payment for services based on actual services provided to Medicare beneficiaries and a contractually mandated or CMS-mandated fee schedule) and Medicare Advantage plan treatment and coding practices (methods of documenting medical services provided to and diagnoses of members) and to incorporate any identified differences into benchmark calculations no later than 2008. This revised rate calculation system established by the MMA and amended by the DRA is likely to eventually result in reduced Medicare Advantage payment rates, which could reduce our revenues and cause our profitability to decline. We may also face the risk of reduced or insufficient government funding and we may need to terminate our Medicare Advantage contracts with respect to unprofitable markets, which may have a material adverse effect on our financial position, results of operations or cash flows. In addition, as a result of the competitive bidding process, we may in the future be required to reduce benefits or charge our members an additional premium in order to maintain our current level of profitability, either of which could make our health plans less attractive to members and adversely affect our membership.

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

CMS has implemented a risk adjustment payment system for Medicare health plans to improve the accuracy of payments and establish incentives for Medicare plans to enroll and treat less healthy Medicare beneficiaries. CMS is phasing in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments on various clinical and demographic factors including hospital inpatient diagnoses, diagnosis data from ambulatory treatment settings, including hospital outpatient facilities and physician visits, gender, age and Medicaid eligibility. CMS requires that all managed care companies capture, collect and submit the necessary diagnosis code information to CMS twice a year for reconciliation with CMS s internal database. As part of the phase-in, during 2003, risk adjusted payments accounted for 10% of Medicare health plan payments, with the remaining 90% being reimbursed in accordance with the traditional CMS demographic rate books. The portion of risk adjusted payments was increased to 30% in 2004, 50% in 2005 and 75% in 2006, and has increased to 100% in 2007. As a result of this process, it is difficult to predict with certainty our future revenue or profitability. In addition, our own risk scores for any period may result in favorable or unfavorable adjustments to the payments we receive from CMS and our Medicare premium revenue. There can be no assurance that our contracting physicians and hospitals will be successful in improving the accuracy of recording diagnosis code information, which has an impact on our risk scores.

Payments to Medicare Advantage plans are also adjusted by a budget neutrality factor that was implemented in 2003 by Congress and CMS to prevent health plan payments from being reduced overall while, at the same time, directing risk adjusted payments to plans with more chronically ill enrollees. In general, this adjustment has favorably impacted payments to all Medicare Advantage plans. The President s budget for 2005 assumed the phasing out of the budget neutrality adjustments over a five year period from 2007 through 2011. On December 21, 2005, the U.S. Senate passed legislation that reduces federal funding for Medicare Advantage plans by approximately $6.2 billion over five years. Among other changes, the legislation provides for an accelerated phase out of budget neutrality for risk adjustment of payments made to Medicare Advantage plans. The U.S. House of Representatives has passed similar legislation but must approve the final version of the Senate legislation before the legislation can go to the President for signature. These legislative changes may change payments to Medicare Advantage plans in general.

In addition, on August 1, 2007, the U.S. House of Representatives passed the Children s Health and Medicare Protection Act of 2007 (H.R. 3162), which, among other things, would amend the Social Security Act to improve the federal government s children s health insurance program and make other changes under the Medicare and Medicaid programs. H.R. 3162 includes provisions that would gradually reduce

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Medicare Advantage payments over a four-year period to equalize payments for services made through Medicare Advantage plans and the traditional fee-for-service Medicare program by 2011. The proposed reductions in Medicare Advantage rates are the result of hearings by the health subcommittee of the House Ways and Means Committee regarding recommendations contained in MedPac s semi-annual report to Congress on Medicare payment policy dated March 1, 2007. Among other things, MedPac reported that the federal government s spending on care for beneficiaries in a private Medicare Advantage plan is on average 12% higher than spending on care for beneficiaries through the traditional Medicare program. MedPac recommended a gradual reduction in Medicare Advantage rates to ensure that payment rates between Medicare Advantage plans and the traditional Medicare program are equalized. H.R. 3162 was referred to the Senate on September 4, 2007 for consideration; however, Congress did not enact H.R. 3162. Instead, Congress enacted the Medicare, Medicaid, and SCHIP Extension Act of 2007 in order to protect physician payment reductions through June 30, 2008. This legislation did not include any payment reductions to Medicare Advantage plans, but it included several provisions affecting Medicare Advantage plans, including; (i) extended the statutory authority to allow existing SNPs to continue to operate through December 31, 2009; (ii) placed a moratorium on approval of new SNPs; and (iii) removed $1.5 billion from the stabilization fund for regional preferred provider organizations in 2012, which would have no impact on plans in Puerto Rico. Congress is expected to enact a Medicare bill this year in order to prevent further physician payment reductions. As of the date of this Annual Report on Form 10-K, the U.S. Congress has not enacted H.R. 3162 or other bill that includes the MedPac recommendations from 2007 for gradual reductions in Medicare Advantage payments. In its annual report to Congress dated March 1, 2008, MedPac found that projected Medicare Advantage payments had increased and continued to support financial neutrality between payment rates for fee-for-service and Medicare Advantage programs. Also, MedPac recommended changes to SNPs, including requiring a contract with states to coordinate Medicaid benefits. We cannot provide assurances if, when or to what degree Congress may enact H.R. 3162 or similar legislation, including the MedPac recommendations, but any reduction in Medicare Advantage rates could have a material adverse effect on our revenue, financial position, results of operations or cash flow.

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

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

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 our or our insurance subsidiaries capital stock, without the prior approval of the Commissioner of Insurance. Our amended and restated articles of incorporation (the articles) prohibit any institutional investor from owning 10% or more of our voting power and any person that is not an institutional investor from owning 5% or more of our voting power. We cannot, however, assure you that ownership of our securities will remain below these thresholds. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide that we will have the power to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles. If the Commissioner of Insurance determines that a change of

control has occurred, we could be subject to fines and penalties, and in some instances the Commissioner of Insurance would have the discretion to revoke our operating licenses.

We are also subject to change of control limitations pursuant to our BCBSA license agreements. The BCBSA ownership limits restrict beneficial ownership of our voting capital stock to less than 10% for an institutional investor and less than 5% for a noninstitutional 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.

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

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

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

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

Certain implementing regulations of HIPAA require us to comply with standards regarding the formats for electronic transmission, and the privacy and security of certain health information within our company and with third parties, such as managed care providers, business associates and our members. These rules also provide access rights and other rights for health plan beneficiaries with respect to their health information. These regulations include standards for certain electronic transactions, including encounter and claims information, health plan eligibility and payment information. Compliance with HIPAA is enforced by the Department of Health and Human Service s Office for Civil Rights for privacy, CMS for security and electronic transactions, and by the Department of Justice for criminal violations. Further, the Gramm-Leach-Bliley Act imposes certain privacy and security requirements on insurers that may apply to certain aspects of our business as well.

We continue to implement and revise our health information policies and procedures to monitor and ensure our compliance with these laws and regulations. Furthermore, Puerto Rico s ability to promulgate its own laws and regulations (including those issued in response to 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 provisions in Puerto Rico insurance laws, 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;

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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 provisions in Puerto Rico insurance laws, 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.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

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

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

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

Item 3. Legal Proceedings.

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

Management believes, based on the opinion of legal counsel, that the aggregate liabilities, if any, arising from such claims, assessments, audits and lawsuits would not have a material adverse effect on our consolidated financial position or results of operations. However, given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could, have a material adverse effect on our operating results and/or cash flows. Where our management believes that a loss is both probable and estimable, such amounts have been recorded. In other cases, it is at least reasonably possible that we

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may incur a loss related to one or more of the mentioned pending lawsuits or investigations, but we are unable to estimate the range of possible loss which may be ultimately realized, either individually or in the aggregate, upon their resolution.

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

Sánchez Litigation

On September 4, 2003, José Sánchez and others filed a putative class action complaint against us, present and former directors of the board of directors and our managed care subsidiary, and others, in the United States District Court for the District of Puerto Rico, alleging violations under the Racketeer Influenced and Corrupt Organizations Act (RICO). The class action complaint, which was amended on March 24, 2005, requested damages in excess of $40 million. The plaintiffs purported to represent, among others, providers of medical products and services covered under policies issued or administered by the defendants, as well as the subscribers to those policies. Among other allegations, the suit alleged a scheme to defraud the plaintiffs by acquiring control of our managed care subsidiary through illegally capitalizing our managed care subsidiary and later converting it to a for profit corporation and depriving the shareholders of their ownership rights. The plaintiffs base their allegations on the alleged decisions of our managed care subsidiary s board of directors and shareholders, purportedly made in 1979, to operate with certain restrictions in order to turn our managed care subsidiary into a charitable corporation. On December 10, 2007, the U.S. Supreme Court dismissed this case and it is now final.

Jordán et al Litigation

On April 24, 2002, Octavio Jordán, Agripino Lugo, Ramón Vidal, and others filed a suit against the Corporation, TSI and others in the Court of First Instance for San Juan, Superior Section, alleging, among other things, violations by the defendants of provisions of the Puerto Rico Insurance Code, antitrust violations, unfair business practices, breach of contract with providers, and damages in the amount of $12.0 million. The plaintiffs also asserted that, in light of TSI s former tax-exempt status, the assets of TSI belong to a charitable trust held in the benefit of the people of Puerto Rico (the charitable trust claim). They also requested that we sell shares to them pursuant to a contract with TSI dated August 16, 1989 regarding the acquisition of shares. We believe that many of the allegations brought by the plaintiffs in this complaint have been resolved in favor of the Corporation and TSI in previous cases brought by the same plaintiffs in the United States District Court for the District of Puerto Rico and in the local courts. The defendants, including us and TSI, answered the complaint, filed a counterclaim and filed several motions to dismiss.

On May 9, 2005, the plaintiffs amended the complaint to allege causes of action similar to those dismissed in the previous case and to seek damages of approximately $207.0 million. Defendants moved to dismiss all claims in the amended complaint. Plaintiffs opposed the motions to dismiss and defendants filed corresponding replies. In 2006, the Court held several hearings concerning these dispositive motions and stayed all discovery until the motions were resolved.

On January 19, 2007, the Court denied a motion by the plaintiffs to dismiss the defendants counterclaim for malicious prosecution and abuse of process. The Court ordered plaintiffs to answer the counterclaim by February 20, 2007. Although they filed after the required date, plaintiffs filed an answer to the counterclaim.

On February 7, 2007, the Court dismissed the charitable trust, RICO and violation of due process claims as to all of the plaintiffs. The tort, breach of contract and violation of the Puerto Rico corporations law claims were dismissed only against certain of the physician plaintiffs. The Court allowed the count based on antitrust to proceed, and in reconsideration allowed the charitable trust and RICO claims to proceed. We appealed to the Puerto Rico Court of Appeals the denial of the motion to dismiss as to the antitrust allegations and the Court s decision to reconsider the claims previously dismissed.

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On May 30, 2007 the Puerto Rico Court of Appeals granted leave to replead the RICO and antitrust claims only to the physician plaintiffs, consistent with certain requirements set forth in its opinion, to allow the physician plaintiffs the opportunity to cure the deficiencies and flaws the Court found in plaintiffs allegations. The Court dismissed the charitable trust claim as to all plaintiffs, denying them the opportunity to replead that claim, and dismissed the RICO and antitrust claims as to the non-physician plaintiffs. Also, the Court of Appeals granted leave to replead a derivative claim capacity on behalf of the Corporation to the lone shareholder plaintiff. The plaintiffs moved for the reconsideration of this judgment. On July 18, 2007 the Court of Appeals denied the plaintiffs motion for reconsideration, which has granted plaintiffs leave to replead certain matters. On August 17, 2007, plaintiffs filed a petition for certiorari by the Puerto Rico Supreme Court, which we opposed on August 27, 2007. The plaintiffs petition for certiorari was denied by the Puerto Rico Supreme Court on November 9, 2007.

Thomas Litigation

On May 22, 2003, a putative class action suit was filed by Kenneth A. Thomas, M.D. and Michael Kutell, M.D., on behalf of themselves and all others similarly situated and the Connecticut State Medical Society against BCBSA and substantially all of the other Blue Cross and Blue Shield plans in the United States, including our managed care subsidiary. The case is pending before the U.S. District Court for the Southern District of Florida, Miami District. The individual plaintiffs bring this action on behalf of themselves and a class of similarly situated physicians seeking redress for alleged illegal acts of the defendants, which they allege have resulted in a loss of their property and a detriment to their business, and for declaratory and injunctive relief to end those practices and prevent further losses. Plaintiffs alleged that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to doctors so that they are not paid in a timely manner for the covered, medically necessary services they render.

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

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

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

The parties have been ordered to engage in mediation by the District Court, and twenty four plans, including our managed care subsidiary, are actively participating in the mediation efforts. The mediation resulted in the creation of a Settlement Agreement that was filed with the Court on April 27, 2007, and on May 31, 2007, the District Court preliminarily approved the Settlement Agreement. We have recorded an accrual for the estimated settlement, which is included within the accounts payable and accrued liabilities in our audited consolidated financial statements as of and for the year ended December 31, 2007. A final approval hearing for the Settlement Agreement was held on November 14, 2007, after which additional defendants joined the settlement. The Court has yet to issue the final approval of the settlement.

Lens Litigation

On October 23, 2007, Ivonne Houellemont, Ivonne M. Lens and Antonio A. Lens, heirs of Dr. Antonio Lens-Aresti, a former shareholder of TSI, filed a suit against TSI in the Court of First Instance for San Juan, Superior Section. The plaintiffs are seeking the return of 16 shares (prior to giving effect to the 3,000-for-one split) of TSI that were redeemed in 1996, a year after the death of Dr. Lens-Aresti, or compensation in the amount of $40,000 per share which they allege is a share s present value, alleging that they were fraudulently induced to submit the shares for redemption in 1996. At the time of Dr. Lens-

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Aresti s death, the bylaws of TSI would not have permitted the plaintiffs to inherit Dr. Lens-Aresti s shares, as those bylaws provided that in the event of a shareholder s death, shares could be redeemed at the price originally paid for them or could be transferred only to an heir who was either a doctor or dentist. The plaintiffs complaint also states that they purport to represent as a class all heirs of the TSI s former shareholders whose shares were redeemed upon such shareholders deaths. On October 31, 2007, the Corporation filed a motion to dismiss the claims as barred by the applicable statute of limitations. On December 21, 2007, the plaintiffs filed an opposition to our motion to dismiss, alleging that the two year statute of limitations is not applicable in connection with the redemption of the stock by the Corporation that took place in 1996. On March 3, 2008, the Corporation filed a reply to plaintiffs opposition to the motion to dismiss. In its reply, the Corporation renews its motion to dismiss and further argues that plaintiffs argument is wrong because the statute of limitations has expired, pursuant the two year term provide, under the Uniform Security Act of Puerto Rico Civil code for cases of this nature. Management believes that the statute of limitations has expired and expects to prevail in this litigation. Regarding the plaintiffs attempt to represent a purported class, as of the date of this Annual Report on Form 10-K, no further efforts have been made by the plaintiffs in this case.

Colón Litigation

On October 15, 2007, José L. Colón-Dueño, a former holder of one share of TSI predecessor stock, filed suit against TSI and the Commissioner of Insurance in the Court of First Instance for San Juan, Superior Section.

Mr. Colón-Dueño owned one share of TSI predecessor stock that was redeemed in 1999 for its original purchase price pursuant to an order issued by the Commissioner of Insurance requiring the redemption of a total of 1,582 shares that had been previously sold by the company. The Company appealed this Commissioner of Insurance s order to the Puerto Rico Court of Appeals, which upheld that order by decision dated March 31, 2000. The plaintiff requests that the court direct TSI to return his share of stock and pay damages in excess of $500,000 and attorney s fees. On January 23, 2008, the Company filed a motion for summary judgment, on the ground *inter alia* that the finding of the Insurance Commissioner is firm and final and cannot be collaterally attacked in this litigation. Plaintiffs have petitioned the Court to hold the motion in abeyance pending discovery. TSI believes that this claim is meritless, as the validity of the share repurchase was decided by the Court of Appeals in 2000, and plans to vigorously contest this matter.

Puerto Rico Center for Municipal Revenue Collection

On March 1, 2006 and March 3, 2006, respectively, the Puerto Rico Center for Municipal Revenue Collection (CRIM) imposed a real property tax assessment of approximately $1.3 million and a personal property tax assessment of approximately $4.0 million upon TSI for the fiscal years 1992-1993 through 2002-2003, during which time TSI qualified as a tax-exempt entity under Puerto Rico law pursuant to rulings issued by the Puerto Rico tax authorities. In imposing the tax assessments, CRIM contends that because a for-profit corporation, such as TSI, is not entitled to such an exemption, the rulings recognizing the tax exemption that were issued should be revoked on a retroactive basis and property taxes should be applied to TSI for the period when it was exempt. On March 28, 2006 and March 29, 2006, respectively, TSI challenged the real and personal property tax assessments in the Court of First Instance for San Juan, Superior Section.

On October 29, 2007, the Court entered summary judgment for CRIM affirming the real property tax assessment of approximately $1.3 million. TSI filed a motion for reconsideration of the Court s summary judgment decision, which was denied. On November 29, 2007 TSI appealed this determination before the Court of Appeals and has requested an argumentative hearing. On January 19, 2008 CRIM filed an allegation in opposition of TSI s appeal and on March 3, 2008 TSI filed its response to the allegation submitted by CRIM.

On December 5, 2007, the Court entered a summary judgment for CRIM with respect to the personal property assessment that was notified on January 22, 2008. On January 31, 2008, TSI filed a motion for reconsideration, which was denied. TSI appealed this decision on February 21, 2008 before the Court of Appeals and also requested a consolidation of both property tax cases.

Management believes that these municipal tax assessments are improper and currently expects to prevail in these litigations.

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Puerto Rico House of Representatives Investigation

On October 25, 2007, the House of Representatives of the Legislative Assembly (the House) of the Commonwealth of Puerto Rico approved a resolution ordering the House s Committee on Health to investigate TSI, our managed care subsidiary. The resolution states that TSI originally intended to operate as a not-for-profit entity in order to provide low-cost health insurance and improve the health services offered by certain government agencies. The resolution orders the Committee to investigate the effects of TSI s alleged failure to provide low-cost health insurance, among other obligations, and requires the Committee to prepare and submit a report to the House detailing its findings, conclusions and recommendations on or prior to sixty (60) days from the approval of the resolution. The Committee may refer any finding of wrongdoing to the Secretary of Justice of the Commonwealth for further investigation. We believe that TSI and its predecessor managed care companies have complied with such obligations in all material respects, but cannot predict the outcome of the proposed investigation and are currently unable to ascertain the impact these matters may have on our business, if any.

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

None.

Part II

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

Market Information

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

The following table presents high and low sales prices for the quarterly period in which our Class B common stock was publicly traded:

	High	Low
Fourth quarter (beginning December 7, 2007)	$21.20	$14.78

On February 29, 2008 the closing price of our Class B common stock on the NYSE was $20.20.

Holders

As of February 28, 2008, there were 16,042,809 and 16,266,554 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A and Class B common stock as of February 11, 2008 was 1,885 and 4,360, respectively.

Dividends

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

Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Our subsidiaries are subject to regulatory surplus requirements and additional regulatory requirements, which may restrict their ability to declare and pay dividends or distributions to us. We are required to maintain minimum capital of

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$1.0 million for our managed care subsidiary, $2.5 million for our life insurance subsidiary and $3.0 million for our property and casualty insurance subsidiary. In addition, our secured term loan restricts our ability to pay dividends if a default thereunder has occurred and is continuing.

In March 2007, we declared and paid dividends amounting to approximately $2.4 million. In January 2006 we declared and paid dividends amounting to $6.2 million. We did not declare any dividends in prior years.

We 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.

Securities Authorized for Issuance Under Equity Compensation Plan

The information required by this item is incorporated by reference to the section Compensation Discussion and Analysis included in our definitive Proxy Statement.

Recent Sales of Unregistered Securities

Not applicable.

Purchases of Equity Securities by the Issuer

Not applicable.

Performance Graph

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

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

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	12/7/07	12/14/07	12/21/07	12/28/07	12/31/07
GTS	$100.00	$122.11	$126.07	$134.19	$133.40
S&P500 Index	$100.00	$ 97.56	$ 98.66	$ 98.26	$ 97.59
MSHP Index	$100.00	$ 99.53	$101.47	$101.07	$100.38

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Item 6. Selected Financial Data.

Statement of Earnings Data

(Dollar amounts in millions, except per share data)	**2007**	**2006 (1)**	**2005**	**2004**	**2003**
Years ended December 31,					
Premiums earned, net	$1,483.6	1,511.6	1,380.2	1,299.0	1,264.4
Administrative service fees	14.0	14.1	14.4	9.2	8.3
Net investment income	47.2	42.7	29.1	26.8	24.7
Total operating revenues	1,544.8	1,568.4	1,423.7	1,335.0	1,297.4
Net realized investments gains	5.9	0.8	7.2	11.0	8.4
Net unrealized investment gain (loss) on trading securities	(4.1)	7.7	(4.7)	3.0	14.9
Other income, net	3.2	2.3	3.7	3.4	4.7
Total revenues	1,549.8	1,579.2	1,429.9	1,352.4	1,325.4
Benefits and expenses:					
Claims incurred	1,223.8	1,259.0	1,208.3	1,115.8	1,065.4
Operating expenses	237.5	236.1	181.7	171.9	165.1
Total operating costs	1,461.3	1,495.1	1,390.0	1,287.7	1,230.5
Interest expense	15.9	16.6	7.6	4.6	3.2
Total benefits and expenses	1,477.2	1,511.7	1,397.6	1,292.3	1,233.7
Income before taxes	72.6	67.5	32.3	60.1	91.7
Income tax expense	14.1	13.0	3.9	14.3	65.4
Net income	58.5	54.5	28.4	45.8	26.3
Basic net income per share (2):	$ 2.15	2.04	1.06	1.71	0.95
Diluted net income per share:	$ 2.15	2.04	1.06	1.71	0.95
Dividend declared per common share (3):	$ 0.82	0.23			

Balance Sheet Data

	2007	**2006 (1)**	**2005**	**2004**	**2003**
December 31,					
Cash and cash equivalents	$ 240.2	81.6	49.0	35.1	47.7

Total assets	$1,659.5	1,345.5	1,137.5	919.7	834.6
Long-term borrowings	$ 170.9	183.1	150.6	95.7	48.4
Total stockholders equity	$ 482.5	342.6	308.7	301.4	254.3

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Additional Managed Care Data [4]

	2007	2006 (1)	2005	2004	2003
Additional Managed Care Data (4)					
Years ended December 31,					
Medical loss ratio	87.1%	87.6%	90.3%	88.3%	86.6%
Operating expense ratio	11.2%	11.5%	10.8%	10.8%	10.8%
Medical membership (period end)	977,190	979,506	1,252,649	1,236,108	1,235,349

(1) On January 31, 2006 we completed the acquisition of GA Life (now TSV). The results of operations and financial condition of GA Life are included in this table for the period following the effective date of the acquisition. See note 17 to the audited consolidated financial statements for the years ended December 31, 2007, 2006 and 2005.

(2) Further details of the calculation of basic earnings per share are set

forth in notes 2 and 21 of the audited financial consolidated financial statements for the years ended December 31, 2007, 2006 and 2005.

(3) Shareowners holding qualifying shares were excluded from dividend payment. See note 18 of the audited financial consolidated financial statements for the years ended December 31, 2007, 2006 and 2005.

(4) Does not reflect inter-segment eliminations.

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

This financial discussion contains an analysis of our consolidated financial position and financial performance as of December 31, 2007 and 2006, and consolidated results of operations for 2007, 2006 and 2005. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

Overview

We are the largest managed care company in Puerto Rico in terms of membership, with over 45 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the Commercial, Commonwealth of Puerto Rico Health Reform (the Reform) and Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plans (PDP)) markets. The Reform is a government of Puerto Rico-funded managed care program for the medically indigent, similar to the Medicaid program in the U.S. We have the exclusive right to use the Blue Shield name and mark throughout Puerto Rico, serve approximately one million members across all regions of Puerto Rico and hold a leading market position covering approximately 25% of the population. For the years ended December 31, 2007 and 2006 respectively, our managed care segment represented approximately 86.1% and 88.6% of our total consolidated premiums earned, net, and approximately 78.3% and 62.2% of our operating income. We also have significant positions in the life insurance and property and casualty insurance markets. Our life insurance segment had a market share of approximately 15% (in terms of premiums written) as of December 31, 2006. Our property and casualty segment had a market share of approximately 9% (in terms of direct premiums) as of December 31, 2006.

We participate in the managed care market through our subsidiary, TSI. Our managed care subsidiary is a BCBSA licensee, which provides us with exclusive use of the Blue Shield brand in Puerto Rico. We offer products to the Commercial, including corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement, Reform and Medicare (including Medicare Advantage and PDP) markets.

We participate in the life insurance market through our subsidiary, TSV, and in the property and casualty insurance market through our subsidiary, STS. TSV and STS represented approximately 5.9% and 6.4%, respectively, of our consolidated premiums earned, net for the year ended December 31, 2007 and 14.6% each, of our operating income for that period.

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The Commissioner of Insurance of the Commonwealth of Puerto Rico recognizes only statutory accounting practices for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Puerto Rico insurance laws and for determining whether its financial condition warrants the payment of a dividend to its stockholders. No consideration is given by the Commissioner of Insurance of the Commonwealth of Puerto Rico to financial statements prepared in accordance with U.S. generally accepted accounting principles (GAAP) in making such determinations. See note 24 to our audited consolidated financial statements.

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

(Dollar amounts in millions)	**Years ended December 31, 2007**	**2006**	**2005**
Premiums earned, net:			
Managed care	$1,301.8	1,339.8	1,279.5
Life insurance	88.9	86.9	17.1
Property and casualty insurance	96.9	88.5	86.8
Intersegment premiums earned	(4.0)	(3.6)	(3.2)
Consolidated premiums earned, net	$1,483.6	1,511.6	1,380.2
Administrative service fees:			
Managed care	$ 17.2	16.9	15.5
Intersegment premiums earned	(3.2)	(2.8)	(1.1)
Consolidated administrative service fees	$ 14.0	14.1	14.4
Operating income:			
Managed care	$ 57.4	45.5	16.1
Life insurance	10.7	11.2	3.0
Property and casualty insurance	10.7	11.2	12.3
Intersegment premiums earned	4.7	5.4	2.3
Consolidated operating income	$ 83.5	73.3	33.7

We have one-year contracts with the government of Puerto Rico to be the Reform insurance carrier for two of the eight geographical regions into which Puerto Rico is divided for purposes of the Reform. In October 2006, the contract for the Metro-North region, for which we were the carrier, was awarded to another managed care company, effective November 1, 2006. The premiums earned, net of the Metro-North region during the years 2006 and 2005 amounted to $161.6 million and $200.9 million, respectively. The operating income of this region during the years 2006 and 2005 amounted to $5.4 million and $3.5 million, respectively.

Results of Operations

Revenue

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

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

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

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

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

Other Premium Revenue. Other premium revenue includes premiums generated from the sale of life insurance and property and casualty insurance products. Premiums on life insurance policies are billed in the month prior to the effective date of the policy, with a one-month grace period, and the related revenue is recorded as earned during the coverage period. If the insured fails to pay within the one-month grace period, we may cancel the policy. We recognize premiums on property and casualty contracts as earned on a pro rata basis over the policy term. 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 income and other income consists of net realized gains on investment securities. See note 2(e) to our audited consolidated financial statements.

Expenses

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

The medical loss ratio (MLR), which is calculated by dividing managed care claims incurred by managed care premiums earned, net is one of our primary management tools for measuring these costs and their

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

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

Membership

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

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

We believe that the Medicare Advantage program (including PDP) provides a significant opportunity for growth in membership. We commenced offering Medicare Advantage products in 2005, with the introduction of our *Medicare Selecto* and *Medicare Optimo* plans. Membership enrolled in our Medicare Advantage programs increased by 40.6% in 2007; from 27,078 as of December 31, 2006 to 38,070 members as of December 31, 2007. In January 2006, we launched our stand-alone PDP plan, *FarmaMed*, which as of December 31, 2007, had 11,175 members. We expect that Medicare Advantage enrollment will continue to growth, but not at the same pace as in this initial period.

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

	As of December 31,		
	2007	**2006**	**2005**
Commercial [(1)]	574,251	580,850	612,218
Reform [(2)]	353,694	357,515	628,438
Medicare [(3)]	49,245	41,141	11,993
Total	977,190	979,506	1,252,649

(1) Commercial membership includes corporate

accounts, self-funded employers, individual accounts, Medicare Supplement, Federal government employees and local government employees.

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

(3) Includes Medicare Advantage as well as stand-alone PDP plan membership.

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Significant Transactions

Effective January 31, 2006, we completed the acquisition of 100% of the common stock of GA Life for $37.5 million, and effective June 30, 2006 we merged the operations of our former life insurance subsidiary, SVTS, into GA Life (now TSV). GA Life s results of operations and financial condition are included in our consolidated financial statements for the period following January 31, 2006. Our historical results of operations and comparable basis information for 2005 are included in the following tables. Comparable basis information was determined by adding the historical statements of earnings of GA Life from February 1, 2005 to December 31, 2005 to our statement of earnings for the year 2005. Comparable basis information is presented in order to provide a more meaningful comparison of the 2006 and 2005 periods. Comparable basis is not calculated in accordance with GAAP and is not intended to represent or be indicative of the results of operations that would have been reported by us had the acquisition been completed as of January 31, 2005. In addition, comparable basis information does not adjust for the inclusion in our 2006 results the coinsurance funds withheld agreement with GA Life during January of that year. Comparable basis information, unlike the pro forma financial information included in note 17 of the audited financial consolidated financial statements for the years ended December 31, 2007, 2006 and 2005, does not reflect adjustments, such as interest expense associated with indebtedness incurred in connection with the acquisition.

Consolidated

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

Total income taxes	3.9	(0.8)	3.1
Net income	$ 28.4	15.5	43.9

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Life and Disability Insurance Segment

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

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2007, 2006 and 2005. The 2006 historical results of operations of GA Life (nowTSV) are included in the following table for the period following January 31, 2006, the effective date of the acquisition. The 2005 comparable basis information is presented to provide a more meaningful comparison of the 2006 and 2005 periods, see Significant Transactions Consolidated included in this Item.

(Dollar amounts in millions)	**2007**	**2006**	**Comparable Basis 2005**	**2005**
Years ended December 31,				
Revenues:				
Premiums earned, net	$1,483.6	1,511.6	1,441.8	1,380.2
Administrative service fees	14.0	14.1	14.4	14.4
Net investment income	47.2	42.7	39.7	29.1
Total operating revenues	1,544.8	1,568.4	1,495.9	1,423.7
Net realized investment gains	5.9	0.8	11.6	7.2
Net unrealized investment gain (loss) on trading securities	(4.1)	7.7	(4.7)	(4.7)
Other income, net	3.2	2.3	3.7	3.7

Total revenues	1,549.8	1,579.2	1,506.5	1,429.9
Benefits and expenses:				
Claims incurred	1,223.8	1,259.0	1,237.3	1,208.3
Operating expenses	237.5	236.1	213.2	181.7
Total operating costs	1,461.3	1,495.1	1,450.5	1,390.0
Interest expense	15.9	16.6	9.0	7.6
Total benefits and expenses	1,477.2	1,511.7	1,459.5	1,397.6
Income before taxes	72.6	67.5	47.0	32.3
Income tax expense	14.1	13.0	3.1	3.9
Net income	$ 58.5	54.5	43.9	28.4

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Year ended December 31, 2007 compared with the year ended December 31, 2006

Operating Revenues

Consolidated premiums earned, net and administrative service fees decreased by $28.1 million, or 1.8%, to $1,497.6 million during the year ended December 31, 2007 compared to the year ended December 31, 2006. This decrease was primarily due to a decrease in the premiums earned, net in our managed care segment, principally due to the decreased volume of the Reform business after the termination of the contract for the Metro-North region, offset in part by the growth of our Medicare Advantage business and the increases in premium rates of the Reform business during 2007.

Consolidated net investment income presented an increase of $4.5 million, or 10.5%, to $47.2 million during the year ended December 31, 2007. This increase is primarily the result of an increase of $3.5 million attributed to a higher yield in 2007, a higher balance of invested assets and the acquisition of GA Life effective January 31, 2006. Net investment income earned by GA Life during the month of January 2006 amounted to $1.0 million, which is not included in our consolidated financial statements.

Net Realized Investment Gains

Consolidated net realized investment gains increased by $5.1 million to $5.9 million during 2007. This increase is primarily the result of higher sales of investments in 2007, particularly in trading securities, in order to keep the portfolio within our established targets in each investment sector.

Net Unrealized Gain (Loss) on Trading Securities and Other Income, Net

The combined balance of our consolidated net unrealized loss on trading securities and other income, net was a loss of $0.9 million during the year ended December 31, 2007, a decrease of $10.9 million, as compared to the combined gain of $10.0 million in 2006. This decrease is attributable to the net result of the unrealized loss on the trading portfolio, offset in part by an increase in the fair value of the derivative component of our investment in structured notes linked to foreign stock indexes. This unrealized loss on trading securities is due to the sale of one equity portfolio which had a net unrealized gain at the time of sale. This sale had the effect of eliminating the unrealized gain that was offsetting unrealized losses in our trading portfolio.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2007 decreased by $35.2 million, or 2.8%, to $1,223.8 million when compared to the claims incurred during the year ended December 31, 2006. This decrease is principally due to decreased claims in the managed care segment as a result of the decreased volume of the Reform business due to the termination of the contract for the Metro-North region, net of increased enrollment in the Medicare Advantage business. The consolidated loss ratio decreased by 0.8 percentage points, to 82.5% in the 2007 period. The lower loss ratio is mainly the result of an overall increase in premium rates, lower utilization trends and a change in the mix of business. During the year ended December 31, 2007, the weight in the mix of business of the managed care segment corresponding to the Reform business decreased as a result of the termination of the contract for the Metro-North area. The Reform business has a higher loss ratio than other businesses within this segment. On the other hand, the Medicare Advantage business, which has a lower loss ratio than other businesses within the managed care segment, has a higher weight in the mix of business in the 2007 period.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2007 increased by $1.4 million, or .6%, to $237.5 million as compared to operating expenses during the 2006 period. This increase is primarily attributed to increases in professional services expense (mainly legal expenses), normal increases in payroll and payroll related expense, as well as higher technology related costs due to the new systems initiative of our managed care subsidiary. This increase is offset in part by the decrease in the operating expenses for the Reform business resulting from the reduction in volume of this business. The consolidated operating expense ratio increased by 0.4 percentage points during the 2007 period mainly due to fixed expenses not affected by a reduction in volume.

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Income tax expense

The consolidated effective tax rate remained flat, with a slight increase of 0.1 percentage points, from 19.3% in 2006 to 19.4% in 2007.

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

Operating Revenues

Consolidated premiums earned, net and administrative service fees increased $131.1 million, or 9.4%, to $1,525.7 million in 2006 compared to 2005. On a comparable basis, including GA Life s results from both periods, consolidated earned premiums, net and administrative service fees increased by $69.5 million, or 4.8%. These increases were primarily due to an increase in the operating revenues of our managed care segment, which was attributable principally to strong growth from our Medicare Advantage and PDP products, offset in part by the Reform sector due to the loss of the Metro-North region.

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

Net Realized Investment Gains

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

Net Unrealized Gain (Loss) on Trading Securities and Other Income, Net

The combined balance of our consolidated net unrealized gain on trading securities and other income, net was $10.0 million during the 2006 period, an increase of $11.0 million on both an actual and comparable basis. This increase is attributable to unrealized equity securities gains in our trading portfolios. The unrealized loss in 2005 arose upon the sale of securities in a gain position to take advantage of the temporary reduction in capital gains tax rate, as discussed above.

Claims Incurred

Consolidated claims incurred during 2006 increased by $50.7 million, or 4.2%, to $1,259.0 million in 2006 when compared to the claims incurred from 2005 levels. On a comparable basis, the consolidated claims incurred increased by $21.7 million, or 1.8%, principally due to increased claims in the managed care segment as a result of increased enrollment in the Medicare Advantage and PDP sectors, net of a decrease in the Reform sector. In addition, the loss ratio on a comparable basis decreased by 2.5 percentage points from 85.8% to 83.3%.

Operating Expenses

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

Interest Expense

Consolidated interest expense for the year ended December 31, 2006 increased by $9.0 million to $16.6 million. On a comparable basis, consolidated interest expense increased by $7.6 million, primarily due to the interest expense corresponding to new debt incurred during the fourth quarter of 2005 and during the first quarter of 2006 in connection with the GA Life acquisition.

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Income Tax Expense

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

Managed Care Operating Results

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico: Commercial, Reform and Medicare (including Medicare Advantage and PDP). For the year ended December 31, 2007, the Commercial sector represented 47.5% and 22.0% of our consolidated premiums earned, net and operating income, respectively. During the same period the Reform sector represented 21.7% and 16.9%, of our consolidated premiums earned, net and our operating income, respectively. Premiums earned, net and operating income generated from our Medicare contracts (including PDP) during the year ended December 31, 2007 represented 16.9% and 11.3%, respectively, of our consolidated earned premiums, net and operating income, respectively.

(Dollar amounts in millions, except enrollment data)	**2007**	**2006**	**2005**
Years ended December 31,			
Medical operating revenues:			
Medical premiums earned, net:			
Commercial	$ 718.7	713.2	734.5
Reform	327.5	455.8	510.8
Medicare	255.6	170.8	34.2
Medical premiums earned	1,301.8	1,339.8	1,279.5
Administrative service fees	17.2	16.9	15.5
Net investment income	19.7	18.8	17.0
Total medical operating revenues	1,338.7	1,375.5	1,312.0
Medical operating costs:			
Medical claims incurred	1,133.2	1,173.6	1,155.9
Medical operating expenses	148.1	156.4	140.0
Total medical operating costs	1,281.3	1,330.0	1,295.9
Medical operating income	$ 57.4	45.5	16.1
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	4,983,980	5,272,987	5,632,249
Self funded	1,930,850	1,861,833	1,840,716
Total commercial	6,914,830	7,134,820	7,472,965
Reform	4,262,248	6,484,270	7,465,777
Medicare	554,040	461,718	71,947
Total member months	11,731,118	14,080,808	15,010,689

Medical loss ratio	87.1%	87.6%	90.3%
Medical expense ratio	11.2%	11.5%	10.8%

Year ended December 31, 2007 compared with the year ended December 31, 2006

Medical Operating Revenues

Medical premiums earned during 2007 decreased by $38.0 million, or 2.8%, to $1.3 billion when compared to earned premiums during 2006, principally as a result of the following:

Medical premiums earned in the Reform business decreased by $128.3 million, or 28.1%, to $327.5 million during the 2007 period. This fluctuation is due to a decrease in member months enrollment in the Reform business by 2,222,022, or 34.3%, mainly as the result of the termination

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of the contract for the Metro-North region, the tightening of membership restrictions by the Puerto Rico government, and the shift in membership of dual eligibles to Medicare Advantage policies offered by us and our competitors. The member months enrollment of the Metro-North region was 2,040,714 during the year ended December 31, 2006. The effect of this decrease in membership was mitigated by an increase in premium rates, effective July 1, 2007, of approximately 8.7% and a retroactive increase in rates of approximately 6.7% effective November 1, 2006.

Medical premiums generated by the Medicare business increased during 2007 by $84.8 million, or 49.6%, to $255.6 million, primarily due to an increase in member months enrollment of 92,322, or 20.0%. The increase in member months is the net result of an increase of 135,238, or 48.1%, in the membership of our Medicare Advantage products and a decrease of 42,916, or 23.8%, in the membership of our PDP product. We expect that Medicare Advantage enrollment will continue to experience growth, but at a slower pace than in prior periods. In addition, the segment recognized an additional premium adjustment of $3.2 million related to the 2006 risk scores review performed by CMS.

Medical premiums generated by the Commercial business increased by $5.5 million, or 0.8%, to $718.7 million during the 2007 period. This increase is primarily the result of an increase in average premium rates of 6.5%, partially offset by a decrease in member months enrollment of 289,007, or 5.5%.

Administrative service fees increased by $0.3 million, or 1.8%, to $17.2 million during the 2007 period due to an increase in member months enrollment of self-funded arrangements of 69,017, or 3.7%, and to a shift of several self-funded groups to arrangements where the administrative service fee is based on contracts instead of claims paid.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2007 decreased by $40.4 million, or 3.4%, to $1.1 billion when compared to the year ended December 31, 2006. The decrease in medical claims incurred is mostly related to the medical claims incurred of the Reform business, which decreased by $119.9 million due its decreased enrollment, partially offset by a combined increase of $85.7 million in the medical claims incurred of the Medicare Advantage and PDP businesses due to an increase in members. The medical loss ratio decreased by 0.5 percentage points during the 2007 period, to 87.1%, primarily due to an overall increase in premium rates, lower utilization trends and a change in the mix of business of the segment. During the year ended December 31, 2007 the weight in the mix of business corresponding to the Reform business decreased as a result of the termination of the contract for the Metro-North area. The Reform business has a higher medical loss ratio than other businesses within the segment. On the other hand, the Medicare Advantage business, which has a lower medical loss ratio than other businesses, had a higher weight in the mix of business in the 2007 period.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2007 decreased by $8.3 million, or 5.3%, to $148.1 million when compared to 2006. This decrease is primarily attributed to the decrease in direct costs of the Reform business due to its reduction in volume. The segment s operating expense ratio decreased by 0.3 percentage points during the 2007 period.

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

Medical Operating Revenues

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

Medical premiums generated by the Medicare Advantage business increased during 2006 by $136.6 million, or 399.4%, primarily due to an increase in member months enrollment of 389,771, or 541.7%. The increase in member months enrollment is the result of an increase of 209,327, or 290.9%, in the membership of our Medicare Advantage product and a members months

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enrollment 180,444 of our new PDP product. The increase in members of our Medicare Advantage business reflects the initial ramp-up of this business, which commenced in 2005, and the introduction of additional Medicare Advantage policies. In January 2006, we expanded our Medicare Advantage business with the introduction of Medicare *Platino* for the dual-eligible population, the medically indigent Medicare-qualified beneficiaries. Also in January 2006, we introduced a new PDP product, *FarmaMed*, which had premiums of $15.1 million during the 2006 period. In 2006, many members of our PDP business transferred to one of our Medicare Advantage policies, we expect this trend to continue in 2007 and, as a result, to experience a decrease in the enrollment of this business.

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

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

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

Medical Claims Incurred

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

Medical Operating Expenses

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

Life Insurance Operating Results

The 2006 historical results of operations of GA Life (now TSV) are included in this table for the period following January 31, 2006, the effective date of the acquisition. The 2005 comparable basis information included in the following table is presented to provide a more meaningful comparison of the 2006 and 2005 periods, see Significant Transactions Consolidated included in this Item.

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(Dollar amounts in millions)	2007	2006	Comparable Basis 2005	2005
Years ended December 31,				
Operating revenues:				
Premiums earned, net				
Premiums earned, net	$ 97.4	91.9	87.9	24.2
Premiums earned ceded	(8.8)	(9.7)	(10.1)	(8.0)
Assumed premiums earned		4.4	0.4	0.4
Net premiums earned	88.6	86.6	78.2	16.6
Commission income on reinsurance	0.3	0.3	0.5	0.5
Premiums earned, net	88.9	86.9	78.7	17.1
Net investment income	15.0	13.7	13.6	3.0
Total operating revenues	103.9	100.6	92.3	20.1
Operating costs:				
Policy benefits and claims incurred	45.7	43.6	37.9	8.9
Underwriting and other expenses	47.5	45.8	39.7	8.2
Total operating costs	93.2	89.4	77.6	17.1
Operating income	$ 10.7	11.2	14.7	3.0
Additional data:				
Loss ratio	51.4%	50.2%	48.2%	52.0%
Expense ratio	53.4%	52.7%	50.4%	48.0%

Year ended December 31, 2007 compared with the year ended December 31, 2006

Operating Revenues

Premiums earned for the segment increased by $5.5 million, or 6.0%, to $97.4 million during the year ended December 31, 2007 as compared to the year ended December 31, 2006, principally reflecting the acquisition of GA Life effective January 31, 2006. Premiums earned by GA Life during the month of January 2006 were $6.6 million, which are not reflected in our consolidated financial statements. Eliminating the effect of GA Life s premiums for the month of January 2006, the premiums earned in the segment decreased by $1.1 million. For the year ended December 31, 2007, the premiums generated by the segment s group disability and group life businesses decreased by $2.6 million and $1.0 million, respectively, offset in part by an increase in the individual life and cancer business of $2.3 million and $0.3 million, respectively.

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

Policy Benefits and Claims Incurred

Policy benefits and claims incurred during the year ended December 31, 2007 increased by $2.1 million, or 4.8%, to $45.7 million in the 2007 period when compared to the 2006 period, principally reflecting the acquisition of GA Life effective January 31, 2006. Policy benefits and claims incurred by GA Life during the month of January 31, 2006, net of the effect of the coinsurance agreement, were $1.0 million. Eliminating the effect of GA Life s policy benefits and claims incurred for the month of January 2006, this segment presented an increase of $1.1 million. This increase is primarily driven by increases in the benefits of the cancer and group life business of $2.0 million and $1.0 million, respectively, and to an increase in policy surrenders of $1.2 million. These increases were partially offset by decreases in the benefits of the group disability and individual life businesses of $1.3 and $1.6 million, respectively. The segment s loss ratio increased by 1.2 percentage points, from 50.2% in 2006 to 51.4% in the 2007 period, principally as a

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result of the inclusion of twelve months of GA Life benefits and claims incurred in the 2007 period (as compared to eleven months in 2006) and a higher loss ratio in the cancer business.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $1.7 or 3.7%, during the year ended December 31, 2007. Considering the effect of underwriting and other expenses of $1.7 million incurred by GA Life during the month of January 2006, net of the effect of the coinsurance agreement, the underwriting and other expenses of the segment remained flat during the 2007 period. The segment s operating expense ratio increased by 0.7 percentage points during the year 2007, from 52.7% in 2006 to 53.4% in 2007.

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

Operating Revenues

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

Our 2006 results reflect $4.4 million of premiums assumed under the coinsurance funds withheld agreement with GA Life, which represents our share of premiums for the month of January 2006. The effects of the reinsurance transactions corresponding to this agreement were eliminated for consolidated financial statement purposes for the period following January 31, 2006.

Policy Benefits and Claims Incurred

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

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased from $8.2 million to $45.8 million in 2006 period. On a comparable basis, underwriting and other expenses increased by $6.1 million, or 15.4%. The segment s operating expense ratio on a comparable basis increased by 2.3 percentage points, from 50.4% in 2005 to 52.7% in 2006. The increase in underwriting and other expenses includes $1.8 million relating to our share of commissions and other operating expenses for the month of January 2006 under the coinsurance agreement with GA Life. The remaining increase in operating expenses was mostly related to management fees charged by TSM and an increase in amortization expense resulting from deferred policy acquisition costs and value of business acquired arising from the acquisition of GA Life.

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Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	**2007**	**2006**	**2005**
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$170.9	158.9	151.1
Premiums ceded	(69.1)	(65.7)	(59.2)
Change in unearned premiums	(4.9)	(4.7)	(5.1)
Premiums earned, net	96.9	88.5	86.8
Net investment income	11.8	9.6	8.7
Total operating revenues	108.7	98.1	95.5
Operating costs:			
Claims incurred	44.9	41.7	43.6
Underwriting and other operating expenses	53.1	45.2	39.6
Total operating costs	98.0	86.9	83.2
Operating income	$ 10.7	11.2	12.3
Additional data:			
Loss ratio	46.3%	47.1%	50.2%
Expense ratio	54.8%	51.1%	45.6%
Combined ratio	101.1%	98.2%	95.8%

Year ended December 31, 2007 compared with the year ended December 31, 2006

Operating Revenues

Total premiums written during the year ended December 31, 2007 increased by $12.0 million, or 7.6%, to $170.9 million, principally as a result of increases in the commercial multi-peril, auto and dwelling lines of business by $6.2 million, $3.2 million and $1.8 million, respectively.

Premiums ceded to reinsurers increased by $3.4 million, or 5.2%, to $69.1 million during 2007. The ratio of premiums ceded to premiums written decreased by 0.9 percentage points, from 41.3% in 2006 to 40.4% in 2007 primarily as a result of lower costs of facultative reinsurance and the effects of the mix of business.

Claims Incurred

Claims incurred during the year ended December 31, 2007 increased by $3.2 million, or 7.7%, to $44.9 million. The loss ratio decreased by 0.8 percentage points during this period, to 46.3% in 2007, primarily as the result of the segment s adherence to underwriting guidelines and enhancements to the claims handling process, which included hiring additional in-house claim adjusters. These efforts have resulted in improved loss ratios in the commercial multi-peril, general liability, auto liability and commercial auto physical damage lines of business.

Underwriting and Other Operating Expenses

Underwriting and other operating expenses for the year ended December 31, 2007 increased by $7.9 million, or 17.5%, to $53.1 million. The operating expense ratio increased by 3.7 percentage points during the same period, to 54.8% in 2007. This increase is primarily due to increases in net commission expense, payroll and payroll related expenses, corporate costs allocations and a provision for a possible loss contingency. The segment has also

experienced an increase in its depreciation expense, including the depreciation and amortization expense related to the segment s investment in a new IT system.

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

Operating Revenues

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

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

Claims Incurred

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

Underwriting and Other Operating Expenses

Underwriting and other operating expenses in 2006 increased by $5.6 million, or 14.1%, to $45.2 million. The operating expense ratio increased by 5.5 percentage points during the same period, to 51.1% in 2006. This increase was primarily due to increases in commission expenses due to commission rate increases reflecting market conditions and increased salaries and benefits expenses, as well as costs associated with the implementation of new IT systems.

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Liquidity and Capital Resources

Cash Flows

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

(dollar amounts in millions)	**2007**	**2006**	**2005**
Years ended December 31,			
Sources of cash:			
Cash provided by operating activities	$115.9	75.6	50.8
Net proceeds from investments sold	1.0		
Proceeds from long-term borrowings		35.0	60.0
Proceeds from short-term borrowings	54.5	117.8	174.1
Proceeds from annuity contracts	6.1	6.0	11.5
Net proceeds from initial public offering	70.3		
Other			3.9
Total sources of cash	247.8	234.4	300.3
Uses of cash:			
Net purchases of investment securities		(9.3)	(94.7)
Acquisition of GA Life, net of cash acquired		(27.8)	
Capital expenditures	(9.4)	(11.9)	(7.6)
Dividends	(2.4)	(6.2)	
Payments of long-term borrowings	(12.1)	(2.5)	(5.1)
Payments of short-term borrowings	(54.5)	(119.5)	(174.0)
Surrenders of annuity contracts	(7.4)	(16.0)	(5.1)
Other	(3.4)	(8.7)	
Total uses of cash	(89.2)	(201.9)	(286.5)
Net increase in cash and cash equivalents	$158.6	32.5	13.8

Year ended December 31, 2007 compared to year ended December 31, 2006

Cash provided by operating activities increased by $40.3 million, or 53.3%, to $115.9 million for the year ended December 31, 2007, principally due to the net effect of an increase of $14.2 million in net proceeds received from the sale of trading securities, a reduction in claims paid of $54.4 million, a reduction in cash paid to suppliers and employees of $8.6 million, partially offset by a reduction in premiums collected of $16.2 million. These fluctuations were impacted by the termination of the contract for the Metro-North region of our managed care segment. In addition, in 2007 there was an increase of $23.1 million in the amount of income taxes paid that is the result of the higher taxable income in 2007 of our managed care subsidiary, which has a higher effective tax rate than the other segments.

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

On December 2007, the Corporation received net proceeds amounting to $70.3 million upon our initial public offering.

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

Capital expenditures decreased by $2.5 million as the result of the completion of the renovation of a building adjacent to our corporate headquarters which was completed during the last quarter of 2006. In addition, our property and

casualty insurance segment acquired new hardware and software as part of its new insurance application during 2006. In March 2007, we declared and paid dividends to our stockholders amounting to $2.4 million.

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On August 1, 2007, we repaid the outstanding balance of $10.5 million of one of our secured term loans upon its maturity.

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

Cash provided by operating activities increased by $24.8 million, or 48.8%, to $75.6 million during 2006, principally due to a 10% increase in premiums collected, offset in part by a 4% increase in claims losses and benefits paid, reflecting primarily lower utilization trends in the managed care segment during 2006. In addition, our operating cash flows during 2006 include the operating cash flows of GA Life, which were not present in prior years. This increase in cash was offset in part by a decrease in net proceeds from sales of our trading portfolio following the sale of $71.9 million of our corporate bond trading portfolio during 2005.

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

Net purchases of investment securities decreased by $85.4 million during the 2006 period, primarily as a result of 2005 acquisitions of available-for-sale securities with the proceeds from the sale of our corporate bond trading portfolio.

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

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

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

The 2006 period reflects net surrenders of policyholder deposits of $10.0 million while the 2005 period presents net proceeds from annuity contracts of $6.4 million. This fluctuation was principally due to an increase in the amount of policyholder deposit surrenders and a decrease in the proceeds received from the fixed deferred policyholder deposits product in 2006.

Financing and Financing Capacity

We have several short-term facilities available to address timing differences between cash receipts and disbursements. These short-term facilities are mostly in the form of arrangements to sell securities under repurchase agreements. As of December 31, 2007, we had $53.0 million of available credit under these facilities. There were no outstanding short-term borrowings under these facilities as of December 31, 2007.

As of December 31, 2007, we had the following senior unsecured notes payable:

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

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

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

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whole or in part, as determined by our managed care subsidiary. Most of the proceeds obtained from this issuance were used to repay $37.0 million of short-term borrowings. The remaining proceeds were used for general business purposes.

The 6.3% notes, the 6.6% notes and the 6.7% notes contain certain covenants. At December 31, 2007, we and our managed care subsidiary, as applicable, are in compliance with these covenants.

In addition, as of December 31, 2007 we are a party to a secured term loan with a commercial bank, FirstBank 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 repayment of $0.1 million. As of December 31, 2007, this secured loan had an outstanding balance of $25.9 million and an average annual interest rate of 6.4%.

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 covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2007, we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the secured loan s outstanding balances. Principal repayments on this loan are expected to be paid out from our operating and investing cash flows.

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

We were also a party to another secured loan whose outstanding balance of $10.5 million was repaid upon its maturity on August 1, 2007. The average annual interest rate of this secured loan was 6.7%.

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

Planned Capital Expenditures

During 2005, our managed care business began a project to change a significant part of its operations computer system. This project is expected to be carried out in phases until 2012 at a cost of approximately $64.0 million. Our managed care business expects to incur costs of approximately $24.5 million during 2008. We estimate that $21.0 million of the costs incurred in 2008 will be capitalized over the system s useful life and the remaining amount will be expensed. This amount is expected to be paid out of the operating cash flows of our managed care business.

Contractual Obligations

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

The table below describes the payments due under our contractual obligations, aggregated by type of contractual obligation, including the maturity profile of our debt, operating leases and other long-term liabilities, and excludes an estimate of the future cash outflows related to the following liabilities:

Liability for future policy benefits This liability was excluded because we do not expect to make payments in the future until the occurrence of an insurable event, such as death or disability, or because the occurrence of a payment triggering event, such as the surrender of a policy or contract, is not under our control. The determination of the timing of payment of this liability is not reasonably fixed and determinable since the insurable event has not yet occurred. As of December 31, 2007, our liability for future policy benefits amounted to $194.1 million.

Unearned premiums This amount accounts for the premiums collected prior to the end of coverage period and does not represent a future cash outflow. As of December 31, 2007, we had $132.6 million in unearned premiums.

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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, 2007, our policyholder deposits had a carrying amount of $45.9 million.

Other long-term liabilities Due to the indeterminate nature of their cash outflows, $59.4 million of other long-term liabilities are not reflected in the following table, including $29.2 million of liability for the pension benefits and $21.3 million in liabilities to the Federal Employees Health Benefit Plan.

		Contractual obligations by year					
(Dollar amounts in millions)	**Total**	**2008**	**2009**	**2010**	**2011**	**2012**	**Thereafter**
Long-term borrowings (1)	$302.9	12.6	12.6	12.5	12.4	12.2	240.6
Operating leases	13.3	5.3	3.7	2.2	1.2	0.5	0.4
Purchase obligations (2)	235.5	235.2	0.1	0.1	0.1		
Claim liabilities (3)	299.0	203.2	57.0	12.8	8.9	6.0	11.1
	$850.7	456.3	73.4	27.6	22.6	18.7	252.1

(1) As of December 31, 2007, our long-term borrowings consist of our managed care subsidiary s 6.3% senior unsecured notes payable (which are unconditionally guaranteed as to payment of principal, premium, if any, and interest by us), our 6.6% senior unsecured notes payable, our 6.7% senior unsecured notes payable, and a loan payable to a commercial bank. Total

contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.3%, 6.6% and 6.7% senior unsecured notes, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity dates of the notes in 2019, 2020, and 2021, respectively. We may redeem the notes starting five years after issuance; however no redemption is considered in this schedule. The interest payments related to our loan payable were estimated using the interest rate applicable as of December 31, 2007. The actual amount of interest payments of the loans payable will differ from the amount included in this

schedule due to the loans variable interest rate structure. See the Financing and Financing Capacity section for additional information regarding our long-term borrowings.

(2) Purchase obligations represent payments required by us under material agreements to purchase goods or services that are enforceable and legally binding and where all significant terms are specified, including: quantities to be purchased, price provisions and the timing of the transaction. Other purchase orders made in the ordinary course of business for which we are not liable are excluded from the table above. Estimated pension plan contributions amounting to $5.0 million were included within the total

purchase obligations. However, this amount is an estimate which may be subject to change in view of the fact that contribution decisions are affected by various factors such as market performance, regulatory and legal requirements and plan funding policy.

(3) Claim liabilities represent the amount of our claims processed and incomplete as well as an estimate of the amount of incurred but not reported claims and loss-adjustment expenses. This amount does not include an estimate of claims to be incurred subsequent to December 31, 2007. The expected claims payments are an estimate and may not necessarily present the actual claims payments to be made by us.

Also, the estimated claims payments included in the table above do not include $54.8 million of reserves ceded under reinsurance contracts. Since reinsurance contracts do not relieve us from our obligations to policyholders, in the event that any of the reinsurance companies is unable to meet its obligations under the existing reinsurance agreements, we would be liable for such defaulted amounts.

Off-Balance Sheet Arrangements

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

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Restriction on Certain Payments by the Corporation s Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico. 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. Our managed care subsidiary is required to have minimum capital of $1.0 million, our life insurance subsidiary is required to have minimum capital of $2.5 million and our property and casualty insurance subsidiary is required to have minimum capital of $3.0 million. As of December 31, 2007, 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 our managed care subsidiary 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 (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2007, both we and our managed care subsidiary s estimated RBC ratio were above the 200% of our RBC required by the BCBSA and the 375% of our RBC level required by the BCBSA to avoid monitoring.

Other Contingencies

Legal Proceedings

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

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

Guarantee Associations

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared to be insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. During 2006 and 2005, we paid assessments in connection with insurance companies declared insolvent in the amount of $1.0 million each year. During the year ended December 31, 2007 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) and of the Sindicato de Aseguradores de Responsabilidad Profesional para

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Médicos. Both syndicates were organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the previously mentioned syndicates cannot meet their obligations. During 2007, 2006 and 2005, 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 2007, 2006 and 2005, the Association distributed a dividend based on the good experience of the business amounting to $1.0 million, $0.8 million and $0.9 million, respectively.

Critical Accounting Estimates

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

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

Claim Liabilities

Claim liabilities as of December 31, 2007 by segment were as follows:

(Dollar amounts in millions)	**Managed Care**	**Life Insurance**	**Property and Casualty Insurance**	**Consolidated**
Claims processed and incomplete [1]	$ 85.5	26.6	74.0	186.1
Unreported losses [2]	111.3	8.6	30.1	150.0
Unpaid loss-adjustment expenses [3]	4.8	0.3	12.6	17.7
	$201.6	35.5	116.7	353.8

(1) The liability for claims

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

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

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

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

We recognize claim liabilities as follows:

Managed Care Segment

At December 31, 2007, claim liabilities for the managed care segment amounted to $201.6 million and represented 57.0% of our total consolidated claim liabilities and 17.1% of our total consolidated liabilities.

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

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

Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns and claim submission patterns. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 77% of the claims are paid within three months after the last day of the month in which they were

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incurred and about 13% are within the next three months, for a total of 90% 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.

As described above, completion factors and trend factors can have a significant impact on determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2007 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

(Dollar amounts in millions)

Completion Factor [1] (Decrease) Increase		**Claims Trend Factor [2] (Decrease) Increase**	
In completion factor	**In unpaid claim liabilities**	**In claims trend factor**	**In unpaid claim liabilities**
(0.6)%	$ 8.7	(0.6)%	$ 6.3
(0.4)%	5.8	(0.4)%	4.2
(0.2)%	2.9	(0.2)%	2.0
0.2%	(2.9)	0.2%	(2.0)
0.4%	(5.8)	0.4%	(4.5)
0.6%	(8.6)	0.6%	(6.3)

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

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

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

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments, or run-out, becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred claims related to prior years result from claims being settled for amounts less than originally estimated. The reverse is true of reserve shortfalls. Medical claim liabilities are usually described as having a short tail , which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 95%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 5% related to claims incurred prior to the previous calendar year-end. In 2005, the managed care segment began offering Medicare Advantage products for the first time. There has been a rapid growth in this line of business from minimal enrollment in 2005 to approximately 49,000 members by the end of 2007. There have been some increases in both completion and trend factors because of the growth of this business. The effect should lessen with the maturity of this

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business. Management has not noted any significant emerging trends in claim frequency and severity, other than as described above, and the normal fluctuation in 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 8 to the audited consolidated financial statements). This table shows that the segments estimates of this liability have approximated the actual development.

(Dollar amounts in millions	**2006**	**2005**	**2004**
Years ended December 31,			
Total incurred claims:			
As reported [1]	$1,184.3	1,148.2	1,062.7
On a retrospective basis	1,160.7	1,137.5	1,070.4
Variance	$ 23.6	10.7	(7.7)
Variance to total incurred claims as reported	2.0%	0.9%	-0.7%

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

Management expects that substantially all of the development of the 2007 estimate of medical claims payable will be known during 2008 and that the variance of the total incurred claims on a retrospective basis when compared to reported incurred claims will be similar to the prior years.

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

Through the management of our cash flows and investment portfolio.

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

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

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

Life Insurance Segment

At December 31, 2007, claim liabilities for the life insurance segment amounted to $35.5 million and represented 10.0% of total consolidated claim liabilities and 3.0% of our total consolidated liabilities.

The claim liabilities related to the life insurance segment are based on methods and underlying assumptions in accordance with GAAP and applicable actuarial standards. The estimate of claim liabilities for this segment is based on the amount of benefits contractually determined and on actuarial estimates of the amount of loss inherent in that period s claims, including losses for which claims have not been reported. This estimate relies on actuarial

observations of ultimate loss experience for similar historical events. Principal assumptions used in the establishment of claim liabilities for this segment are mortality, morbidity and claim submission patterns, among others.

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

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

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

Property and Casualty Insurance Segment

At December 31, 2007, claim liabilities for the property and casualty insurance segment amounted to $116.7 million and represented 33.0% of the total consolidated claim liabilities and 9.9% 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.

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

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

At December 31, 2007, the actuarial reserve range determined by the actuaries was from $110.9 million to $125.3 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 $5.0 million and $3.9 million, respectively.

Liability for Future Policy Benefits

Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. We compute the amounts for actuarial liabilities in conformity with GAAP.

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Liabilities for future policy benefits for whole life and term insurance products are computed by the net level premium method, using interest assumptions ranging from 5.0% to 5.4% and withdrawal, mortality and morbidity assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.

The liabilities for all products, except for universal life and deferred annuities, are based upon a variety of actuarial assumptions that are uncertain. The most significant of these assumptions is the level of anticipated death and health claims. Other assumptions that are less significant to the appropriate level of the liability for future policy benefits are anticipated policy persistency rates, investment yields, and operating expense levels. These are reviewed frequently by our subsidiary s external actuaries, to assure that the current level of liabilities for future policy benefits is sufficient, in combination with anticipated future cash flows, to provide for all contractual obligations. For all products except for universal life and deferred annuities, according to Statement of Financial Accounting Standards (SFAS) No. 60, *Accounting and Reporting by Insurance Enterprises*, 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 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 according to FASB No. 60 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.

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Impairment of Investments

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

During the years ended December 31, 2007. 2006 and 2005 we recognized other-than-temporary impairments amounting to $1.1 million, $2.1 million and $1.0 million, respectively, on equity securities classified as available for sale. As of December 31, 2007, of the total amount of investments in securities of $1,005.5 million, $67.1 million, or 6.7%, are classified as trading securities, and thus are recorded at fair value with changes estimated fair value recognized in the statement of operations. The remaining $938.4 million is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $774.7 million, or 82.6%, 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 $163.7 million, or 17.4%, are from corporate fixed and equity securities and mutual funds. Gross unrealized losses as of December 31, 2007 of the available-for-sale and held-to-maturity portfolios amounted to $7.6 million.

The impairment analysis as of December 31, 2007 and 2006 indicated that, other than the equity security for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was other-than-temporarily impaired as of that date; however, several factors are beyond management s control, such as the following: financial condition of the issuer, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management s judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income. Taking into account the quality of the securities in the investment portfolio, the amount of unrealized losses within the available-for-sale and held-to-maturity portfolios, and past experience, management believes that, the amount of likely future impairments in the next year should not be material.

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

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2007 and 2006 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 $15.9 million and $18.2 million as of December 31, 2007 and 2006, 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

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and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

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

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

Other Significant Accounting Policies

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

Recently Issued Accounting Standards

Statement of Financial Accounting Standards (SFAS) No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities*, was issued in February 2007. This statement permits entities to choose to measure many financial instruments and certain other items at fair value that are not currently required to be measured at fair value. The objective of this statement is to improve financial reporting by providing entities with the opportunity to mitigate volatility in reported earnings caused by measuring related assets and liabilities differently without having to apply complex hedge accounting provisions. This statement also establishes presentation and disclosure requirements designed to facilitate comparisons between entities that choose different measurement attributes for similar types of assets and liabilities. This statement does not affect any existing accounting literature that requires certain assets and liabilities to be carried at fair value and does not establish requirements for recognizing and measuring dividend income, interest income, or interest expense. This statement does not eliminate disclosure requirements included in other accounting standards. This statement is effective as of the beginning of an entity s first fiscal year beginning after November 15, 2007. Early adoption is permitted as of the beginning of a fiscal year that begins on or before November 15, 2007, provided the entity also elects to apply the provisions SFAS No. 157, *Fair Value Measurements*. We are currently evaluating the effect of this statement on our consolidated financial statements.

In September 2006, the FASB issued FASB Statement No. 157, *Fair Value Measurement* (Statement 157). Statement 157 defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements. The Statement does not require any new fair value measures. The Statement is effective for fair value measures already required or permitted by other standards for fiscal years beginning after November 15, 2007. The Company is required to adopt Statement 157 beginning on January 1, 2008. Statement 157 is required to be applied prospectively, except for certain financial instruments. Any transition adjustment will be recognized as an adjustment to opening retained earnings in the year of adoption. In November 2007, the FASB proposed a one-year deferral of Statement 157 s fair-value measurement requirements for nonfinancial assets and liabilities that are not required or permitted to be measured at fair value on a recurring basis. The Company is currently evaluating the impact of adopting Statement 157 on its results of operations and financial position.

In December 2007, the FASB issued FASB Statement No. 141R, *Business Combinations* (Statement 141R) and FASB Statement No. 160, *Noncontrolling Interests in Consolidated Financial Statements an amendment to ARB No. 51* (Statement 160). Statements 141R and 160 require most identifiable assets, liabilities, noncontrolling interests, and goodwill acquired in a business combination to be recorded at full fair value and require noncontrolling interests (previously referred to as minority interests) to be reported as a component of equity, which changes the accounting for transactions with noncontrolling interest holders. Both Statements are effective for periods beginning on or after December 15, 2008, and earlier adoption is prohibited. Statement 141R will be applied to business combinations occurring after the effective date. Statement 160 will be applied prospectively to all noncontrolling interests, including any

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that arose before the effective date. The Company currently does not expect the adoption of Statement 141R and Statement 160 to have an impact on its results of operations and financial position.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

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

Market Risk Exposure

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

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

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

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

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

Our investment portfolio is predominantly comprised of obligations of U.S. government-sponsored enterprises, U.S. Treasury securities, obligations of state and political subdivisions, obligations of the Commonwealth of Puerto Rico, municipal securities and obligations of U.S. states and its political subdivisions and obligations from U.S. and Puerto Rican government instrumentalities. These investments comprised approximately 82.6% of the total portfolio value as of December 31, 2007, of which 9.8% consisted of U. S. agency-backed mortgage backed securities and collateralized mortgage obligations. The remaining balance of the investment portfolio consists of an equity securities portfolio that seeks to replicate the S&P 500 Index, a large-cap growth index, a large-cap value index, mutual funds, investments in local stocks from well-known financial institutions and investments in corporate bonds.

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

- the market risk information is limited by the assumptions and parameters established in creating the related sensitivity analysis, including the impact of prepayment rates on mortgages; and

- the model assumes that the composition of assets and liabilities remains unchanged throughout the year.

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

Interest Rate Risk

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

Equity Price Risk

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

Risk Measurement

Trading Portfolio

Our trading securities are a source of market risk. As of December 31, 2007, our trading portfolio was comprised of investments in publicly-traded common stocks. The securities in the trading portfolio are believed by management to be high quality and are diversified across industries and readily marketable. Trading securities are recorded at fair value, and changes in fair value are included in operations. The fair value of the investments in trading securities is exposed to equity price risk. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2007 and 2006, the hypothetical loss in the fair value of these investments would have been approximately $6.7 million and $8.3 million, respectively.

Other than Trading Portfolio

Our available-for-sale and held-to-maturity securities are also a source of market risk. As of December 31, 2007 approximately 92.1% and 100.0% of our investments in available-for-sale and held-to-maturity securities, respectively, consisted of fixed income securities. The remaining balance of the available-for-sale portfolio is comprised of equity securities. Available-for-sale securities are recorded at fair value and changes in the fair value of these securities, net of the related tax effect, are excluded from operations and are reported as a separate component of other comprehensive income (loss) until realized. Held-to-maturity securities are recorded at amortized cost and adjusted for the amortization or accretion of premiums or discounts. The fair value of the investments in the other-than-trading portfolio is exposed to both interest rate risk and equity price risk.

Interest Rate Risk

We have evaluated the net impact to the fair value of our fixed income investments of a significant one-time change in interest rate risk using a combination of both statistical and fundamental methodologies. From these shocked values a resultant market price appreciation/depreciation can be determined after portfolio cash flows are modeled and evaluated over instantaneous 100, 200 and 300 basis point rate shifts. Techniques used in the evaluation of cash flows include Monte Carlo simulation through a series of probability distributions over 200 interest rate paths. Necessary prepayment speeds are compiled using Salomon Brothers Yield Book, which sources numerous factors in deriving speeds, including but not limited to: historical speeds, economic indicators, street consensus speeds, etc. Securities evaluated by us under these scenarios include mortgage pass-through certificates and collateralized mortgage obligations of U.S. agencies, and private label structures, provided that cash flows information is available. The following table sets forth the result of this analysis for the years ended December 31, 2007 and 2006.

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(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2007:			
Base Scenario	$867.5		
+100 bp	819.3	(48.2)	(5.6)%
+200 bp	777.3	(90.2)	(10.4)%
+300 bp	732.6	(134.9)	(15.6)%
December 31, 2006:			
Base Scenario	$749.7		
+100 bp	716.6	(33.1)	(4.4)%
+200 bp	685.8	(63.9)	(8.5)%
+300 bp	657.1	(92.6)	(12.4)%

We believe that an interest rate shift in a 12-month period of 100 basis points represents a moderately adverse outcome, while a 200 basis point shift is significantly adverse and a 300 basis point shift is unlikely given historical precedents. Although we classify 95.0% of our fixed income securities as available-for-sale, our cash flows and the intermediate duration of our investment portfolio should allow us to hold securities until maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Equity Price Risk

Our equity securities in the available-for-sale portfolio are comprised primarily of stock of several Puerto Rican financial institutions and mutual funds. Assuming an immediate decrease of 10% in the market value of these securities as of December 31, 2007 and 2006, the hypothetical loss in the fair value of these investments would have been approximately $7.1 million and $6.2 million, respectively.

Other Risk Measurement

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

We have an interest-rate related derivative instrument to manage the variability caused by interest rate changes in the cash flows of its secured term loan. This swap changes the variable-rate cash flow exposure on the debt obligations to fixed-rate cash flows. Shifting interest rates have an effect on the fair value of the interest rate swap agreement. We assess interest rate risk by monitoring changes in interest rate exposures that may adversely impact the fair value of the interest rate swap agreement. We monitor interest rate risk attributable to both our outstanding or forecasted debt obligations as well as our offsetting hedge position. As of December 31, 2007 and 2006, the estimated fair value of the interest rate swap amounted to $0.1 million and $0.5 million, respectively, and was included within other assets in the consolidated balance sheets. Assuming an immediate decrease of 10% in period-end rates as of December 31, 2007 and 2006, the hypothetical loss in the estimated fair value of the interest rate swap is estimated to approximate $9.3

thousand and $0.1 million, respectively.

We have invested in other derivative instruments with a market value of approximately $14.6 million and $14.0 million as of December 31, 2007 and 2006 in order to diversify our investment in securities and participate in foreign stock markets.

In 2005, we invested in two structured note agreements amounting to $5.0 million each, under which the interest income received is linked to the performance of the Dow Jones Euro STOXX 50 and Nikkei 225 Equity Indices (the Indices). Under these agreements the principal invested by us is protected, the only

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amount that varies according to the performance of the Indices is the interest to be received upon the maturity of the instruments. Should the Indices experience a negative performance during the holding period of the structured notes, no interest will be received and no amount will be paid to the issuer of the structured notes. The contingent interest payment component within the structured note agreements meets the definition of an embedded derivative. In accordance with the provisions of SFAS No. 133, *Accounting for Derivative Instruments and Certain Hedging Activities*, as amended, the embedded derivative component of the structured note is separated from the structured notes and accounted for separately as a derivative instrument. The derivative component of the structured notes exposes us to credit risk and market risk. We minimize credit risk by entering into transactions with counterparties that we believe to be high-quality based on their credit ratings. The market risk is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken. As of December 31, 2007 and 2006, the fair value of the derivative component of the structured notes amounted to $6.3 million and $6.4 million, respectively, and is included within other assets in the consolidated balance sheets. Assuming an immediate decrease of 10% in the period-end Indices as of December 31, 2007 and 2006, the hypothetical loss in the estimated fair value of the derivative component of the structured notes would have been approximately $0.6 million each year. The investment component of the structured notes, which had a fair value of $8.3 million and $7.6 million as of December 31, 2007 and 2006, respectively, is accounted for as a held-to-maturity debt security and is included within investment in securities in the consolidated balance sheet and its risk measurement is evaluated along the other investments in Other Than Trading Portfolio above.

Item 8. Financial Statements and Supplementary Data.

Financial Statements

For our audited consolidated financial statements as of December 31, 2007 and 2006 and for the three years ended December 31, 2007 see Index to financial statements in Item 15 Exhibits and Financial Statement Schedules to this Annual Report on Form 10-K.

Selected Quarterly Financial Data

For the selected unaudited quarterly financial data corresponding to the years 2007 and 2006, see note 27 of the audited consolidated financial statements as of December 31, 2007, 2006 and 2005.

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

None.

Item 9A. Controls and Procedures.

Management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act.

Our management is also responsible for establishing and maintaining effective internal controls over financial reporting as such term is defined in Exchange Act Rule 13a-15(f) (internal controls). The Company s internal control is designed to provide reasonable assurance regarding the reliability of our financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

Because of its inherent limitations internal controls over financial reporting may not prevent or detect misstatements. Accordingly, even effective internal controls can provide only reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP.

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Management, under the supervision and with the participation of our chief executive officer and chief financial officer, assessed the effectiveness of the Company s internal controls as of December 31, 2007. Management s assessment was based on criteria established in Internal Control Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Based on this assessment, management has concluded that the Company s internal controls were effective as of December 31, 2007 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with GAAP.

This Annual Report on Form 10-K does not include a report by the Corporation s registered public accounting firm on the effectiveness of internal control over financial reporting pursuant to temporary rules of the SEC that permit the Corporation to provide only management s report in its Annual Report.

Item 9B. Other Information.

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance.

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

The remaining information required by this item is incorporated by reference to the sections Nominees for Election , Executive Officers , Section 16(a) Beneficial Ownership Reporting Compliance , Standing Committees Nominations Committee , Standing Committees Audit Committee , and Standing Committees Audit Committee Financial Experts included in the Corporation s definitive Proxy Statement.

Item 11. Executive Compensation.

The information required by this item is incorporated by reference to the sections Compensation Discussion and Analysis and Standing Committees Compensation Committee Interlocks and Insider Participation included in the Corporation s definitive Proxy Statement.

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

The information required by this item is incorporated by reference to the sections Principal Shareholders , Stock Ownership of Directors and Executive Officers and Compensation Discussion and Analysis included in the Corporation s definitive Proxy Statement.

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

The information required by this item is incorporated by reference to the section Other Relationships, Transactions and Events and Board of Directors Independence included in the Corporation s definitive Proxy Statement.

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Item 14. Principal Accountant Fees and Services

The information required by this item is incorporated by reference to the section Disclosure of Auditor s Fees included in the Corporation s definitive Proxy Statement.

Item 15. Exhibits and Financial Statements Schedules.

Financial Statements and Schedules

Financial Statements	*Description*
F-1	Report of Independent Registered Public Accounting Firm
F-2	Consolidated Balance Sheets as of December 31, 2007 and 2006
F-3	Consolidated Statements of Earnings for the years ended December 31, 2007, 2006 and 2005
F-4	Consolidated Statements of Stockholders Equity and Comprehensive Income for the years ended December 31, 2007, 2006 and 2005
F-5	Consolidated Statements of Cash Flows for the years ended December 31, 2007, 2006 and 2005
F-7	Notes to Consolidated Financial Statements December 31, 2007, 2006 and 2005

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

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

Exhibits

Exhibits	*Description*
3(i)(a)	Amended and Restated Articles of Incorporation of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3(i) to TSM s Annual Report on Form 10-K for the Year Ended December 31, 2006 (File No. 0-49762) and to Exhibit 3(i) to TSM s Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2007 (File No. 0-49762)).
3(i)(b)*	Amendment to Article Tenth A of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation.
3(i)(c)*	Amendment to Article Fifth of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation.
3(i)(d)*	Articles of Incorporation of Triple-S Management Corporation, as currently in effect.
3(ii)	Amended and Restated Bylaws (incorporated herein by reference to Exhibit 3.1 to TSM s Current Report on Form 8-K filed on October 23, 2007 (File No. 0-49762)).

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Exhibits	*Description*
10.1	Puerto Rico Health Insurance Contract for the North and South-West Regions (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the Quarter Ended June 30, 2007 (File No. 0-49762)).
10.2	Amendment to agreement between Puerto Rico Health Insurance Administration and Triple-S, Inc. for the provision of health insurance coverage to eligible population in the North and South-West regions (incorporated herein by reference to Exhibit 10.1 of TSM s Quarterly Report on Form 10-Q for the Quarter Ended September 30, 2007 (File No. 0-49762)).
10.3	Federal Employees Health Benefits Contract (incorporated herein by reference to Exhibit 10.5 to TSM s General Form of Registration of Securities on Form 10 (File No. 0-49762)).
10.4	Credit Agreement with FirstBank Puerto Rico in the amount of $41,000,000 (incorporated herein by reference to Exhibit 10.6 to TSM s General Form of Registration of Securities on Form 10 (File No. 0-49762)).
10.5	Credit Agreement with FirstBank Puerto Rico in the amount of $20,000,000 (incorporated herein by reference to Exhibit 10.7 to TSM s General Form of Registration of Securities on Form 10 (File No. 0-49762)).
10.6	Non-Contributory Retirement Program (incorporated herein by reference to Exhibit 10.8 to TSM s General Form of Registration of Securities on Form 10 (File No. 0-49762)).
10.7	BCBSA Licensure Documents (incorporated herein by reference to Exhibit 10.10 to TSM s General Form of Registration of Securities on Form 10 (File No. 0-49762)).
10.8	Blue Shield License and other Agreements with Blue Cross Blue Shield Association (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2007 (File No. 0-49762).
10.9	Stock Purchase Agreement by and between Triple-S Management Corporation and Great American Financial Resources, Inc. dated December 15, 2005 (incorporated herein by reference to Exhibit 10.9 to TSM s Registration Statement on Form S-1 filed on November 16, 2007 (File No. 0-49762)).
10.10	Reinsurance Agreement between Great American Life Assurance Company of Puerto Rico and Seguros de Vida Triple-S, Inc. dated December 15, 2005 (incorporated herein by reference to Exhibit 10.14 to TSM s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 0-49762)).
10.11	6.30% Senior Unsecured Notes Due September 2019 Note Purchase Agreement, dated September 30, 2004, between Triple-S Management Corporation, Triple-S, Inc. and various institutional accredited investors (incorporated herein by reference to Exhibit 10.15 to TSM s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 0-49762)).

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Exhibits	*Description*
10.12	6.60% Senior Unsecured Notes Due December 2020 Note Purchase Agreement, dated December 15, 2005, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.16 to TSM s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 0-49762)).
10.13	6.70% Senior Unsecured Notes Due December 2021 Note Purchase Agreement, dated January 23, 2006, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.1 to TSM s Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2006 (File No. 0-49762)).
10.14	Triple-S Management Corporation 2007 Incentive Plan, dated October 16, 2007 (incorporated herein by reference to Exhibit C to TSM s 2007 Proxy Statement (File No. 0-49762)).
10.15*	Software License and Maintenance Agreement between Quality Care Solutions, Inc, and Triple-S, Inc. dated August 16, 2007.
10.15(a)*	Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc. and Triple-S, Inc.
10.15(b)*	Addendum Number Two to the Software License and Maintenance Agreement between Quality Care Solutions, Inc. and Triple-S, Inc.
10.15(c)*	Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc. and Triple-S, Inc.
10.16*	Work order Agreement between Quality Care Solutions, Inc. and Triple-S, Inc.
11.1	Statement re computation of per share earnings; an exhibit describing the computation of the earnings per share has been omitted as the detail necessary to determine the computation of earnings per share can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K.
12.1	Statement re computation of ratios; an exhibit describing the computation of the loss ratio, expense ratio and combined ratio has been omitted as the detail necessary to determine the computation of the loss ratio, operating expense ratio and combined ratio can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K.
21.1	List of Subsidiaries of Triple-S Management Corporation (incorporated herein by reference to Exhibit 21 to TSM s General Form of Registration of Securities on Form 10 (File No. 0-49762)).
31.1*	Certification of the President and Chief Executive Officer required by Rule 13a-14(a)/15d-14(a).
31.2*	Certification of the Vice President of Finance and Chief Financial Officer required by Rule 13a-14(a)/15d-14(a).
32.1*	Certification of the President and Chief Executive Officer required pursuant to 18 U.S. Section 1350.

32.2* Certification of the Vice President of Finance and Chief Financial Officer required pursuant to 18 U.S. Section 1350.

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

* Filed herein.

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SIGNATURES

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

Triple-S Management Corporation
Registrant

By: /s/ Ramón M. Ruiz-Comas — Date: March 11, 2008
Ramón M. Ruiz-Comas
President and Chief Executive Officer

By: /s/ Juan J. Román — Date: March 11, 2008
Juan J. Román
Vice President of Finance and Chief Financial Officer

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

By: /s/ Wilmer Rodríguez-Silva — Date: March 11, 2008
Wilmer Rodríguez-Silva, MD
Director and Chairman of the Board

By: /s/ Vicente J. León-Irizarry — Date: March 11, 2008
Vicente J. León-Irizarry, CPA
Director and Vice-Chairman of the Board

By: /s/ Luis A. Clavell-Rodríguez — Date: March 11, 2008
Luis A. Clavell-Rodríguez, MD
Director and Secretary of the Board

By: /s/ Jesús R. Sánchez-Colón — Date: March 11, 2008
Jesús R. Sánchez-Colón, DMD
Director and Assistant Secretary of the Board

By: /s/ Adamina Soto-Martínez — Date: March 11, 2008
Adamina Soto-Martínez, CPA
Director and Treasurer of the Board

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By: /s/ Carmen Ana Culpeper-Ramírez
Ms. Carmen Ana Culpeper-Ramírez
Director and Assistant Treasurer of the Board

Date: March 11, 2008

By: /s/ Valeriano Alicea-Cruz
Valeriano Alicea-Cruz, MD
Director

Date: March 11, 2008

By: /s/ José Arturo Álvarez-Gallardo
Mr. José Arturo Álvarez-Gallardo
Director

Date: March 11, 2008

By: /s/ Arturo R. Córdova-López
Arturo R. Córdova-López, MD
Director

Date: March 11, 2008

By: /s/ Porfirio E. Díaz-Torres
Porfirio E. Díaz-Torres, MD
Director

Date: March 11, 2008

By: /s/ Antonio F. Faría-Soto
Mr. Antonio F. Faría-Soto
Director

Date: March 11, 2008

By: /s/ Manuel Figueroa-Collazo
Manuel Figueroa-Collazo, PE, Ph.D.
Director

Date: March 11, 2008

By: /s/ José Hawayek-Alemañy
José Hawayek-Alemañy, MD
Director

Date: March 11, 2008

By: /s/ Wilfredo López-Hernández
Wilfredo López-Hernández, MD
Director

Date: March 11, 2008

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By: /s/ Jaime Morgan-Stubbe
Jaime Morgan-Stubbe, Esq.
Director

Date: March 11, 2008

By: /s/ Roberto Muñoz-Zayas
Roberto Muñoz-Zayas, MD
Director

Date: March 11, 2008

By: /s/ Miguel A. Nazario-Franco
Mr. Miguel A. Nazario-Franco
Director

Date: March 11, 2008

By: /s/ Juan E. Rodríguez-Díaz
Juan E. Rodríguez-Díaz, Esq.
Director

Date: March 11, 2008

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES

Consolidated Financial Statements

December 31, 2007, 2006, and 2005

(With Independent Auditors Report Thereon)

TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Triple-S Management Corporation:

We have audited the accompanying consolidated balance sheets of Triple-S Management Corporation and Subsidiaries (the Company) as of December 31, 2007 and 2006, and the related consolidated statements of earnings, stockholders equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2007. These consolidated financial statements are the responsibility of the Company s management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, as well evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Triple-S Management Corporation and Subsidiaries at December 31, 2007 and 2006, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2007, in conformity with U.S. generally accepted accounting principles.

As discussed in note 15 to the consolidated financial statements, the Company adopted the recognition and disclosure provisions of Statement of Financial Accounting Standards No. 158, *Employers Accounting for Defined Benefit Pension and Other Postretirement Plans*, as of December 31, 2006.

/s/ KPMG LLP
March 7, 2008

Stamp No. 2222076 of the Puerto Rico
Society of Certified Public Accountants
was affixed to the record copy of this report.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Balance Sheets
December 31, 2007, and 2006
(Dollar amounts in thousands, except per share data)

	2007	2006
Assets		
Investments and cash:		
Equity securities held for trading, at fair value (cost of $54,757 in 2007 and $66,930 in 2006)	$ 67,158	83,447
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $816,536 in 2007 and $714,113 in 2006)	823,629	702,566
Equity securities (cost of $66,747 in 2007 and $50,132 in 2006)	71,050	61,686
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $43,849 in 2007 and $46,881 in 2006)	43,691	47,989
Policy loans	5,481	5,194
Cash and cash equivalents	240,153	81,564
Total investments and cash	1,251,162	982,446
Premium and other receivables, net	202,268	165,626
Deferred policy acquisition costs and value of business acquired	117,239	111,417
Property and equipment, net	43,415	41,615
Net deferred tax asset	6,783	9,292
Other assets	38,675	35,113
Total assets	$ 1,659,542	1,345,509
Liabilities and Stockholders Equity		
Claim liabilities:		
Claims processed and incomplete	$ 186,065	147,211
Unreported losses	149,996	150,735
Unpaid loss-adjustment expenses	17,769	16,736
Total claim liabilities	353,830	314,682
Liability for future policy benefits	194,131	180,420
Unearned premiums	132,599	113,582
Policyholder deposits	45,959	45,425
Liability to Federal Employees Health Benefits Program	21,338	13,563
Accounts payable and accrued liabilities	228,980	110,609
Borrowings	170,946	183,087
Income tax payable		9,242
Liability for pension benefits	29,221	32,300
Total liabilities	1,177,004	1,002,910

Stockholders equity:		
Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 16,042,809 and 26,733,000 at December 31, 2007 and 2006, respectively	16,043	26,733
Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 16,266,554 shares at December 31, 2007	16,266	
Additional paid-in capital	188,935	124,031
Retained earnings	267,336	211,266
Accumulated other comprehensive loss, net	(6,042)	(19,431)
	482,538	342,599
Commitments and contingencies		
Total liabilities and stockholders equity	$ 1,659,542	1,345,509

See accompanying notes to consolidated financial statements.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Earnings
Years ended December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

	2007	2006	2005
Revenues:			
Premiums earned, net	$ 1,483,548	1,511,626	1,380,204
Administrative service fees	14,018	14,089	14,445
Net investment income	47,194	42,657	29,138
Total operating revenues	1,544,760	1,568,372	1,423,787
Net realized investment gains	5,931	837	7,161
Net unrealized investment gain (loss) on trading securities	(4,116)	7,699	(4,709)
Other income, net	3,217	2,323	3,732
Total revenues	1,549,792	1,579,231	1,429,971
Benefits and expenses:			
Claims incurred	1,223,775	1,258,981	1,208,367
Operating expenses	237,533	236,065	181,703
Total operating costs	1,461,308	1,495,046	1,390,070
Interest expense	15,839	16,626	7,595
Total benefits and expenses	1,477,147	1,511,672	1,397,665
Income before taxes	72,645	67,559	32,306
Income tax expense (benefit):			
Current	15,906	15,407	4,033
Deferred	(1,779)	(2,381)	(160)
Total income taxes	14,127	13,026	3,873
Net income	$ 58,518	54,533	28,433
Basic net income per share	$ 2.15	2.04	1.06

Diluted net income per share	$	2.15	2.04	1.06

See accompanying notes to consolidated financial statements.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES

Consolidated Statements of Stockholders Equity
and Comprehensive Income
Years ended December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

	Class A common stock	Class B common stock	Additional paid-in capital	Retained earnings	Accumulated other comprehensive income (loss)	Total stockholders equity
Balance, December 31, 2004	$ 26,712		124,052	134,531	16,138	301,433
Comprehensive income:						
Net income				28,433		28,433
Net unrealized change in fair value of available for sale securities					(18,832)	(18,832)
Net change in minimum pension liability					(2,788)	(2,788)
Net change in fair value of cash- flow hedges					457	457
Total comprehensive income						7,270
Balance, December 31, 2005	26,712		124,052	162,964	(5,025)	308,703
Dividends declared				(6,231)		(6,231)
Adjustment to initially apply SFAS No. 158, net of tax					(16,081)	(16,081)
Other	21		(21)			
Comprehensive income:						
Net income				54,533		54,533
Net unrealized change in fair value of available for sale securities					(3,212)	(3,212)
Net change in minimum pension liability					4,952	4,952
Net change in fair value of cash- flow hedges					(65)	(65)
Total comprehensive income						56,208
Balance, December 31, 2006	26,733		124,031	211,266	(19,431)	342,599

Dividends declared				(2,448)		(2,448)
Sale of stock in public offering	(10,813)	16,100	64,992			70,279
Grant of restricted Class B common stock		166				166
Share-based compensation			34			34
Other	123		(122)			1
Comprehensive income:						
Net income				58,518		58,518
Net unrealized change in fair value of available for sale securities					9,549	9,549
Defined benefit pension plan:						
Prior service cost, net					3,935	3,935
Actuarial loss					155	155
Net change in fair value of cash- flow hedges					(250)	(250)
Total comprehensive income						71,907
Balance, December 31, 2007	$ 16,043	16,266	188,935	267,336	(6,042)	482,538

See accompanying notes to consolidated financial statements.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES

Consolidated Statements of Cash Flows

Years ended December 31, 2007, 2006, and 2005

(Dollar amounts in thousands, except per share data)

	2007	2006	2005
Cash flows from operating activities:			
Net income	$ 58,518	54,533	28,433
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	7,562	6,443	5,230
Net amortization (accretions) of investments	354	511	(153)
Provision for doubtful receivables	(2,305)	5,125	1,067
Deferred tax benefit	(1,779)	(2,381)	(160)
Net gain on sale of securities	(5,931)	(837)	(7,161)
Net unrealized (gain) loss on trading securities	4,116	(7,699)	4,709
Share-based compensation	200		
Proceeds from trading securities sold or matured:			
Fixed maturities sold			102,667
Equity securities	43,614	27,919	36,156
Acquisition of securities in trading portfolio:			
Fixed maturities			(30,502)
Equity securities	(23,921)	(22,409)	(25,785)
Gain (loss) on sale of property and equipment	28	22	(1)
(Increase) decrease in assets:			
Premiums receivable	(8,458)	(27,951)	(8,805)
Agent balances	(4,061)	395	(3,183)
Accrued interest receivable	(309)	588	(17)
Other receivables	(3,637)	(4,521)	5,099
Funds withheld reinsurance receivable		118,635	(118,635)
Reinsurance recoverable on paid losses	(17,872)	(6,147)	(3,419)
Deferred policy acquisition costs and value of business acquired	(5,822)	(7,026)	(62,856)
Other assets	(3,179)	(4,031)	(14,423)
Increase (decrease) in liabilities:			
Claims processed and incomplete	38,854	2,803	2,412
Unreported losses	(739)	3,342	15,900
Loss-adjustment expenses	1,033	1,791	(74)
Liability for future policy benefits	13,711	14,022	
Liability for future policy benefits related to funds withheld reinsurance		(118,635)	118,635
Unearned premiums	19,017	15,579	11,120
Policyholder deposits	1,800	1,810	1,231
Liability to FEHBP	7,775	9,207	(5,435)
Accounts payable and accrued liabilities	7,359	1,903	588
Income tax payable	(10,034)	12,595	(1,827)
Net cash provided by operating activities	$ 115,894	75,586	50,811

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Consolidated Statements of Cash Flows
Years ended December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

	2007	2006	2005
Cash flows from investing activities:			
Proceeds from investments sold or matured:			
Securities available for sale:			
Fixed maturities sold	$ 299,561	51,519	13,099
Fixed maturities matured	41,248	32,826	22,822
Equity securities	1,000	1,209	3,488
Securities held to maturity:			
Fixed maturities matured	13,246	492	1,816
Acquisition of investments:			
Securities available for sale:			
Fixed maturities	(327,409)	(81,496)	(118,758)
Equity securities	(18,379)	(11,620)	(6,876)
Securities held to maturity:			
Fixed maturities	(8,244)	(2,197)	(10,252)
Acquisition of business, net of $10,403 of cash acquired		(27,793)	
Net disbursements for policy loans	(287)	(415)	
Capital expenditures	(9,390)	(11,871)	(7,574)
Net cash used in investing activities	(8,654)	(49,346)	(102,235)
Cash flows from financing activities:			
Net proceeds from initial public offering	70,279		
Change in outstanding checks in excess of bank balances	(3,076)	(8,224)	3,914
Repayments of short-term borrowings	(54,519)	(119,547)	(174,035)
Proceeds from short-term borrowings	54,519	117,807	174,075
Repayments of long-term borrowings	(12,141)	(2,503)	(5,140)
Proceeds from long-term borrowings		35,000	60,000
Dividends	(2,448)	(6,231)	
Proceeds from annuity contracts	6,150	6,008	11,510
Surrenders of annuity contracts	(7,416)	(16,036)	(5,074)
Other	1		
Net cash provided by financing activities	51,349	6,274	65,250
Net increase in cash and cash equivalents	158,589	32,514	13,826
Cash and cash equivalents, beginning of year	81,564	49,050	35,224

Cash and cash equivalents, end of year	$ 240,153	81,564	49,050

See accompanying notes to consolidated financial statements.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Notes to Consolidated Financial Statements
December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

(1) Nature of Business

Triple-S Management Corporation (the Company or TSM) was incorporated under the laws of the Commonwealth of Puerto Rico on January 17, 1997 to engage, among other things, as the holding company of entities primarily involved in the insurance industry.

The Company has the following wholly owned subsidiaries that are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance): (1) Triple-S, Inc. (TSI) a managed care organization that provides health benefits services to subscribers through contracts with hospitals, physicians, dentists, laboratories, and other organizations located mainly in Puerto Rico; (2) Triple-S Vida, Inc. (TSV), which is engaged in the underwriting of life and accident and health insurance policies and the administration of annuity contracts; and (3) Seguros Triple-S, Inc. (STS), which is engaged in the underwriting of property and casualty insurance policies. The Company and TSI are members of the Blue Cross and Blue Shield Association (BCBSA).

Effective January 31, 2006, the Company completed the acquisition of 100% of the common stock of Great American Life Assurance Company of Puerto Rico (GA Life) (now Triple-S Vida, Inc.) and, effective June 30, 2006, the Company merged the operations of its former life and accident and health insurance subsidiary, Seguros de Vida Triple-S, Inc. (SVTS), into GA Life. The results of operations and financial position of GA Life are included in the Company s consolidated financial statements for the period following January 31, 2006. Prior to completing the acquisition of GA Life, the operations of SVTS were the sole component of the Company s life insurance segment. Effective November 1, 2007, GA Life changed its name to Triple-S Vida, Inc., after receiving required regulatory approvals.

The Company also has two other wholly owned subsidiaries, Interactive Systems, Inc. (ISI) and Triple-C, Inc. (TC). ISI is mainly engaged in providing data processing services to the Company and its subsidiaries. TC is mainly engaged as a third-party administrator for TSI in the administration of the Commonwealth of Puerto Rico Health Care Reform s (the Reform) business. Also, TC provides healthcare advisory services to TSI and other health insurance-related services to the health insurance industry.

A substantial majority of the Company s business activity is with insurers located throughout Puerto Rico, and as such, the Company is subject to the risks associated with the Puerto Rico economy.

(2) Significant Accounting Policies

The following are the significant accounting policies followed by the Company and its subsidiaries:

(a) Basis of Presentation

The accompanying consolidated financial statements have been prepared in conformity with U.S. generally accepted accounting principles (GAAP).

The consolidated financial statements include the financial statements of the Company and its subsidiaries. All significant intercompany balances and transactions have been eliminated in consolidation.

(b) Use of Estimates

The preparation of the consolidated financial statements in conformity with GAAP requires the Company to make a number of estimates and assumptions relating to the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates. The most significant items on the consolidated balance sheets that involve a greater degree of accounting

(Continued)

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Notes to Consolidated Financial Statements
December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

estimates and actuarial determinations subject to changes in the near future are the allowance for doubtful receivables, deferred policy acquisition costs and value of business acquired, claim liabilities, the liability for future policy benefits, and liability for pension benefits . As additional information becomes available (or actual amounts are determinable), the recorded estimates will be revised and reflected in operating results. Although some variability is inherent in these estimates, the Company believes the amounts provided are adequate.

(c) Reclassifications

Certain amounts in the 2006 and 2005 consolidated financial statements were reclassified to conform to the 2007 presentation.

(d) Cash Equivalents

The Company considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents. Cash equivalents of $192,534 and $37,271 at December 31, 2007 and 2006, respectively, consist principally of obligations of government-sponsored enterprises and certificates of deposit with an initial term of less than three months.

(e) Investments

Investment in securities at December 31, 2007 and 2006 consists mainly of obligations of government-sponsored enterprises, U.S. Treasury securities and obligations of U.S. government instrumentalities, obligations of the Commonwealth of Puerto Rico and its instrumentalities, municipal securities, obligations of states of the United States and political subdivisions of the states, corporate bonds, mortgage-backed securities, collateralized mortgage obligations, and equity securities. The Company classifies its debt and equity securities in one of three categories: trading, available for sale, or held to maturity. Trading securities are bought and held principally for the purpose of selling them in the near term. Securities classified as held to maturity are those securities in which the Company has the ability and intent to hold the security until maturity. All other securities not included in trading or held to maturity are classified as available for sale.

Trading and available-for-sale securities are recorded at fair value. The fair values of debt securities (both available for sale and held to maturity investments) and equity securities are based on quoted market prices at the reporting date for those or similar investments. Held-to-maturity debt securities are recorded at amortized cost, adjusted for the amortization or accretion of premiums and discounts. Unrealized holding gains and losses on trading securities are included in operations. Unrealized holding gains and losses, net of the related tax effect, on available-for-sale securities are excluded from earnings and are reported as a separate component of other comprehensive income until realized. Realized gains and losses from the sale of available-for-sale securities are included in earnings and are determined on a specific-identification basis.

Transfers of securities between categories are recorded at fair value at the date of transfer. Unrealized holding gains and losses are recognized in operations for transfers into trading securities. Unrealized holding gains or losses associated with transfers of securities from held to maturity to available for sale are recorded as a separate component of other comprehensive income. The unrealized holding gains or losses included in

the separate component of other comprehensive income for securities transferred from available for sale to held to maturity, are maintained and amortized into earnings over the remaining life of the security as an adjustment to yield in a manner consistent with the amortization or accretion of premium or discount on the associated security.

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TRIPLE-S MANAGEMENT CORPORATION AND SUBSIDIARIES
Notes to Consolidated Financial Statements
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A decline in the fair value of any available-for-sale or held-to-maturity security below cost that is deemed to be other than temporary results in an impairment to reduce the carrying amount to fair value. The impairment is charged to earnings and a new cost basis for the security is established. To determine whether an impairment is other than temporary, the Company considers whether it has the ability and intent to hold the investment until a market price recovery and considers whether evidence indicating the cost of the investment is recoverable outweighs evidence to the contrary. Evidence considered in this assessment includes the reasons for the impairment, the severity and duration of the impairment, market conditions, changes in value subsequent to year-end, forecasted performance of the investee, and the general market condition in the geographic area or industry the investee operates in.

Premiums and discounts are amortized or accreted over the life of the related held-to-maturity or available-for-sale security as an adjustment to yield using the effective interest method. Dividend and interest income are recognized when earned.

The Company regularly invests in mortgaged-backed securities and other securities subject to prepayment and call risk. Significant changes in prevailing interest rates may adversely affect the timing and amount of cash flows on such securities. In addition, the amortization of market premium and accretion of market discount for mortgaged-backed securities is based on historical experience and estimates of future payment speeds on the underlying mortgage loans. Actual prepayment speeds will differ from original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

(f) Revenue Recognition

(i) Managed Care

Subscriber premiums on the managed care business are billed in advance of their respective coverage period and the related revenue is recorded as earned during the coverage period. Managed care premiums are billed in the month prior to the effective date of the policy with a grace period of up to two months. If the insured fails to pay, the policy can be canceled at the end of the grace period at the option of the Company. Managed care premiums are reported as earned when due.

Premiums for the Medicare Advantage (MA) business are based on a bid contract with the Centers for Medicare and Medicaid Services (CMS) and billed in advance of the coverage period. MA contracts provide for a risk factor to adjust premiums paid for members that represent a higher or lower risk to the Company. Retroactive rate adjustments are made periodically based on the aggregate health status and risk scores of the Company s MA membership. These risk adjustments are evaluated quarterly based on actuarial estimates. Actual results could differ from these estimates. As additional information becomes available, the recorded estimate will be revised and reflected in operating results.

The Company offers prescription drug coverage to Medicare eligible beneficiaries as part of its MA plans (MA-PD) and on a stand-alone basis (stand-alone PDP). Premiums are based on a bid contract with CMS that considers the estimated costs of providing prescription drug benefits to enrolled participants. MA-PD and stand-alone PDP premiums are subject to adjustment, positive or negative, based upon the application of risk corridors that compare the estimated prescription drug costs included in the bids to CMS to actual prescription drug costs. Variances exceeding certain thresholds may result in CMS making additional payments to the Company or in the Company refunding CMS a portion of

the premiums collected. The Company estimates and records adjustments to earned premiums related to estimated risk corridor payments based upon actual prescription drug costs for each reporting period as if the annual contract were to end at the end of each reporting period.

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Administrative service fees include revenue from certain groups which have managed care contracts that provide for the group to be at risk for all or a portion of their claims experience. For these groups, the Company is not at risk and only handles the administration of the insurance coverage for an administrative service fee. The Company pays claims under self-funded arrangements from its own funds, and subsequently receives reimbursement from these groups. Claims paid under self funded arrangements are excluded from the claims incurred in the accompanying consolidated financial statements. Administrative service fees under the self-funded arrangements are recognized based on the group s membership or incurred claims for the period multiplied by an administrative fee rate plus other fees. In addition, some of these self-funded groups purchase aggregate and/or specific stop-loss coverage. In exchange for a premium, the group s aggregate liability or the group s liability on any one episode of care is capped for the year. Premiums for the stop-loss coverage are actuarially determined based on experience and other factors and are recorded as earned over the period of the contract in proportion to the coverage provided. This fully insured portion of premiums is included within the premiums earned, net in the accompanying consolidated statements of earnings.

(ii) Life and Accident and Health Insurance

Premiums on life insurance policies are billed in advance of their respective coverage period and the related revenue is recorded as earned when due. Premiums on accident and health and other short-term policies are recognized as earned primarily 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. Revenues from universal life and interest sensitive policies represent amounts assessed against policyholders, including mortality charges, surrender charges actually paid, and earned policy service fees. The revenues for limited payment contracts are recognized over the period that benefits are provided rather than on collection of premiums.

(iii) Property and Casualty Insurance

Premiums on property and casualty contracts are recognized as earned on a pro rata basis over the policy term. The portion of premiums related to the period prior to the end of coverage is recorded in the consolidated balance sheets as unearned premiums and is transferred to premium revenue as earned.

(g) Allowance for Doubtful Receivables

The allowance for doubtful receivables is based on management s evaluation of the aging of accounts and such other factors, which deserve current recognition. Actual results could differ from these estimates. Receivables are charged against their respective allowance accounts when deemed to be uncollectible.

(h) Deferred Policy Acquisition Costs and Value of Business Acquired

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

In the life and accident and health business deferred acquisition costs consist of commissions and certain expenses related to the production of life, annuity, accident and health, and credit business. The amount of deferred policy acquisition costs is reduced by a provision for future maintenance and settlement expenses

which are not provided through future premiums. The related amortization is provided, considering interest, over the anticipated premium-paying period of the related policies in proportion to the ratio of annual premium revenue to expected total premium revenue to be received over the life of the policies. Expected premium revenue is estimated by using the same mortality and withdrawal assumptions used in computing liabilities for future policy benefits. The method followed in computing deferred policy acquisition costs limits the amount

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of such deferred costs to their estimated net realizable value. In determining estimated net realizable value, the computations give effect to the premiums to be earned, related investment income, losses and loss-adjustment expenses, and certain other costs expected to be incurred as the premium is earned. Costs deferred on universal life and interest sensitive products are amortized as a level percentage of the present value of anticipated gross profits from investment yields, mortality and surrender charges. Estimates used are based on the Company s experience as adjusted to provide for possible adverse deviations. These estimates are periodically reviewed and compared with actual experience. When it is determined that future expected experience differs significantly from that assumed, the estimates are revised for current and future issues.

The value assigned to the insurance in-force of TSV at the date of the acquisition is amortized using methods similar to those used to amortize the deferred policy acquisition costs of the life and accident and health business.

In 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.

(i) Property and Equipment

Property and equipment are stated at cost. Maintenance and repairs are expensed as incurred. Depreciation is calculated on the straight-line method over the estimated useful lives of the assets. Costs of computer equipment, programs, systems, installations, and enhancements are capitalized and amortized straight-line over their estimated useful lives. The following is a summary of the estimated useful lives of the Company s property and equipment:

Asset category	Estimated useful life
Buildings	20 to 50 years
Building improvements	3 to 5 years
Leasehold improvements	Shorter of estimated useful life or lease term
Office furniture	5 years
Computer software	3 to 10 years
Computer equipment, equipment, and automobiles	3 years

(j) Software Development Costs

In March 1998, the American Institute of Certified Public Accountants (AICPA) issued Statement of Position (SOP) 98-1, *Accounting for the Costs of Computer Software Developed or Obtained for Internal Use*, which provides guidance on accounting for such costs. SOP 98-1 requires computer software costs that are incurred in the preliminary project stage to be expensed as incurred. Once the capitalization criteria of SOP 98-1 have been met, directly attributable development costs should be capitalized. It also provides that upgrade and maintenance costs should be expensed. Our treatment of such costs is consistent with SOP 98-1, with the costs capitalized being amortized over the expected useful life of the software. During the year ended December 31, 2006 the Company capitalized approximately $3,640 associated with the implementation of new software. No software development costs were capitalized during the year ended December 31, 2007.

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(k) Long-Lived Assets

In accordance with Statement of Financial Accounting Standards(SFAS) No. 144, *Accounting for the Impairment or Disposal of Long-lived Assets*, long-lived assets, such as property and equipment, and purchased intangible assets subject to amortization, are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of assets to be held and used is measured by a comparison of the carrying amount of an asset to estimated undiscounted future cash flows expected to be generated by the asset. If the carrying amount of an asset exceeds its estimated future cash flows, an impairment charge is recognized by the amount by which the carrying amount of the asset exceeds the fair value of the asset. Assets to be disposed of would be separately presented in the balance sheets and reported at the lower of the carrying amount or fair value less costs to sell, and are no longer depreciated. The assets and liabilities of a disposal group classified as held for sale would be presented separately in the appropriate asset and liability sections of the consolidated balance sheets.

Goodwill and intangible assets that have indefinite useful lives are tested annually for impairment, and are tested for impairment more frequently if events and circumstances indicate that the asset might be impaired. An impairment loss is recognized to the extent that the carrying amount exceeds the asset s fair value. For goodwill, the impairment determination is made at the reporting unit level and consists of two steps. First, the Company determines the fair value of a reporting unit and compares it to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit s goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation, in accordance with SFAS No. 141, *Business Combinations*. The residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

(l) Claim Liabilities

Claims processed and incomplete and unreported losses for managed care policies represent the estimated amounts to be paid to providers based on experience and accumulated statistical data. Loss-adjustment expenses related to such claims are currently accrued based on estimated future expenses necessary to process such claims.

TSI contracts with various independent practice associations (IPAs) for certain medical care services provided to some policies subscribers. The IPAs are compensated on a capitation basis. In the Reform business and one of the MA policies, TSI retains a portion of the capitation payments to provide for incurred but not reported losses. At December 31, 2007 and 2006, total withholdings and capitation payable amounted to $29,119 and $23,796, respectively, which are recorded as part of the liability for claims processed and incomplete in the accompanying consolidated balance sheets.

Unpaid claims and loss-adjustment expenses of the life and accident and health business are based on a case-basis estimates for reported claims, and on estimates, based on experience, for unreported claims and loss-adjustment expenses. The liability for policy and contract claims and claims expenses has been established to cover the estimated net cost of insured claims.

The liability for losses and loss-adjustment expenses for the property and casualty business represents individual case estimates for reported claims and estimates for unreported losses, net of any salvage and subrogation based on past experience modified for current trends and estimates of expenses for investigating and settling claims.

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The above liabilities are necessarily based on estimates and, while management believes that the amounts are adequate, the ultimate liability may be in excess of or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are continually reviewed, and any adjustments are reflected in the consolidated statements of earnings in the period determined.

(m) Future Policy Benefits

The liability for future policy benefits has been computed using the level-premium method based on estimated future investment yield, mortality, and withdrawal experience. The interest rate assumption is 5.0% for all years in issue. Mortality has been calculated principally on select and ultimate tables in common usage in the industry. Withdrawals have been determined principally based on industry tables, modified by Company s experience.

(n) Policyholder Deposits

Amounts received for annuity contracts are considered deposits and recorded as a liability. Interest accrued on such deposits, which amounted to $1,800, $1,810, and $1,230, during the years ended December 31, 2007, 2006, and 2005, respectively, is recorded as interest expense in the accompanying consolidated statements of earnings.

(o) Reinsurance

In the normal course of business, the insurance-related subsidiaries seek to limit their exposure that may arise from catastrophes or other events that cause unfavorable underwriting results by reinsuring certain levels of risk in various areas of exposure with other insurance enterprises or reinsurers.

Reinsurance premiums, commissions, and expense reimbursements, related to reinsured business are accounted for on bases consistent with those used in accounting for the original policies issued and the terms of the reinsurance contracts. Accordingly, reinsurance premiums are reported as prepaid reinsurance premiums and amortized over the remaining contract period in proportion to the amount of insurance protection provided.

Premiums ceded and recoveries of losses and loss-adjustment expenses have been reported as a reduction of premiums earned and losses and loss-adjustment expenses incurred, respectively. Commission and expense allowances received by STS in connection with reinsurance ceded have been accounted for as a reduction of the related policy acquisition costs and are deferred and amortized accordingly. Amounts recoverable from reinsurers are estimated in a manner consistent with the claim liability associated with the reinsured policy.

(p) Derivative Instruments and Hedging Activities

The Company accounts for derivative instruments, including certain derivative instruments embedded in other contracts, and hedging activities in accordance with the provisions of Statement of SFAS No. 133, *Accounting for Derivative Instruments and Certain Hedging Activities*, as amended, which requires entities to recognize all derivative instruments, whether or not designated in hedging relationships, as either assets or liabilities in the balance sheet at their respective fair values. Changes in the fair value of derivative

instruments are recorded in earnings, unless specific hedge accounting criteria are met in which case the change in fair value of the instrument is recorded within other comprehensive income.

On the date the derivative contract designated as a hedging instrument is entered into, the Company designates the instrument as either a hedge of the fair value of a recognized asset or liability or of an unrecognized firm commitment (fair-value hedge), a hedge of a forecasted transaction or the variability of cash flows to be received or paid related to a recognized asset or liability (cash-flow hedge), a foreign currency fair-value or

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cash-flow hedge (foreign-currency hedge), or a hedge of a net investment in a foreign operation. For all hedging relationships the Company formally documents the hedging relationship and its risk-management objective and strategy for undertaking the hedge, the hedging instrument, the hedged item, the nature of the risk being hedged, how the hedging instrument s effectiveness in offsetting the hedged risk will be assessed, and a description of the method of measuring ineffectiveness. This process includes linking all derivatives that are designated as fair-value, cash-flow, or foreign-currency hedges to specific assets and liabilities on the balance sheet or to specific firm commitments or forecasted transactions. The Company also formally assesses, both at the hedge s inception and on an ongoing basis, whether the derivatives that are used in hedging transactions are highly effective in offsetting changes in fair values or cash flows of hedged items. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a fair-value hedge, along with the loss or gain on the hedged asset or liability or unrecognized firm commitment of the hedged item that is attributable to the hedged risk, are recorded in earnings. Changes in the fair value of a derivative that is highly effective and that is designated and qualifies as a cash-flow hedge are recorded in other comprehensive income to the extent that the derivative is effective as hedge, until earnings are affected by the variability in cash flows of the designated hedged item. Changes in the fair value of derivatives that are highly effective as hedges and that are designated and qualify as foreign-currency hedges are recorded in either earnings or other comprehensive income, depending on whether the hedge transaction is a fair-value hedge or a cash-flow hedge. However, if a derivative is used as a hedge of a net investment in a foreign operation, its changes in fair value, to the extent effective as a hedge, are recorded in the cumulative translation adjustments account within other comprehensive income. The ineffective portion of the change in fair value of a derivative instrument that qualifies as either a fair-value hedge or a cash-flow hedge is reported in earnings. Changes in the fair value of derivative trading instruments are reported in current period earnings.

The Company discontinues hedge accounting prospectively when it is determined that the derivative is no longer effective in offsetting changes in the fair value or cash flows of the hedged item, the derivative expires or is sold, terminated, or exercised, the derivative is de-designated as a hedging instrument, because it is unlikely that a forecasted transaction will occur, a hedged firm commitment no longer meets the definition of a firm commitment, or management determines that designation of the derivative as a hedging instrument is no longer appropriate.

In all situations in which hedge accounting is discontinued and the derivative is retained, the Company continues to carry the derivative at its fair value on the balance sheet and recognizes any subsequent changes in its fair value in earnings. When hedge accounting is discontinued because it is determined that the derivative no longer qualifies as an effective fair-value hedge, the Company no longer adjusts the hedged asset or liability for changes in fair value. The adjustment of the carrying amount of the hedged asset or liability is accounted for in the same manner as other components of the carrying amount of that asset or liability. When hedge accounting is discontinued because the hedged item no longer meets the definition of a firm commitment, the Company removes any asset or liability that was recorded pursuant to recognition of the firm commitment from the balance sheet, and recognizes any gain or loss in earnings. When it is probable that a forecasted transaction will not occur, the Company discontinues hedge accounting if not already done and recognizes immediately in earnings gains and losses that were accumulated in other comprehensive income.

(q) Income Taxes

Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The

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effect on deferred tax assets and liabilities of a change in tax rates is recognized in the consolidated statements of earnings in the period that includes the enactment date. Beginning with the adoption of FASB Interpretation No. 48, *Accounting for Uncertainty in Income Taxes* (FIN 48) as of January 1, 2007, the Company recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs. Prior to the adoption of FIN 48, the Company recognized the effect of income tax positions only is such positions were probably of being sustained.

The Company records any interest and penalties related to unrecognized tax benefits within the operating expenses in our consolidated statement of earnings.

(r) Insurance-Related Assessments

The Company accounts for insurance-related assessments in accordance with the provisions of SOP No. 97-3, *Accounting by Insurance and Other Enterprises for Insurance-related Assessments*. This SOP prescribes liability recognition when the following three conditions are met: (1) the assessment has been imposed or the information available prior to the issuance of the financial statements indicates it is probable that an assessment will be imposed; (2) the event obligating an entity to pay (underlying cause of) an imposed or probable assessment has occurred on or before the date of the financial statements; and (3) the amount of the assessment can be reasonably estimated. Also, this SOP provides for the recognition of an asset when the paid or accrued assessment is recoverable through either premium taxes or policy surcharges.

(s) Commitments and Contingencies

Liabilities for loss contingencies arising from claims, assessments, litigation, fines, and penalties and other sources are recorded when it is probable that a liability has been incurred and the amount of the assessment and/or remediation can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred. Recoveries of costs from third parties, which are probable of realization, are separately recorded as assets, and are not offset against the related liability.

(t) Share-based Compensation

The Company accounts for share-based compensation in accordance with the provisions of SFAS No. 123 (R), *Share-Based Payment*. This statement requires that all share-based compensation be recognized as an expense in the financial statements and that such cost be measured at the fair value of the award. The Company recognizes compensation expense based on estimated grant date fair value using the Black-Scholes option-pricing model.

(u) Earnings Per Share

The Company calculates and presents earnings per share in accordance with SFAS No. 128, *Earnings per Share*. Basic earnings per share excludes dilution and is computed by dividing net income available to all classes of common stockholders by the weighted average number of all classes of common shares outstanding for the period, excluding non-vested restricted stocks. Diluted earnings per share is computed in

the same manner as basic earnings per share except that the number of shares is increased to include the number of additional common shares that would have been outstanding if the potentially dilutive common shares had been issued. Dilutive common shares are included in the diluted earnings per share calculation using the treasury stock method. See note 21 for additional earnings per share information. As disclosed in note 18, the accompanying consolidated financial statements give retroactive effect to the 3,000-for-one stock split of shares of common stock effected on May 1, 2007.

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(v) Fair Value of Financial Instruments

Financial instruments that potentially subject the Company to concentrations of credit risk consist principally of investments in corporate bonds, premiums receivable, accrued interest receivable, and other receivables.

The fair value information of financial instruments in the accompanying consolidated financial statements was determined as follows:

(i) Cash and Cash Equivalents

The carrying amount approximates fair value because of the short-term nature of such instruments.

(ii) Investment in Securities

The fair value of investment securities is estimated based on quoted market prices for those or similar investments. Additional information pertinent to the estimated fair value of investment in securities is included in note 3.

(iii) Policy Loans

Policy loans have no stated maturity dates and are part of the related insurance contract. The carrying amount of policy loans approximates fair value because their interest rate is reset periodically in accordance with current market rates.

(iv) Receivables, Accounts Payable, and Accrued Liabilities

The carrying amount of receivables, accounts payable, and accrued liabilities approximates fair value because they mature and should be collected or paid within 12 months after December 31.

(v) Policyholder Deposits

The fair value of policyholder deposits is the amount payable on demand at the reporting date, and accordingly, the carrying value amount approximates fair value.

(vi) Borrowings

The carrying amounts and fair value of the Company s borrowings are as follows:

	2007		2006	
	Carrying amount	Fair value	Carrying amount	Fair value
Loans payable to bank	$ 25,946	25,946	38,087	38,087
6.3% senior unsecured notes payable	50,000	47,625	50,000	47,897
6.6% senior unsecured notes payable	60,000	57,825	60,000	58,104
6.7% senior unsecured notes payable	35,000	33,950	35,000	34,062

Totals	$ 170,946	165,346	183,087	178,150	

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The carrying amount of the loans payable to bank approximates fair value due to its floating interest-rate structure. The fair value of the senior unsecured notes payable was determined using market quotations. Additional information pertinent to long-term borrowings is included in note 10.

(vii) Derivative Instruments

Current market pricing models were used to estimate fair value of interest-rate swap agreement and structured notes agreements. Fair values were determined using market quotations provided by outside securities consultants or prices provided by market makers. Additional information pertinent to the estimated fair value of derivative instruments is included in note 11.

(w) Recently Issued Accounting Standards

In February 2007, the FASB issued SFAS No. 159, *The Fair Value Option for Financial Assets and Financial Liabilities including an amendment of FASB Statement No. 115* (Statement 159). Statement 159 gives the Company the irrevocable option to carry most financial assets and liabilities at fair value that are not currently required to be measured at fair value. If the fair value option is elected, changes in fair value would be recorded in earnings at each subsequent reporting date. SFAS 159 is effective for the Company s 2008 fiscal year. The Company is currently evaluating the impact the adoption of this statement could have on its financial condition, results of operations and cash flows.

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurement* (Statement 157). Statement 157 defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements. The Statement does not require any new fair value measures. The Statement is effective for fair value measures already required or permitted by other standards for fiscal years beginning after November 15, 2007. The Company is required to adopt Statement 157 beginning on January 1, 2008. Statement 157 is required to be applied prospectively, except for certain financial instruments. Any transition adjustment will be recognized as an adjustment to opening retained earnings in the year of adoption. In November 2007, the FASB proposed a one-year deferral of Statement 157 s fair-value measurement requirements for nonfinancial assets and liabilities that are not required or permitted to be measured at fair value on a recurring basis. The Company is currently evaluating the impact of adopting Statement 157 on its results of operations and financial position.

In December 2007, the FASB issued SFAS No. 141R, *Business Combinations* (Statement 141R) and SFAS No. 160, *Noncontrolling Interests in Consolidated Financial Statements an amendment to ARB No. 51* (Statement 160). Statements 141R and 160 require most identifiable assets, liabilities, noncontrolling interests, and goodwill acquired in a business combination to be recorded at full fair value and require noncontrolling interests (previously referred to as minority interests) to be reported as a component of equity, which changes the accounting for transactions with noncontrolling interest holders. Both Statements are effective for periods beginning on or after December 15, 2008, and earlier adoption is prohibited. Statement 141R will be applied to business combinations occurring after the effective date. Statement 160 will be applied prospectively to all noncontrolling interests, including any that arose before the effective date. The Company currently does not expect the adoption of Statement 141R and Statement 160 to have an impact on its results of operations and financial position.

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(3) Investment in Securities

The amortized cost for debt and equity securities, gross unrealized gains, gross unrealized losses, and estimated fair value for trading, available-for-sale, and held-to-maturity securities by major security type and class of security at December 31, 2007 and 2006 were as follows:

	2007			
	Amortized cost	**Gross unrealized gains**	**Gross unrealized losses**	**Estimated fair value**
Trading securities:				
Equity securities	$54,757	15,170	(2,769)	67,158

	2006			
	Amortized cost	**Gross unrealized gains**	**Gross unrealized losses**	**Estimated fair value**
Trading securities:				
Equity securities	$66,930	17,436	(919)	83,447

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	2007			
	Amortized cost	**Gross unrealized gains**	**Gross unrealized losses**	**Estimated fair value**
Securities available for sale:				
Obligations of government-sponsored enterprises	$ 479,525	7,311	(238)	486,598
U.S. Treasury securities and obligations of U.S. government instrumentalities	85,396	3,034		88,430
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	75,951	254	(1,176)	75,029
Municipal securities	15,223	228	(16)	15,435
Obligations of states of the United States and political subdivisions of the states	2,116	19	(2)	2,133
Corporate bonds	86,061	246	(2,717)	83,590
Mortgage-backed securities	14,138	75	(85)	14,128
Collateralized mortgage obligations	58,126	416	(256)	58,286
Total fixed maturities	816,536	11,583	(4,490)	823,629
Equity securities	66,747	7,354	(3,051)	71,050
Total	$ 883,283	18,937	(7,541)	894,679

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	2006			
	Amortized cost	**Gross unrealized gains**	**Gross unrealized losses**	**Estimated fair value**
Securities available for sale:				
Obligations of government-sponsored enterprises	$ 444,710	243	(7,576)	437,377
U.S. Treasury securities and obligations of U.S. government instrumentalities	93,652		(944)	92,708
Obligations of the Commonwealth Commonwealth of Puerto Rico and its instrumentalities	53,388	138	(1,823)	51,703
Corporate bonds	48,882	6	(966)	47,922
Mortgage-backed securities	16,001	56	(214)	15,843
Collateralized mortgage obligations	57,480	147	(614)	57,013
Total fixed maturities	714,113	590	(12,137)	702,566
Equity securities	50,132	13,112	(1,558)	61,686
Total	$ 764,245	13,702	(13,695)	764,252

	2007			
	Amortized cost	**Gross unrealized gains**	**Gross unrealized losses**	**Estimated fair value**
Securities held to maturity:				
Obligations of government-sponsored enterprises	$ 31,507	227	(20)	31,714
Mortgage-backed securities	3,134		(48)	3,086
Corporate bonds	8,348		(1)	8,347
Certificates of deposit	702			702
Total	$ 43,691	227	(69)	43,849

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	2006			
	Amortized cost	**Gross unrealized gains**	**Gross unrealized losses**	**Estimated fair value**
Securities held to maturity:				
Obligations of government-sponsored enterprises	$ 31,034	5	(816)	30,223
Mortgage-backed securities	3,775		(106)	3,669
Corporate bonds	11,513	8	(569)	10,952
Certificates of deposit	667			667
Index linked certificate of deposit	1,000	370		1,370
Total	$ 47,989	383	(1,491)	46,881

The fair values of investment in securities are determined based on quoted market prices or bid quotations received from securities dealers. If a quoted market price is not available, fair value is estimated using quoted market prices for similar securities.

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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, 2007 and 2006 were as follows:

	2007					
	Less than 12 months		12 months or longer		Total	
	Estimated fair value	Gross unrealized losses	Estimated fair value	Gross unrealized losses	Estimated fair value	Gross unrealized losses
Securities available for sale:						
Obligations of government- sponsored enterprises	$ 12,875	(134)	34,957	(104)	47,832	(238)
Obligations of the Commonwealth of Puerto Rico and its instrumentalities			28,841	(1,176)	28,841	(1,176)
Municipal securities	1,259	(16)			1,259	(16)
Obligations of states of the United States and political subdivisions of the states	1,214	(2)			1,214	(2)
Corporate bonds	56,185	(1,398)	10,654	(1,319)	66,839	(2,717)
Mortgage-backed securities			8,265	(85)	8,265	(85)
Collateralized mortgage obligations	6,718	(104)	16,528	(152)	23,246	(256)
Total fixed maturities	78,251	(1,654)	99,245	(2,836)	177,496	(4,490)
Equity securities	14,454	(1,408)	17,911	(1,643)	32,365	(3,051)
Total for securities available for sale	$ 92,705	(3,062)	117,156	(4,479)	209,861	(7,541)
Securities held to maturity:						
Obligations of government- sponsored enterprises	$		10,831	(20)	10,831	(20)
Mortgage-backed securities			3,086	(48)	3,086	(48)

Corporate bonds		8,347	(1)	8,347	(1)
Total for securities held to maturity	$	22,264	(69)	22,264	(69)

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	2006					
	Less than 12 months		12 months or longer		Total	
	Estimated fair value	Gross unrealized losses	Estimated fair value	Gross unrealized losses	Estimated fair value	Gross unrealized losses
Securities available for sale:						
Obligations of government- sponsored enterprises	$ 71,628	(636)	346,369	(6,940)	417,997	(7,576)
U.S. Treasury securities and obligations of U.S. government instrumentalities	92,708	(944)			92,708	(944)
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	4,588	(68)	31,165	(1,755)	35,753	(1,823)
Corporate bonds	43,190	(560)	3,959	(406)	47,149	(966)
Mortgage-backed securities	10,969	(137)	2,841	(77)	13,810	(214)
Collateralized mortgage obligations	11,958	(52)	23,112	(562)	35,070	(614)
Total fixed maturities	235,041	(2,397)	407,446	(9,740)	642,487	(12,137)
Equity securities	6,570	(681)	11,113	(877)	17,683	(1,558)
Total for securities available for sale	$ 241,611	(3,078)	418,559	(10,617)	660,170	(13,695)
Securities held to maturity:						
Obligations of government- sponsored enterprises	$		5,854	(816)	5,854	(816)
Mortgage-backed securities			3,669	(106)	3,669	(106)
Corporate bonds			9,444	(569)	9,444	(569)

Total for securities held to maturity	$	18,967	(1,491)	18,967	(1,491)

The Company 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 the length of time and the extent to which cost exceeds fair value, the prospects and financial condition of the issuer, and the Company s intent and ability to retain the investment to allow for recovery in fair value, among other factors. This process is not exact and further requires consideration of risks such as credit and interest rate risks. Consequently, if an investment s cost exceeds its fair value solely due to changes in interest rates, impairment may not be appropriate. If after monitoring and analyzing, the Company 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. The impairment is charged to operations and a new cost basis for the security is established. During the three year-period ended December 31, 2007, 2006 and 2005, the Company recognized other-than-temporary impairments amounting to $1,087, $2,098 and $1,036, respectively, on some of its equity securities classified as available for sale.

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Obligations of Government-sponsored Enterprises, U.S. Treasury Securities and Obligations of U.S. Government Instrumentalities, Obligations of States of the United States and Political Subdivisions of the States, and Obligations of the Commonwealth of Puerto Rico and its Instrumentalities: The unrealized losses on the Company s investments in obligations of government-sponsored enterprises, U.S. Treasury securities and obligations of U.S. government instrumentalities, obligations of states of the United States and political subdivisions of the states, and in obligations of the Commonwealth of Puerto Rico and its instrumentalities were mainly caused by interest rate increases. The contractual terms of these investments do not permit the issuer to settle the securities at a price less than the par value of the investment. Because the decline in fair value is attributable to changes in interest rates and not credit quality, and because the Company has the ability and intent to hold these investments until a market price recovery or maturity, these investments are not considered other-than-temporarily impaired.

Corporate Bonds: The Company s unrealized losses on investments in corporate bonds are comprised of small unrealized losses in most of the corporate bonds. Unrealized losses of these bonds were mostly caused by interest rate increases. Because the decline in fair value is attributable to changes in interest rates and because the Company has the ability and intent to hold these investments until a market price recovery or maturity, these investments are not considered other-than-temporarily impaired.

Mortgage-Backed Securities and Collateralized Mortgage Obligations: The unrealized losses on investments in mortgage-backed securities and collateralized mortgage obligations were caused by interest rate increases. The contractual cash flows of these securities are guaranteed by a U.S. government-sponsored enterprise. Because the decline in fair value is attributable to changes in interest rates and not credit quality, and because the Company has the ability and intent to hold these investments until a market price recovery or maturity, these investments are not considered other-than-temporarily impaired.

Equity Securities: The Company s investment in equity securities classified as available for sale consist mainly of investments in common and preferred stock of domestic banking institutions and investments in several mutual funds. The unrealized loss experienced in the investment in common stocks of domestic banking institutions is mainly due to the increase in interest rates, which significantly impact banking institutions, and to the general economic conditions in the past three years. The unrealized loss related to the Company s investments in preferred stock of domestic banking institutions and in investments in several mutual funds investing in fixed income securities is mainly caused by interest rate increases. Because the unrealized losses on equity securities were mainly caused by interest rate increases and not credit quality, and because the Company has the ability and intent to hold these investments until a market price recovery, these investments are not considered other-than-temporarily impaired.

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Maturities of investment securities classified as available for sale and held to maturity were as follows at December 31, 2007:

	Amortized cost	Estimated fair value
Securities available for sale:		
Due in one year or less	$ 40,625	40,557
Due after one year through five years	105,952	106,398
Due after five years through ten years	226,026	229,272
Due after ten years	371,669	374,988
Collateralized mortgage obligations	58,126	58,286
Mortgage-backed securities	14,138	14,128
	$ 816,536	823,629
Securities held to maturity:		
Due in one year or less	$ 2,637	2,634
Due after one year through five years	25,949	25,973
Due after five years through ten years	3,200	3,201
Due after ten years	8,771	8,955
Mortgage-backed securities	3,134	3,086
	$ 43,691	43,849

Expected maturities may differ from contractual maturities because some issuers have the right to call or prepay obligations with or without call or prepayment penalties.

Investments with an amortized cost of $5,249 and $5,237 (fair value of $5,220 and $5,053) at December 31, 2007 and 2006, respectively, were deposited with the Commissioner of Insurance to comply with the deposit requirements of the Insurance Code the Commonwealth of Puerto Rico (the Insurance Code). Investment with an amortized cost of $527 and $500 (fair value of $527 and $500) at December 31, 2007 and 2006, respectively, were deposited with the Commissioner of Insurance of the Government of the U.S. Virgin Islands.

Investments with a face value of $510 and $500 (fair value of $508 and $484) at December 31, 2007 and 2006, respectively, were held by a financial institution as collateral for the Company s interest-rate swap agreement (see note 11).

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Information regarding realized and unrealized gains and losses from investments for the years ended December 31, 2007, 2006, and 2005 is as follows:

	2007	2006	2005
Realized gains (losses):			
Fixed maturity securities:			
Trading securities:			
Gross gains from sales	$		2,235
Gross losses from sales			(542)
			1,693
Securities available for sale:			
Gross gains from sales	1,208		137
Gross losses from sales	(1,797)	(687)	(214)
	(589)	(687)	(77)
Total debt securities	(589)	(687)	1,616
Equity securities:			
Trading securities:			
Gross gains from sales	8,873	4,318	6,339
Gross losses from sales	(1,558)	(1,488)	(1,776)
	7,315	2,830	4,563
Securities available for sale:			
Gross gains from sales	260	792	2,043
Gross losses from sales and impairments	(1,055)	(2,098)	(1,061)
	(795)	(1,306)	982
Total equity securities	6,520	1,524	5,545

Net realized gains on securities	$ 5,931	837	7,161

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	2007	2006	2005
Changes in unrealized gains (losses):			
Recognized in income:			
Fixed maturities trading	$		(1,755)
Equity securities trading	(4,116)	7,699	(2,954)
	$ (4,116)	7,699	(4,709)
Recognized in accumulated other comprehensive income:			
Fixed maturities available for sale	$ 18,640	(2,434)	(9,615)
Equity securities available for sale	(7,251)	(1,581)	(11,742)
	$ 11,389	(4,015)	(21,357)
Not recognized in the consolidated financial statements:			
Fixed maturities held to maturity	$ 1,266	(114)	(963)

The deferred tax liability on unrealized gains and losses recognized in accumulated other comprehensive income during the years 2007, 2006, and 2005 aggregated $1,842, $2, and $805, respectively.

As of December 31, 2007, investments in obligations that are payable from and secured by the same source of revenue or taxing authority, other than investment instruments of the U.S. and the Commonwealth of Puerto Rico governments, did not exceed 10% of stockholders equity. As of December 31, 2007, no investment in equity securities individually exceeded 10% of stockholders equity.

(4) Net Investment Income

Components of net investment income were as follows:

	Year ended December 31		
	2007	2006	2005
Fixed maturities	$ 37,205	35,217	24,094
Equity securities	5,271	3,821	3,228
Policy loans	394	336	
Cash equivalent interest and interest-bearing deposits	2,187	1,903	702
Other	2,137	1,380	1,114
Total	$ 47,194	42,657	29,138

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(5) Premium and Other Receivables, Net

Premium and other receivables as of December 31 were as follows:

	2007	2006
Premium	$ 54,330	53,377
Self-funded group receivables	31,344	24,854
FEHBP	10,202	9,187
Agent balances	32,874	28,813
Accrued interest	8,363	8,054
Reinsurance recoverable on paid losses	58,757	40,885
Other	22,323	18,686
	218,193	183,856
Less allowance for doubtful receivables:		
Premium	11,753	12,128
Other	4,172	6,102
	15,925	18,230
Premium and other receivables, net	$ 202,268	165,626

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(6) Deferred Policy Acquisition Costs and Value of Business Acquired

The movement of deferred policy acquisition costs (DPAC) and value of business acquired (VOBA) for the years ended December 31, 2007, 2006, and 2005 is summarized as follows:

	DPAC	VOBA	Total
Balance, December 31, 2004	$ 18,712		18,712
Additions	26,257		26,257
Ceding commission of coinsurance funds with held agreement (see note 17)	60,000		60,000
Amortization	(23,401)		(23,401)
Net change	62,856		62,856
Balance, December 31, 2005	81,568		81,568
Capitalization upon acquisition of GA Life		22,823	22,823
Termination of coinsurance funds withheld agreement	(60,000)		(60,000)
Acquisition of business ceded in coinsurance funds with held agreement		60,000	60,000
Additions	44,056		44,056
VOBA interest at an average rate of 5.29%		4,427	4,427
Amortization	(26,799)	(14,658)	(41,457)
Net change	(42,743)	72,592	29,849
Balance, December 31, 2006	38,825	72,592	111,417
Additions	46,898		46,898
VOBA interest at an average rate of 5.27%		3,874	3,874
Amortization	(32,508)	(12,442)	(44,950)
Net change	14,390	(8,568)	5,822
Balance, December 31, 2007	$ 53,215	64,024	117,239

The amortization expense of the deferred policy acquisition costs and value of business acquired is included within the operating expenses in the accompanying consolidated statement of earnings.

The estimated amount of the year-end VOBA balance expected to be amortized during the next five years is as follows:

Year ending December 31:	
2008	$10,410
2009	9,265
2010	8,279
2011	7,230
2012	6,460

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(7) Property and Equipment, Net

Property and equipment as of December 31 are composed of the following:

	2007	2006
Land	$ 6,531	6,531
Buildings and building and leasehold improvements	43,664	41,214
Office furniture and equipment	15,868	13,264
Computer equipment and software	36,361	31,457
Automobiles	539	413
	102,963	92,879
Less accumulated depreciation and amortization	59,548	51,264
Property and equipment, net	$ 43,415	41,615

(8) Claim Liabilities

The activity in claim liabilities during 2007, 2006, and 2005 is as follows:

	2007	2006	2005
Claim liabilities at beginning of year	$ 314,682	297,563	279,325
Reinsurance recoverable on claim liabilities	(32,066)	(28,720)	(26,555)
Net claim liabilities at beginning of year	282,616	268,843	252,770
Claim liabilities acquired from GA Life		8,771	
Claims incurred:			
Current period insured events	1,240,100	1,266,132	1,202,952
Prior period insured events	(31,007)	(19,669)	5,415
Total	1,209,093	1,246,463	1,208,367
Payments of losses and loss-adjustment expenses:			
Current period insured events	1,003,283	1,046,477	1,004,060
Prior period insured events	189,430	194,984	188,234

Total	1,192,713	1,241,461	1,192,294
Net claim liabilities at end of year	298,996	282,616	268,843
Reinsurance recoverable on claim liabilities	54,834	32,066	28,720
Claim liabilities at end of year	$ 353,830	314,682	297,563

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As a result of differences between actual amounts and estimates of insured events in prior years, the amounts included as incurred claims for prior period insured events differ from anticipated claims incurred.

The credits in the incurred claims and loss-adjustment expenses for prior period insured events for 2007 and 2006 are due primarily to better than expected utilization trends. The amount of incurred claims and loss-adjustment expenses for prior period insured events for 2005 is due to higher than expected cost per service and utilization trends.

Reinsurance recoverable on unpaid claims is reported as premium and other receivables, net in the accompanying consolidated financial statements.

The claims incurred disclosed in this table exclude the change in the liability for future policy benefits amounting to $14,682 and $12,518 during the years ended December 31, 2007 and 2006, respectively. As of December 31, 2005 the Company had no liability for future policy benefits.

(9) Federal Employees Health Benefits Program (FEHBP)

TSI entered into a contract, renewable annually, with OPM as authorized by the Federal Employees Health Benefits Act of 1959, as amended, to provide health benefits under the FEHBP. The FEHBP covers postal and federal employees resident in the Commonwealth of Puerto Rico and the United States Virgin Islands as well as retirees and eligible dependents. The FEHBP is financed through a negotiated contribution made by the federal government and employees payroll deductions.

The accounting policies for the FEHBP are the same as those described in the Company s summary of significant accounting policies. Premium rates are determined annually by TSI and approved by the federal government. Claims are paid to providers based on the guidelines determined by the federal government. Operating expenses are allocated from TSI s operations to the FEHBP based on applicable allocation guidelines (such as, the number of claims processed for each program).

The operations of the FEHBP do not result in any excess or deficiency of revenue or expense as this program has a special account available to compensate any excess or deficiency on its operations to the benefit or detriment of the federal government. Any transfer to/from the special account necessary to cover any excess or deficiency in the operations of the FEHBP is recorded as a reduction/increment to the premiums earned. The contract with OPM provides that the cumulative excess of the FEHBP earned income over health benefits charges and expenses represents a restricted fund balance denoted as the special account. Upon termination of the contract and satisfaction of all the FEHBP s obligations, any unused remainder of the special reserve would revert to the Federal Employees Health Benefit Fund. In the event that the contract terminates and the special reserve is not sufficient to meet the FEHBP s obligations, the FEHBP contingency reserve will be used to meet such obligations. If the contingency reserve is not sufficient to meet such obligations, the Company is at risk for the amount not covered by the contingency reserve.

The contract with OPM allows for the payment of service fees as negotiated between TSI and OPM. Service fees, which are included within the other income, net in the accompanying consolidated statements of earnings, amounted to $895, $861, and $800, respectively, for each of the years in the three-year period ended December 31, 2007.

A contingency reserve is maintained by the OPM at the U.S. Treasury, and is available to the Company under certain conditions as specified in government regulations. Accordingly, such reserve is not reflected in the accompanying consolidated balance sheets. The balance of such reserve as of December 31, 2007 and 2006 was $18,004 and $17,747, respectively. The Company received $5,512, $4,850, and $1,059, of payments made from

the contingency reserve fund of OPM during 2007, 2006, and 2005, respectively.

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The claim payments and operating expenses charged to the FEHBP are subject to audit by the U.S. government. Management is of the opinion that an adjustment, if any, resulting from such audits will not have a significant effect on the accompanying financial statements. The claim payments and operating expenses reimbursed in connection with the FEHBP have been audited through 2004 by OPM.

(10) Borrowings

A summary of the borrowings entered by the Company at December 31, 2007 and 2006 is as follows:

	2007	2006
Secured note payable of $20,000, payable in various installments through August 31, 2007, with interest payable on a monthly basis at a rate reset periodically of 130 basis points over selected LIBOR maturity (which was 6.67% at December 31, 2006).	$	10,500
Senior unsecured notes payable of $50,000 due September 2019. Interest is payable semiannually at a fixed rate of 6.30%.	50,000	50,000
Senior unsecured notes payable of $60,000 due December 2020. Interest is payable monthly at a fixed rate of 6.60%.	60,000	60,000
Senior unsecured notes payable of $35,000 due January 2021. Interest is payable monthly at a fixed rate of 6.70%.	35,000	35,000
Secured loan payable of $41,000, payable in monthly installments of $137 through July 1, 2024, plus interest at a rate reset periodically of 100 basis points over selected LIBOR maturity (which was 6.24% and 6.35% at December 31, 2007 and 2006, respectively).	25,946	27,587
Total borrowings	$ 170,946	183,087

Aggregate maturities of the Company s borrowings as of December 31, 2007 are summarized as follows:

Year ending December 31:	
2008	$ 1,640
2009	1,640
2010	1,640
2011	1,640
2012	1,640
Thereafter	162,746
	$ 170,946

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All of the Company s senior notes can be prepaid at par, in total or partially, five years after issuance as determined by the Company. The Company s senior unsecured notes contain certain covenants with which TSI and the Company have complied with at December 31, 2007.

Debt issuance costs related to each of the Company s senior unsecured notes were deferred and are being amortized over the term of its respective senior note. Unamortized debt issuance costs related to these senior unsecured notes as of December 31, 2007 and 2006 amounted to $1,239 and $1,338, respectively, and are included within the other assets in the accompanying consolidated balance sheets.

The secured loan payable previously described is guaranteed by a first position held by the bank on the Company s land, building, and substantially all leasehold improvements, as collateral for the term of the loan under a continuing general security agreement. This secured loan contains certain covenants, which are customary for this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2007, the Company is in compliance with these covenants.

The Company was also a party to another secured loan whose outstanding balance of $10,500 was repaid upon its maturity on August 1, 2007.

Interest expense on the above borrowings amounted to $11,565, $11,695, and $5,168, for the years ended December 31, 2007, 2006, and 2005, respectively.

(11) Derivative Instruments and Hedging Activities

The Company uses derivative instruments to manage the risks associated with changes in interest rates and to diversify the composition of its investment in securities.

By using derivative financial instruments the Company exposes itself to credit risk and market risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty is obligated to the Company, which creates credit risk for the Company. When the fair value of a derivative contract is negative, the Company owes the counterparty and, therefore, it does not possess credit risk. The Company minimizes the credit risk in derivative instruments by entering into transactions with high-quality counterparties.

Market risk is the adverse effect on the value of a financial instrument that results from a change in interest rates, currency exchange rates, commodity prices, or market indexes. The market risk associated with derivative instruments is managed by establishing and monitoring parameters that limit the types and degree of market risk that may be undertaken.

(a) Cash Flow Hedge

The Company has invested in an interest-rate related derivative hedging instrument to manage its exposure on its debt instruments.

The Company assesses interest rate cash flow risk by continually identifying and monitoring changes in interest rate exposures that may adversely impact expected future cash flows and by evaluating hedging opportunities. The Company maintains risk management control systems to monitor interest rate cash flow risk attributable to both the Company s outstanding or forecasted debt obligations as well as the Company s offsetting hedge positions. The risk management control systems involve the use of analytical techniques to estimate the expected impact of changes in interest rates on the Company s future cash flows.

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The Company has a variable-rate debt that was used to finance the acquisition of real estate from subsidiaries (see note 10). The debt obligations expose the Company to variability in interest payments due to changes in interest rates. Management believes it is prudent to limit the variability of a portion of its interest payments. To meet this objective, on December 6, 2002, management entered into an interest-rate swap agreement, with an effective date of April 1, 2003, to manage fluctuations in cash flows resulting from interest rate risk. The maturity date of the interest-rate swap agreement is March 30, 2008. This swap economically changes the variable-rate cash flow exposure on the debt obligations to fixed cash flows. Under the terms of the interest-rate swap, the Company receives variable interest rate payments and makes fixed interest rate payments, thereby creating the equivalent of fixed-rate debt.

Changes in the fair value of the interest-rate swap, designated as a hedging instrument that effectively offsets the variability of cash flows associated with the variable-rate of the long-term debt obligation, are reported in accumulated other comprehensive income, net of the related tax effect. This amount is subsequently reclassified into interest expense as a yield adjustment of the hedged debt obligation in the same period in which the related interest affects earnings. During the years ended December 31, 2007 and 2006 the Company s interest expense was reduced by $419 and $379, respectively, of interest received related to this agreement. During the year ended December 31, 2005, the Company recorded $127 of interest expense related to this agreement. No amount representing cash-flow hedge ineffectiveness was recorded since the terms of the swap agreement allow the Company to assume no ineffectiveness in the agreement.

As of December 31, 2007 and 2006, the fair value of the interest rate swap amounted to $93 and $502, respectively, and was included within the other assets in the accompanying consolidated balance sheets.

(b) Other Derivative Instruments

The Company has invested in other derivative instruments in order to diversify its investment in securities and participate in the foreign stock market.

During 2005 the Company invested in two structured note agreements amounting to $5,000 each, where the interest income received is linked to the performance of the Dow Jones Euro STOXX 50 and Nikkei 225 Equity Indexes (the Indexes). Under these agreements the principal invested by the Company is protected, the only amount that varies according to the performance of the Indexes is the interest to be received upon the maturity of the instruments. Should the Indexes experience a negative performance during the holding period of the structured notes, no interest will be received and no amount will be paid to the issuer of the structured notes. The contingent interest payment component within the structured note agreements meets the definition of an embedded derivative. In accordance with the provisions of SFAS No. 133, as amended, the embedded derivative component of the structured notes is separated from the structured notes and accounted for separately as a derivative instrument.

The changes in the fair value of the embedded derivative component are recorded as gains or losses in earnings in the period of change. During the year ended December 31, 2007 the Company recorded a loss associated with the change in the fair value of this derivative component of $45. During the years ended December 31, 2006 and 2005 the Company recorded a gain associated with the change in the fair value of this derivative component of $1,046 and $2,833, respectively. The change in the fair value of the embedded derivative component is included within the other income, net in the accompanying consolidated statement of earnings.

As of December 31, 2007 and 2006, the fair value of the derivative component of the structured notes amounted to $6,332 and $6,377, respectively, and is included within the Company s other assets in the accompanying consolidated balance sheets. The investment component of the structured notes is accounted for as held-to-maturity debt securities and is included within the investment in securities in the accompanying

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consolidated balance sheets. As of December 31, 2007 the fair value and amortized cost of the investment component of both structured notes amounted to $8,347 and $8,348, respectively. As of December 31, 2006 the fair value and amortized cost of the investment component of both structured notes amounted to $7,626 and $8,011, respectively.

(12) Agency Contract and Expense Reimbursement

TSI processes and pays claims as fiscal intermediary for the Medicare Part B Program. Claims from this program, which are excluded from the accompanying consolidated statements of earnings, amounted to $322,930, $413,806, and $618,725, for each of the years in the three-year period ended December 31, 2007.

TSI is reimbursed for administrative expenses incurred in performing this service. For the years ended December 31, 2007, 2006, and 2005, TSI was reimbursed by $10,783, $13,073, and $13,889, respectively, for such services, which are deducted from operating expenses in the accompanying consolidated statements of earnings.

The operating expense reimbursements in connection with processing Medicare claims have been audited through 2002 by federal government representatives. Management is of the opinion that no significant adjustments will be made affecting cost reimbursements through December 31, 2007.

(13) Reinsurance Activity

The effect of reinsurance on premiums earned and claims incurred is as follows:

	Premiums earned			Claims incurred[1]		
	2007	**2006**	**2005**	**2007**	**2006**	**2005**
Gross	$ 1,564,873	1,584,857	1,447,054	1,247,788	1,267,871	1,225,065
Ceded	(81,325)	(77,644)	(67,250)	(38,695)	(22,869)	(16,698)
Assumed		4,413	400		1,461	
Net	$ 1,483,548	1,511,626	1,380,204	1,209,093	1,246,463	1,208,367

(1) The claims incurred disclosed in this table exclude the change in the liability for future policy benefits amounting to $14,682 and $12,518 during the years ended December 31, 2007 and 2006,

respectively. As of December 31, 2005 the Company had no liability for future policy benefits.

(a) Reinsurance Ceded Activity

TSI, STS and TSV, in accordance with general industry practices, annually purchase reinsurance to protect them from the impact of large unforeseen losses and prevent sudden and unpredictable changes in net income and stockholders equity of the Company. Reinsurance contracts do not relieve any of the subsidiaries from their obligations to policyholders. In the event that all or any of the reinsuring companies might be unable to meet their obligations under existing reinsurance agreements, the subsidiaries would be liable for such defaulted amounts. During 2007, 2006, and 2005, STS placed 9% of its reinsurance business with one reinsurance company.

TSI has two excess of loss reinsurance treaties whereby it cedes a portion of its premiums to third parties. Reinsurance contracts are primarily for periods of one year, and are subject to modifications and negotiations in each renewal date. Premiums ceded under these contracts amounted to $3,349 and $2,249 in 2007 and 2006,

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respectively. Claims ceded amounted to $2,957 and $3,766 in 2007 and 2006, respectively. Principal reinsurance agreements are as follows:

Organ transplant excess of loss treaty covering 100% of the claims up to a maximum of $1,000 per person, per life.

Routine medical care excess of loss treaty covering 100% of claims from the amount of $100 and up to a maximum of $900 per covered person, per contract year.

STS has a number of pro rata and excess of loss reinsurance treaties whereby the subsidiary retains for its own account all loss payments for each occurrence that does not exceed the stated amount in the agreements and a catastrophe cover, whereby it protects itself from a loss or disaster of a catastrophic nature. Under these treaties, STS ceded premiums of $69,137, $65,723, and $59,244, in 2007, 2006, and 2005, respectively.

Reinsurance cessions are made on excess of loss and on a proportional basis. Principal reinsurance agreements are as follows:

Property quota share treaty covering for a maximum of $20,000 for any one risk. Under this treaty 40.0% of the risk is ceded to reinsurers. The remaining exposure is covered by a property per risk excess of loss treaty that provides reinsurance in excess of $500 up to a maximum of $12,000, or the remaining 60.0% for any one risk.

Personal property catastrophe excess of loss. This treaty provides protection for losses in excess of $5,000 resulting from any catastrophe, subject to a maximum loss of $70,000.

Commercial property catastrophe excess of loss. This treaty provides protection for losses in excess of $5,000 resulting from any catastrophe, subject to a maximum loss of $190,000.

Property catastrophe excess of loss. This treaty provides protection for losses in excess of $70,000 and $190,000 with respect to personal and commercial lines, respectively, resulting from any catastrophe, subject to a maximum of $150,000.

Personal lines quota share. This treaty provides protection of 13.20% on all ground-up losses, subject to a limit of $1,000 for any one risk.

Reinstatement premium protection. This treaty provides a maximum limit of approximately $4,200 for personal lines and $13,800 in commercial lines to cover the necessity of reinstating the catastrophe program in the event it is activated.

Casualty excess of loss treaty. This treaty provides reinsurance for losses in excess of $225 up to a maximum of $12,000.

Medical malpractice excess of loss. This treaty provides reinsurance in excess of $150 up to a maximum of $1,500 per incident.

Builders risk quota share and first surplus covering contractors risk. This treaty provides protection on a 20/80 quota share basis for the initial $2,500 and a first surplus of $10,000 for a maximum of $12,000 for any one risk.

Surety quota share treaty covering contract and miscellaneous surety bond business. This treaty provides reinsurance of up to $5,000 for contract surety bonds, subject to an aggregate of $10,000 per contractor and $3,000 per miscellaneous surety bond.

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Facultative reinsurance is obtained when coverage per risk is required. All reinsurance contracts are for a period of one year, on a calendar basis, and are subject to modifications and negotiations in each renewal.

The ceded unearned reinsurance premiums on STS arising from these reinsurance transactions amounted to $22,963 and $19,892 at December 31, 2007 and 2006, respectively and are reported as other assets in the accompanying consolidated balance sheets.

TSV also cedes insurance with various reinsurance companies under a number of pro rata, excess of loss and catastrophe treaties. Under these treaties, TSV ceded premiums of $8,839, $9,672, and $8,006, in 2007, 2006, and 2005, respectively. Principal reinsurance agreements are as follows:

Group life pro rata agreement, reinsuring 50% of the risk up to $150 on the life of any participating individual of certain groups insured.

Group life insurance facultative agreement, reinsuring risk in excess of $25 of certain group life policies.

Group life insurance facultative excess of loss agreements in which TSV retains a portion of the losses on the life of any participating individual of certain groups insured. Any excess will be recovered from the reinsurer. This agreement provides for various retentions ($25, $50, and $75) of the losses.

Facultative pro rata agreements for the long-term disability insurance, reinsuring 65% of the risk.

Accidental death catastrophic reinsurance covering each and every accident arising out of one event or occurrence resulting in the death or dismemberment of five or more persons. The retention for each event is $250 with a maximum of $1,000 for each event and $2,000 per year.

Several reinsurance agreements, mostly on an excess of loss basis up to a maximum retention of $50. For certain new life products that have been issued since 1999, the retention limit is $175.

(b) Reinsurance Assumed Activity

On December 22, 2005, the Company s former life insurance subsidiary SVTS entered into a coinsurance funds withheld agreement with GA Life. Under the terms of this agreement SVTS assumed 69% of all the business written as of and after the effective date of the agreement. On the effective date of the agreement, SVTS paid an initial ceding commission of $60,000 for its participation in the business written by GA Life as of and after the effective date of the agreement. This amount was considered a policy acquisition cost and was included within the deferred policy acquisition costs as of December 31, 2005. This amount, upon the acquisition of GA Life, was transferred to the value of business acquired when the agreement was canceled.

As in other coinsurance funds withheld agreements, GA Life invests the premiums received from policyholders, pays commissions, processes claims and engages in other administrative activities. GA Life also carries the reserves for the policies written as well as the underlying investments purchased with the premiums received from policyholders.

On January 31, 2006 the Company completed the acquisition of 100% of the common stock of GA Life. The results of operations and financial position of GA Life are included in the Company s consolidated financial statements for the period following January 31, 2006. Effective June 30, 2006, the Company merged the operations of its former life insurance subsidiary, SVTS, into GA Life after receiving required regulatory

approvals. The coinsurance funds withheld agreement was canceled effective February 1, 2006, subsequent to the acquisition of GA Life. Premiums earned and claims incurred assumed during the month ended January 31, 2006 amounted to $4,413 and $2,292, respectively.

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(14) Income Taxes

Under Puerto Rico income tax law, the Company is not allowed to file consolidated tax returns with its subsidiaries. The Company and its subsidiaries are subject to Puerto Rico income taxes. The Company s insurance subsidiaries are also subject to U.S. federal income taxes for foreign source dividend income. As of December 31, 2007, tax years 2003 through 2006 of the Company and its subsidiaries are subject to examination by Puerto Rico taxing authorities.

On January 1, 2007, the Company adopted the provisions of Fin 48: no adjustment was required upon the adoption of this accounting pronouncement.

TSI and STS are taxed essentially the same as other corporations, with taxable income determined on the basis of the statutory annual statements filed with the insurance regulatory authorities. Also, operations are subject to an alternative minimum income tax, which is calculated based on the formula established by existing tax laws. Any alternative minimum income tax paid may be used as a credit against the excess, if any, of regular income tax over the alternative minimum income tax in future years.

TSV operates as a qualified domestic life insurance company and is subject to the alternative minimum tax and taxes on its capital gains. After the merger of GA Life and SVTS, SVTS ceased to exist and its tax responsibilities are now assumed by TSV.

Federal income taxes were recognized by the Company s insurance subsidiaries amounted to approximately $164, $148, and $139 in 2007, 2006, and 2005, respectively.

TSM, TCI, and ISI are subject to Puerto Rico income taxes as a regular corporation, as defined in the P.R. Internal Revenue Code, as amended.

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The income tax expense differs from the amount computed by applying the Puerto Rico statutory income tax rate to the income before income taxes as a result of the following:

	2007	2006	2005
Income before taxes	$ 72,645	67,559	32,306
Statutory tax rate	39.0%	39.0%	39.0%
Income tax expense at statutory rate of 39%	28,332	26,348	12,599
Increase (decrease) in taxes resulting from:			
Exempt interest income	(9,990)	(9,196)	(7,441)
Effect of taxing life insurance operations as a qualified domestic life insurance company instead of as a regular corporation	(1,115)	(1,674)	(752)
Effect of using earnings under statutory accounting principles instead of GAAP for TSI and STS	371	(1,718)	(84)
Effect of taxing capital gains at a preferential rate	(1,406)	(541)	(1,762)
Dividends received deduction	(821)	(325)	(430)
Other permanent disallowances, net	2,308	2,626	1,123
Adjustment to deferred tax assets and liabilities for changes in effective tax rates	(2,131)	(2,009)	1,500
Other adjustments to deferred tax assets and liabilities	(423)	(399)	(723)
Other	(998)	(86)	(157)
Total income tax expense	$ 14,127	13,026	3,873

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Deferred income taxes reflect the tax effects of temporary differences between carrying amounts of assets and liabilities for financial reporting purposes and income tax purposes. The net deferred tax liability at December 31, 2007 and 2006 of the Company and its subsidiaries is composed of the following:

	2007	2006
Deferred tax assets:		
Allowance for doubtful receivables	$ 5,422	6,593
Liability for pension benefits	9,885	12,492
Employee benefits plan	4,856	4,011
Postretirement benefits	1,789	1,863
Deferred compensation	1,519	1,343
Accumulated depreciation	356	379
Impairment loss on investments	565	611
Contingency reserves	50	2,516
Alternative minimum income tax credit	830	458
Other	544	13
Gross deferred tax assets	25,816	30,279
Deferred tax liabilities:		
Deferred policy acquisition costs	(7,102)	(8,903)
Catastrophe loss reserve trust fund	(5,035)	(3,752)
Unrealized gain upon acquisition of GA Life	(2,092)	(3,036)
Unrealized gain on trading securities	(1,859)	(3,217)
Unrealized gain on securities available for sale	(1,842)	(2)
Unrealized gain on derivative instruments	(383)	(387)
Unamortized bond issue costs	(383)	(501)
Cash-flow hedges	(37)	(196)
Other	(300)	(993)
Gross deferred tax liabilities	(19,033)	(20,987)
Net deferred tax asset	$ 6,783	9,292

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management believes that it is more likely than not that the Company will realize the benefits of these deductible differences.

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(15) Pension Plans

On December 31, 2006, the Company adopted the recognition and disclosures provisions of SFAS No. 158, *Employers Accounting for Defined Benefit Pension and Other Post Retirement Plans*.

Noncontributory Defined-Benefit Pension Plan

The Company sponsors a noncontributory defined-benefit pension plan for all of its employees and for the employees for certain of its subsidiaries who are age 21 or older and have completed one year of service. Pension benefits begin to vest after five years of vesting service, as defined, and are based on years of service and final average salary, as defined. The funding policy is to contribute to the plan as necessary to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, plus such additional amounts as the Company may determine to be appropriate from time to time. The measurement date used to determine pension benefit measures for the pension plan is December 31.

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The following table sets forth the plan s benefit obligations, fair value of plan assets, and funded status as of December 31, 2007 and 2006, accordingly:

	2007	2006
Change in benefit obligation:		
Projected benefit obligation at beginning of year	$ 88,774	84,272
Service cost	5,489	5,459
Interest cost	5,072	4,655
Benefit payments	(5,141)	(4,614)
Actuarial losses (gains)	1,774	(1,102)
Plan amendments	(6,370)	104
Projected benefit obligation at end of year	$ 89,598	88,774
Accumulated benefit obligation at end of year	$ 66,042	64,366
Change in fair value of plan assets:		
Fair value of plan assets at beginning of year	$ 59,520	49,501
Actual return on assets (net of expenses)	4,234	6,633
Employer contributions	5,000	8,000
Benefit payments	(5,140)	(4,614)
Fair value of plan assets at end of year	$ 63,614	59,520
Funded status at end of year	$ (25,984)	(29,254)
Amounts in accumulated other comprehensive income not yet recognized as a component of net periodic pension cost:		
Development of prior service cost (credit):		
Balance at beginning of year	$ 606	550
Amortization	(58)	(48)
Prior service cost (credit) arising during the year	(6,370)	104
Unrecognized net prior service cost (credit)	(5,822)	606
Development of actuarial loss:		
Balance at beginning of year	30,409	36,722
Amortization	(1,959)	(2,436)

Loss (gain) arising during the year	1,923	(3,877)
Unrecognized actuarial loss	30,373	30,409
Sum of deferrals	$ 24,551	31,015
Net amount recognized	$ (1,433)	1,761

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The amounts recognized in the balance sheets as of December 31, 2007 and 2006 consist of the following:

	2007	2006
Pension liability	$25,984	29,254
Accumulated other comprehensive loss, net of a deferred tax of $9,501 and $12,017 in 2007 and 2006, respectively	15,050	18,998

The components of net periodic benefit cost and other amounts recognized in other comprehensive income for 2007, 2006, and 2005 were as follows:

	2007	2006	2005
Components of net periodic benefit cost:			
Service cost	$ 5,489	5,459	4,737
Interest cost	5,072	4,655	4,145
Expected return on assets	(4,383)	(3,858)	(3,467)
Amortization of prior service cost	58	48	48
Amortization of actuarial loss	1,959	2,435	2,017
Net periodic benefit cost	$ 8,195	8,739	7,480

Net periodic pension expense may include settlement charges as a result of retirees selecting lump-sum distributions. Settlement charges may increase in the future if the number of eligible participants deciding to receive distributions and the amount of their benefits increases.

The estimated net loss and prior service cost that will be amortized from other comprehensive income into net periodic pension benefits cost during the next twelve months is as follows:

Prior service cost	$ (446)
Actuarial loss	1,764

The following assumptions were used on a weighted average basis to determine benefit obligations of the plan and in computing the periodic benefit cost as of and for the years ended December 31, 2007, 2006, and 2005:

	2007	2006	2005
Discount rate	6.25%	5.75%	5.50%
Expected return on plan assets	8.00%	8.00%	8.00%
Rate of compensation increase	Graded; 3.50% to 8.00%	Graded; 3.50% to 8.00%	Graded; 3.00% to 6.50%

The basis used to determine the overall expected long-term rate of return on assets assumption was an analysis of the historical rate of return for a portfolio with a similar asset allocation. The assumed long-term asset allocation for the plan is as follows: 53% 67% equity securities; 26% 36% debt securities; 4% 12% real estate; and 0% 3% cash. It is common on December 31 to have an increased cash position due to incoming cash contributions as well as outgoing cash disbursements.

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Using historical investment returns, the plan s expected asset mix, and adjusting for the difference between expected inflation and historical inflation, the 25th to 75th percentile range of annual rates of return is 6.5% 9.0%. The Company selected a rate from within this range of 8.00%, which reflects the Company s best estimate for this assumption based on the historical data described above, information on the historical returns on assets invested in the pension trust, and expected future conditions. This rate is net of both investment related expenses and a 0.25% reduction for other administrative expenses charged to the trust.

(a) Plan Assets

The Company s weighted average asset allocations at December 31, 2007 and 2006 were as follows:

Asset category	2007	2006
Equity securities	59%	62%
Debt securities	31	28
Real estate	9	8
Other	1	2
Total	100%	100%

The Company s plan assets are invested in the National Retirement Trust. The National Retirement Trust was formed to provide financial and legal resources to help members of the BCBSA offer retirement benefits to their employees. The investment program for the National Retirement Trust is based on the precepts of capital market theory that are generally followed by institutional investors and who by definition, are long-term oriented investors. This philosophy holds that:

Increasing risk is rewarded with compensating returns over time, and therefore, prudent risk taking is justifiable for long-term investors.

Risk can be controlled through diversification of asset classes and investment approaches, as well as diversification of individual securities.

Risk is reduced by time, and over time the relative performance of different asset classes is reasonably consistent. Over the long-term, equity investments have provided and should continue to provide superior returns over other security types. Fixed-income securities can dampen volatility and provide liquidity in periods of depressed economic activity.

The strategic or long-term allocation of assets among various asset classes is an important driver of long-term returns.

Relative performance of various asset classes is unpredictable in the short-term and attempts to shift tactically between asset classes are unlikely to be rewarded.

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Investments will be made for the sole interest of the participants and beneficiaries of the programs participating in the National Retirement Trust. Accordingly, the assets of the National Retirement Trust shall be invested in accordance with these objectives:

Ensure assets are available to meet current and future obligations of the participating programs when due.

Earn a minimum rate of return no less than the actuarial interest rate.

Earn the maximum return that can be realistically achieved in the markets over the long-term at a specified and controlled level of risk in order to minimize future contributions.

Invest the assets with the care, skill, and diligence that a prudent person acting in a like capacity would undertake. The committee acknowledges that, in the process, it has the objective of controlling the costs involved with administering and managing the investments of the National Retirement Trust.

(b) Cash Flows

The Company expects to contribute $5,000 to its pension program in 2008.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Year ending December 31:	
2008	$2,865
2009	3,797
2010	4,210
2011	4,506
2012	5,538
2013 2017	6,175

Noncontributory Supplemental Pension Plan

In addition, the Company sponsors a noncontributory supplemental pension plan. This plan covers employees with qualified defined benefit retirement plan benefits limited by the U.S. Internal Revenue Code maximum compensation and benefit limits. At December 31, 2007, the Company has recorded a pension liability of $3,237 and $3,046, respectively. The charge to accumulated other comprehensive income related to the noncontributory pension plan at December 31, 2007 and 2006 amounted to $602 and $744, respectively, net of a deferred tax asset of $384 and $475, respectively.

(16) Catastrophe Loss Reserve and Trust Fund

In accordance with Chapter 25 of the Insurance Code, as amended, STS is required to record a catastrophe loss reserve. This catastrophe loss reserve is supported by a trust fund for the payment of catastrophe losses. The reserve increases by amounts determined by applying a contribution rate, not in excess of 5%, to catastrophe written premiums as instructed annually by the Commissioner of Insurance, unless the level of the reserve exceeds 8% of catastrophe exposure, as defined. The reserve also increases by an amount equal to the resulting return in the supporting trust fund and decreases by payments on catastrophe losses or authorized withdrawals from the trust fund. Additions to the catastrophe loss reserve are deductible for income tax purposes.

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This trust may invest its funds in securities authorized by the Insurance Code, but not in investments whose value may be affected by hazards covered by the catastrophic insurance losses. The interest earned on these investments and any realized gains (loss) on investment transactions are part of the trust fund and are recorded as income (expense) of the Company. An amount equal to the investment returns is recorded as an addition to the catastrophe loss reserve.

The assets in this fund, which amounted to $29,096 and $27,051 as of December 31, 2007 and 2006, respectively, are to be used solely and exclusively to pay catastrophe losses covered under policies written in Puerto Rico. As of December 31, 2007 and 2006, assets in this fund amounting to $25,962 and $27,051 are reported within the securities held to maturity in the accompanying consolidated balance sheets. As of December 31, 2007, assets in this fund amounting to $3,134 are also reported within the securities available for sale in the accompanying consolidated balance sheets.

STS is required to make deposits to the trust fund, if any, on or before January 30 of the following year. Contributions are determined by a rate imposed by the Commissioner of Insurance for the catastrophe policies written in that year. Additions in 2007 and 2006, amounting to $822 and $772, respectively, were determined by applying a rate of 1% to catastrophe premiums written.

The amount in the trust fund may be withdrawn or released in the case that STS ceases to underwrite risks subject to catastrophe losses. Also, authorized withdrawals are allowed when the catastrophe loss reserve exceeds 8% of the catastrophe exposure, as defined.

Retained earnings are restricted in the accompanying consolidated balance sheets by the total catastrophe loss reserve balance, which as of December 31, 2007 and 2006 amounted to $29,918 and $27,823, respectively.

(17) Business Combinations

Effective January 31, 2006, the Company acquired 100% of the common stock of GA Life. As a result of this acquisition, the Corporation became one of the leading providers of life insurance policies in Puerto Rico. The acquisition was accounted by the Company in accordance with the provisions of SFAS No. 141, *Business Combinations*. The results of operations and financial condition of GA Life are included in the accompanying consolidated financial statements for the period following the effective date of the acquisition. The aggregate purchase price of the acquired entity amounted to $38,196; of this amount $37,500 was paid in cash on January 31, 2006 and $696 was direct costs related to the acquisition.

The following table summarizes the estimated fair value of the assets acquired and liabilities assumed at the date of acquisition.

Current assets	$ 219,747
Property and equipment	1,500
Value of business acquired	22,823
Total assets acquired	244,070
Total liabilities assumed	(205,874)
Net assets acquired	$ 38,196

The estimated fair value of the value of business acquired was actuarially determined by discounting after-tax profits at a risk rate of return equal to approximately 12%. After-tax profits were forecasted based upon models of the insurance in-force, actual invested assets as of acquisition date and best-estimate actuarial assumptions regarding

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premium income, claims, persistency, expenses and investment income accruing from invested assets plus reinvestment of positive cash flows. The best-estimate actuarial assumptions were based upon GA Life s recent experience in each of its major life and health insurance product lines. The amount of value of business acquired is to be amortized, considering interest, over the anticipated premium-paying period of the related policies in proportion to the ratio of annual premium revenue to the expected total premium revenue to be received over the life of the policies.

The following unaudited pro forma financial information presents the combined results of operations of the Company and GA Life as if the acquisition had occurred at the beginning of each period presented. The unaudited pro forma financial information is not intended to represent or be indicative of the Company s consolidated results of operations that would have been reported had the acquisition been completed as of the beginning of the periods presented and should not be taken as indicative of the Company s future consolidated results of operations.

	Unaudited	
	2006	**2005**
Operating revenues	$1,576,492	1,516,632
Net income	54,850	43,814
Basic net income per share	2.05	1.64

(18) Stockholders Equity

(a) Common Stock

On April 24, 2007, the Company s Board of Directors (the Board) authorized a 3,000-for-one stock split of its Class A common stock effected in the form of a dividend of 2,999 shares for every one share outstanding. This stock split was effective on May 1, 2007 to all stockholders of record at the close of business on April 24, 2007. The total number of authorized shares and par value per share were unchanged by this action. The par value of the additional shares resulting from the stock split was reclassified from additional paid in capital to common stock. All references to the number of shares and per share amounts in this consolidated financial statements are presented after giving retroactive effect to the stock split.

In May 2007, the Company cancelled 24,000 director qualifying shares. Since February 2007, Board members are no longer required to hold qualifying shares to participate in the Board of Directors of the Company.

In December 7, 2007, the Company completed the initial public offering (IPO) of its Class B common stock. In this public offering the Company sold 16,100,000 shares, 10,813,191 of which were shares previously owned by selling shareholders. Proceeds received under this public offering amounted to $70,279, net of $6,380 of expenses directly related to the offering.

For a period of five years after the completion of our IPO, subject to the extension or shortening under certain circumstances, each holder of Class B common stock will benefit from anti-dilution protections provided in our amended and restated articles of incorporation.

(b) Preferred Stock

Authorized capital stock includes 100,000,000 of preferred stock with a par value of $1.00 per share. As of December 31, 2007 and 2006, there are no issued and outstanding preferred stock shares.

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(c) Dividends

On March 12, 2007, the Board declared a cash dividend of $2,448 distributed pro rata among all of the Company s issued and outstanding Class A common shares, excluding those shares issued to the representatives of the community that are members of the Board (the qualifying shares). All stockholders of record as of the close of business on March 23, 2007, except those who only hold qualifying shares, received a dividend per share of $0.09 for each share held on that date.

On January 13, 2006, the Board declared a cash dividend of $6,231 distributed pro rata among all of the Company s issued and outstanding Class A common shares, excluding qualifying shares. All stockholders of record as of the close of business on January 16, 2006, except those who only hold qualifying shares, received a dividend per share of $0.23 for each share held on that date.

(d) Liquidity Requirements

As members of the BCBSA, the Company and TSI are required by membership standards of the association to maintain liquidity as defined by BCBSA. That is, to maintain net worth exceeding the Company Action Level as defined in the National Association of Insurance Commissioners (NAIC) Risk-Based Capital for Insurers Model Act. The companies are in compliance with this requirement.

(19) Comprehensive Income

The accumulated balances for each classification of other comprehensive income are as follows:

	Unrealized gains on securities	Liability for pension benefits	Cash-flow hedges	Accumulated other comprehensive income (loss)
Beginning balance	$ 5	(19,742)	306	(19,431)
Net current period change	8,383	4,090	(250)	12,223
Reclassification adjustments for gains and losses reclassified in income	1,166			1,166
Ending balance	$ 9,554	(15,652)	56	(6,042)

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The related deferred tax effects allocated to each component of other comprehensive income in the accompanying consolidated statements of stockholders equity and comprehensive income in 2007 and 2006 are as follows:

	2007		
	Before-tax amount	**Deferred tax (expense) benefit**	**Net-of-tax amount**
Unrealized holding gains on securities arising during the period	$ 10,005	(1,622)	8,383
Less reclassification adjustment for gains and losses realized in income	1,384	(218)	1,166
Net change in unrealized gain	11,389	(1,840)	9,549
Liability for pension benefits	6,697	(2,607)	4,090
Cash-flow hedges	(409)	159	(250)
Net current period change	$ 17,677	(4,288)	13,389

	2006		
	Before-tax amount	**Deferred tax (expense) benefit**	**Net-of-tax amount**
Unrealized holding gains on securities arising during the period	$ (6,008)	1,201	(4,807)
Less reclassification adjustment for gains and losses realized in income	1,993	(398)	1,595
Net change in unrealized gain	(4,015)	803	(3,212)
Liability for pension benefits	7,915	(2,963)	4,952
Cash-flow hedges	(105)	40	(65)
Adjustment to initially apply SFAS No.158	(26,233)	10,152	(16,081)
Net current period change	$ (22,438)	8,032	(14,406)

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	Before-tax amount	2005 Deferred tax (expense) benefit	Net-of-tax amount
Unrealized holding gains on securities arising during the period	$ (20,452)	2,350	(18,102)
Less reclassification adjustment for gains and losses realized in income	(905)	175	(730)
Net change in unrealized gain	(21,357)	2,525	(18,832)
Minimum pension liability adjustment	(4,515)	1,727	(2,788)
Cash-flow hedges	749	(292)	457
Net current period change	$ (25,123)	3,960	(21,163)

(20) Share-Based Compensation

In December 2007 the Company adopted the 2007 Incentive Plan (the Plan), which permits the board of directors the grant of stock options, restricted stock awards and performance awards to eligible officers, directors and key employees. The Plan authorizes grants to issue up to 4,700,000 of Class B common shares of authorized but unissued stock. At December 31, 2007, there were 3,367,583 additional shares available for the Company to grant under the Plan. Stock options can be granted with an exercise price at least equal the stock s fair market value at the date of grant. The stock option awards vest in equal annual installments over 3 years and its expiration date cannot exceed 7 years. The restricted stock and performance awards are issued at the fair value of the stock on the grant date. Restricted stock awards vest in equal annual installments over 3 years. Performance awards vest on the last day of the performance period, provided that at least minimum performance standards were achieved.

The fair value of each option award is estimated on the date of grant using the Black-Scholes option-pricing model that used the weighted average assumptions in the following table. In absence of adequate historical data, the Company estimates the expected life of the option using the shortcut method allowed by Staff Accounting Bulletin (SAB) No. 107. Since the Company is a newly-public entity, expected volatility is computed based on the average historical volatility of similar entities with publicly traded shares. The risk-free rate for the expected term of the option is based on the U.S. Treasury zero-coupon bonds yield curve in effect at the time of grant.

The following assumptions were used in the development of fair value of option awards:

	2007
Expected dividend yield	0.00%

Expected volatility (per year)	33.00%
Expected term (in years)	4.50
Risk-free interest rate	3.51%

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Stock option activity during the periods indicated is as follows:

	Number of shares	Weighted Average Exercise Price	Weighted Average Contractual Term (Years)	Aggregate Intrinsic Value
Beginning balance		$		
Grants	999,309	14.50		
Ending balance	999,309	$ 14.50	2.92	$ 5,706
Excercisable at end of year		$		

The weighted average grant date fair value of options granted during the year 2007 was $14.50. There were no options exercised during the year ended December 31, 2007.

A summary of the status of the Company s nonvested restricted and performance shares as of December 31, 2007, and changes during the year ended December 31, 2007, are presented below:

	Restricted Awards		Performance Awards	
	Number of shares	Weighted Average Exercise Price	Number of shares	Weighted Average Exercise Price
Beginning balance		$		$
Grants	166,554	14.50	166,554	14.50
Ending balance	166,554	$ 14.50	166,554	$ 14.50
Excercisable at end of year		$		$

At December 31, 2007, there was $8,590 of total unrecognized compensation cost related to nonvested share-based compensation arrangements granted under the Plan. That cost is expected to be recognized over a weighted average period of 2.92 years. No shares vested during the year ended December 31, 2007.

The Company currently uses authorized and unissued Class B common shares to satisfy share award exercises.

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(21) Net Income Available to Stockholders and Basic Net Income per Share

The following table sets forth the computation of basic and diluted earnings per share for the three-year period ended December 31, 2007.

	2007	2006	2005
Numerator for earnings per share:			
Net income available to stockholders	$ 58,518	54,533	28,433
Denominator for basic earnings per share Weighted average of common shares	27,200,067	26,729,500	26,712,000
Effect of dilutive securities Non-vested restricted stock awards	2,038		
Denominator for diluted earnings per share	27,202,105	26,729,500	26,712,000
Basic net income per share	$ 2.15	2.04	1.06
Diluted net income per share	$ 2.15	2.04	1.06

During the year ended December 31, 2007, the weighted average of stock option shares of 83,276 were excluded from the denominator for diluted earnings per share because the stock options were anti-dilutive. There were no anti-dilutive stock options during the years ended December 31, 2006 and 2005.

(22) Commitments

The Company leases its regional offices, certain equipment, and warehouse facilities under noncancelable operating leases. Minimum annual rental commitments at December 31, 2007 under existing agreements are summarized as follows:

Year ending December 31:	
2008	$ 5,338
2009	3,650
2010	2,239
2011	1,248
2012	509
Thereafter	375
Total	$ 13,359

Rental expense for 2007, 2006, and 2005 was $4,007, $3,962, and $2,185, respectively, after deducting the amount of $303, $348, and $495, respectively, reimbursed by Medicare (see note 12).

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(23) Contingencies

(a) Legal Proceedings

(i) At December 31, 2007, the Company is defendant in various lawsuits arising in the ordinary course of business. In the opinion of management, with the advice of its legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated financial position and results of operations of the Company.

(ii) TSM, TSI, and others are defendants in a complaint where the plaintiffs allege that the defendants, among other things, violated provisions of the Puerto Rico Insurance Code, antitrust violations, unfair business practices, breach of contract with providers, and damages. The plaintiffs also asserted that, in light of TSI s former tax exempt status, the assets of TSI belong to a charitable trust held in the benefit of the people of Puerto Rico (the charitable trust claim). The plaintiffs also requested the Company sell shares to them pursuant to a contract with TSI dated August 16, 1989 regarding the acquisition of shares. After a preliminary review of the complaint, it appears that many of the allegations brought by the plaintiffs have been resolved in favor of TSM and TSI in previous cases brought by the same plaintiffs in the U.S. District Court for the District of Puerto Rico and in the local courts. The defendants, including TSM and TSI answered the complaint, filed a counter-claim and filed several motions to dismiss.

On May 9, 2005, the plaintiffs amended the complaint to allege causes of action similar to those dismissed by the U.S. District Court for the District of Puerto Rico in another case. Defendants moved to dismiss the amended complaint. Plaintiffs opposed the motions to dismiss and defendants filed corresponding replies. In 2006, the Court held several hearings concerning these dispositive motions and stayed all discovery until the motions were resolved.

On January 19, 2007, the Court denied a motion by the plaintiffs to dismiss the defendants counterclaim for malicious prosecution and abuse of process. The Court ordered plaintiffs to answer counterclaim by February 20, 2007. Although they filed after the required date, plaintiffs filed an answer to the counterclaim.

On February 7, 2007 the Court dismissed the charitable trust, RICO and violation of due process claims as to all the plaintiffs. The tort, breach of contract and violation of the Puerto Rico corporations law claims, were dismissed only against certain of the physician plaintiffs. The Court allowed the count based on antitrust to proceed, and in reconsideration allowed the charitable trust and RICO claims to proceed. The Company appealed to the Puerto Rico Court of Appeals the denial of the motion to dismiss as to the antitrust allegations and the Court s decision to reconsider the claims previously dismissed.

On May 30, 2007 the Puerto Rico Court of Appeals granted leave to replead the RICO and antitrust claims only to the physician plaintiffs, consistent with certain requirements set forth in its opinion, to allow the physician plaintiffs the opportunity to cure the deficiencies and flaws the Court found in the plaintiffs allegations. The Court dismissed the charitable trust claim as to all plaintiffs, denying them the opportunity to replead that claim, and dismissed the RICO and antitrust claims as to the non-physician plaintiffs. Also, the Court of Appeals granted leave to replead a derivative claim capacity on behalf of the Corporation to the lone shareholder plaintiff. The plaintiffs moved for the reconsideration of this

judgment. On July 18, 2007 the Court of Appeals denied the plaintiffs motion for reconsideration, which has granted plaintiffs leave to replead certain matters. On August 17, 2007, plaintiffs filed a petition for certiorari by the Puerto Rico Supreme Court, which we opposed on August 27, 2007. The plaintiffs petition for certiorari was denied by the Puerto Rico Supreme Court on November 9, 2007. The

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Company is unable to estimate the range of possible loss that may be ultimately realized upon the resolution of this case. In the opinion of management, with the advice of its legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated financial position and results of operations of the Company.

(iii) On May 22, 2003 a putative class action suit was filed by Kenneth A. Thomas, M.D. and Michael Kutell, M.D., on behalf of themselves and all others similarly situated and the Connecticut State Medical Society against the BCBSA and substantially all of the other Blue plans in the United States, including TSI. The individual plaintiffs bring this action on behalf of themselves and a class of similarly situated physicians seeking redress for alleged illegal acts of the defendants, which they allege have resulted in a loss of their property and a detriment to their business, and for declaratory and injunctive relief to end those practices and prevent further losses. Plaintiffs alleged that the defendants, on their own and as part of a common scheme, systematically deny, delay and diminish the payments due to doctors so that they are not paid in a timely manner for the covered, medically necessary services they render.

The class action complaint alleges that the healthcare plans are the agents of BCBSA licensed entities, and as such have committed the acts alleged above and acted within the scope of their agency, with the consent, permission, authorization and knowledge of the others, and in furtherance of both their interest and the interests of other defendants. Management believes that TSI was brought to this litigation for the sole reason of being associated with the BCBSA. However, on June 18, 2004 the plaintiffs moved to amend the complaint to include the Colegio de Médicos y Cirujanos de Puerto Rico (a compulsory association grouping all physicians in Puerto Rico), Marissel Velázquez, MD, President of the Colegio de Médicos y Cirujanos de Puerto Rico, and Andrés Meléndez, MD, as plaintiffs against TSI. Later Marissel Velázquez, MD voluntarily dismissed her complaint against TSI. TSI, along with the other defendants, moved to dismiss the complaint on multiple grounds, including but not limited to arbitration and applicability of the McCarran Ferguson Act. The parties have been ordered to engage in mediation, and twenty four plans, including TSI, are actively participating in the mediation efforts. The mediation resulted in the creation of a Settlement Agreement that was filed with the Court on April 27, 2007, and on May 31, 2007, the District Court preliminarily approved the Settlement Agreement. The Company has recorded its best estimate of the possible outcome of this case as an accrual, which is included within the accounts payable and accrued liabilities in the accompanying consolidated financial statements as of and for the year ended December 31, 2007. A final approval hearing for the Settlement Agreement was held on November 14, 2007. The Court has yet to issue the final approval of the settlement.

(iv) TSI is a defendant in a complaint, filed on October 23, 2007, where the plaintiffs allege that, as heirs of a former shareholder of TSI, they were fraudulently induced to submit shares for redemption in 1996. The plaintiffs are seeking the return of 16 shares (prior to giving effect to the 3,000-for-one stock split) that were redeemed in 1996, a year after the death of the former shareholders, or compensation in the amount of $40,000 per share which they allege is a share s present value. At the time of death of the former shareholder, the bylaws of TSI would not have permitted the plaintiffs to inherit, as those bylaws provided that in the event of a shareholder s death, shares could be redeemed at the price originally paid for them or could be transferred only to an heir who was either a doctor or dentist. The plaintiffs complaint also states that they purport to represent as a class all heirs of the TSI s former shareholders whose shares were redeemed upon such shareholders deaths. On October 31, 2007, the

Corporation filed a motion to dismiss the claims as barred by the applicable statute of limitations. On December 21, 2007, the plaintiffs filed an opposition to our motion to dismiss, alleging that the two year statute of limitations is not applicable in connection with the redemption of the stock that took place in 1996. On

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March 3, 2008, the Company filed a reply to plaintiffs opposition to the motion to dismiss. In its reply, the Corporation renews its motion to dismiss and further argues that plaintiffs argument is wrong because the statute of limitations has expired, pursuant the two year term provided under the Uniform Security Act of Puerto Rico Civil code for cases of this nature. The Company is unable to estimate the range of possible loss that may be ultimately realized upon the resolution of this case. In the opinion of management, with the advice of its legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated financial position and results of operations of the Company.

(v) TSI and the Commissioner of Insurance of Puerto Rico are defendants in a complaint with one former shareholder of TSI predecessor stock that was redeemed in 1999 for its original purchase price pursuant to an order issued by the Commissioner of Insurance, requiring the redemption of a total of 1,582 shares that had been previously sold by the Company. The Company appealed this Commissioner of Insurance s order to the Puerto Rico Court of Appeals, which upheld that order by decision dated March 31, 2000. The plaintiff requests that the court direct TSI to return his share of stock and pay damages and attorney s fees. On January 23, 2008, the Company filed a motion for summary judgment, on the ground *inter alia* that the finding of the Insurance Commissioner is firm and final and cannot be collaterally attacked in this litigation. Plaintiffs have petitioned the Court to hold the motion in abeyance pending discovery. TSI believes that this claim is meritless, as the validity of the share repurchase was decided by the Court of Appeals in 2000, and plans to vigorously contest this matter. The Company is unable to estimate the range of possible loss that may be ultimately realized upon the resolution of this case. In the opinion of management, with the advice of its legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated financial position and results of operations of the Company.

(vi) On March 1, 2006 and March 3, 2006, respectively, the Puerto Rico Center for Municipal Revenue Collection (CRIM) imposed a real property tax assessment of approximately $1.3 million and a personal property tax assessment of approximately $4.0 million upon TSI for the fiscal years 1992-1993 through 2002-2003, during which time TSI qualified as a tax-exempt entity under Puerto Rico law pursuant to rulings issued by the Puerto Rico tax authorities. In imposing the tax assessments, CRIM contends that because a for-profit corporation, such as TSI, is not entitled to such an exemption, the rulings recognizing the tax exemption that were issued should be revoked on a retroactive basis and property taxes should be applied to TSI for the period when it was exempt. On March 28, 2006 and March 29, 2006, respectively, TSI challenged the real and personal property tax assessments.

On October 29, 2007, the Court entered a summary judgment for CRIM affirming the real property tax. TSI filed a motion for reconsideration of the Court s summary judgment decision, which was denied. On November 29, 2007 TSI appealed this determination and has requested an argumentative hearing. On January 19, 2008 CRIM filed an allegation in opposition of TSI s appeal and on March 3, 2008 TSI filed its response to the allegation submitted by CRIM.

On December 5, 2007, the Court entered a summary judgment for CRIM with respect to the personal property assessment that was notified on January 22, 2008. On January 31, 2008, TSI filed a motion for reconsideration, which was denied. TSI appealed this decision on February 21, 2008 and also requested a consolidation of both property tax cases.

The Company believes that these municipal tax assessments are improper and currently expects to prevail in this litigation. The Company is unable to estimate the range of possible loss that may be ultimately realized upon the resolution of this case. In the opinion of management, with the advice of its

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legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated financial position and results of operations of the Company.

(b) Guarantee Associations

Pursuant to the Insurance Code, STS is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED) and of the Sindicato de Aseguradores de Responsabilidad Profesional para Médicos. Both syndicates were organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the subsidiary shares risks with other member companies and, accordingly, is contingently liable in the event that the above-mentioned syndicates cannot meet their obligations. During 2007, 2006 and 2005, no assessments or payments were made for this contingency.

Additionally, pursuant to Article 12 of Rule LXIX of the Insurance Code, STS is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the Association). The Association was organized during 1997 to underwrite insurance coverage of motor vehicle property damage liability risks effective January 1, 1998. As a participant, STS shares the risk, proportionately with other members, based on a formula established by the Insurance Code. During the three-year period ended December 31, 2007, the Association distributed good experience refunds. STS received refunds amounting to $1,023, $769, and $918, in 2007, 2006, and 2005, respectively.

STS is a member of the Asociación de Garantía de Seguros de Todas Clases, excepto Vida, Incapacidad y Salud and TSI, TSV are members of the Asociación de Garantía de Seguros de Vida, Incapacidad y Salud. As members, they are required to provide funds for the payment of claims and unearned premiums reimbursements for policies issued by insurance companies declared insolvent. During 2006 and 2005, STS paid assessments of $995 and $965, respectively. During 2007 no assessment or payment was made by STS in connection with insurance companies declared insolvent. Moreover, no assessments were attributable to TSI and Triple-S Vida, Inc. during 2007, 2006, and 2005.

(24) Statutory Accounting

TSI, TSV and STS (collectively known as the regulated subsidiaries) are regulated by the Commissioner of Insurance. The regulated subsidiaries are required to prepare financial statements using accounting practices prescribed or permitted by the Commissioner of Insurance, which differ from GAAP.

The accumulated earnings of TSI, TSV, and STS are restricted as to the payment of dividends by statutory limitations applicable to domestic insurance companies. Such limitations restrict the payment of dividends by insurance companies generally to unrestricted unassigned surplus funds reported for statutory purposes. As more fully described in note 16, a portion of the accumulated earnings of STS are also restricted by the catastrophe loss reserve balance (amounting to $29,918 and $27,823 as of December 31, 2007 and 2006, respectively) as required by the Insurance Code.

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The net admitted assets, unassigned surplus, and capital and surplus of the insurance subsidiaries at December 31, 2007 and 2006 are as follows:

		2007	
	TSI	**STS**	**TSV**
Net admitted assets	$702,125	273,601	310,428
Unassigned surplus	67,768	57,346	(17,021)
Capital and surplus	217,768	95,765	45,039

		2006	
	TSI	**STS**	**GA Life**
Net admitted assets	$557,146	255,702	292,972
Unassigned surplus	190,419	47,892	(22,790)
Capital and surplus	191,419	84,215	39,270

The net income (loss) of the insurance subsidiaries for the years ended December 31, 2007, 2006, and 2005 is as follows:

	TSI	**STS**	**TSV**
2007	$41,742	14,608	7,736
2006	24,723	9,270	7,077
2005	16,126	10,107	(58,046)

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(25) Supplementary Information on Noncash Transactions Affecting Cash Flow Activities

	2007	2006	2005
Supplementary information:			
Noncash transactions affecting cash flows activities:			
Change in net unrealized gain on securities available for sale, including deferred income tax liability of $1,842, $2, and $805 in 2007, 2006, and 2005, respectively	$ 9,549	(3,212)	(18,832)
Change in cash-flow hedges, including deferred income tax liability of $37, $196, and $236 in 2007, 2006, and 2005, respectively	(250)	(65)	457
Change in liability for pension benefits, and deferred income tax asset of $9,885, $2,340, and $5,303, in 2007, 2006, and 2005, respectively	4,090	4,952	(2,788)
Adjustment to initially apply SFAS No. 158, including deferred income tax effect of $10,152 in 2006.		(16,081)	
Unsettled investment acquisitions	117,706	226	379
Unsettled investment sales		(13)	(2,845)
Other:			
Income taxes paid	25,940	2,813	5,351
Interest paid	14,102	14,215	9,118

On January 31, 2006, the Company acquired GA Life (now TSV). Refer to note 17 for a summary of assets acquired and liabilities assumed as part of the acquisition.

(26) Segment Information

The operations of the Company are conducted principally through three business segments: Managed Care, Life Insurance, and Property and Casualty Insurance. Business segments were identified according to the type of insurance products offered. These segments and a description of their respective operations are as follows:

Managed Care segment TSI is engaged in the sale of managed care products to the commercial market sector (including corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare supplement) as well as to the Medicare Advantage, the Commonwealth of Puerto Rico Health Reform (the Reform) and stand-alone PDP. The following represents a description of the major contracts by sector:

Commercial The premiums for this business are mainly originated through TSI s internal sales force and a network of brokers and independent agents. TSI is a qualified contractor to provide health coverage to federal government employees within Puerto Rico. Earned premiums revenue related to this contract amounted to $121,126, $113,355, and $113,181 for the three-year period ended December 31, 2007, 2006, and 2005, respectively (see note 9). Under its commercial business, TSI also provides health coverage to certain employees of the Commonwealth of Puerto Rico and its instrumentalities. Earned premium revenue related to such health plans amounted to $46,649, $54,143, and $64,623, for

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the three-year period ended December 31, 2007, 2006, and 2005, respectively. TSI also processes and pays claims as fiscal intermediary for the Medicare Part B Program in Puerto Rico and is reimbursed for operating expenses (see note 12).

Medicare TSI provides services through its Medicare health plans pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is terminable for cause if TSI breaches a material provision of the contract or violate relevant laws or regulations. The premiums for this business are mainly originated through TSI s internal sales force and a network of brokers and independent agents. Earned premium revenue related to the Medicare business amounted to $255,570, $170,820 and $34,236 the three-year period ended December 31, 2007, 2006 and 2005, respectively.

Reform TSI participates in the Reform to provide health coverage to medically indigent citizens in Puerto Rico. The Reform program provides health coverage to medically indigent citizens in Puerto Rico, as defined by the laws of the Commonwealth of Puerto Rico. The Reform consists of a single policy with the same benefits for each qualified medically indigent citizen. Earned premium revenue related to this business amounted to $327,544, $455,891, and $510,839, for three-year period ended December 31, 2007, 2006, and 2005, respectively. During these periods, TSI was the sole provider in three of the eight Reform regions in Puerto Rico. Since the Reform s inception in 1995, TSI had been the sole provider for two to three regions each year. The contract for each geographical area is subject to termination in the event of any noncompliance by the insurance company, which is not corrected or cured to the satisfaction of the government entity overseeing the Reform, or on ninety days prior written notice in the event that the government determines that there is an insufficiency of funds to finance the Reform. These contracts usually have one-year terms and expire on June 30. Upon the expiration of the contract for a geographical area, of the Commonwealth of Puerto Rico usually commences an open bidding process to select the carrier for each area. In October 2006, TSI was informed that the new contract to serve one of these regions, Metro-North, had been awarded to another managed care company effective November 1, 2006. The contracts for the other two areas were renewed for additional terms ending June 30, 2008.

Life Insurance segment This segment offers primarily life and accident and health insurance coverage, and annuity products. The premiums for this segment are mainly subscribed through TSV s internal sales force and a network of independent brokers and agents.

Property and Casualty Insurance segment The predominant insurance lines of business of this segment are commercial multiple peril, auto physical damage, auto liability, and dwelling. The premiums for this segment are originated through a network of independent insurance agents and brokers. Agents or general agencies collect the premiums from the insureds, which are subsequently remitted to STS, net of commissions. Remittances are due 60 days after the closing date of the general agent s account current.

The Company evaluates performance based primarily on the operating revenues and operating income of each segment. Operating revenues include premiums earned, net, administrative service fees and net investment income. Operating costs include claims incurred and operating expenses. The Company calculates operating income or loss as operating revenues less operating costs.

The accounting policies for the segments are the same as those described in the summary of significant accounting policies included in the notes to consolidated financial statements. Services provided between reportable segments are done at transfer prices which approximate fair value. The financial data of each segment

is accounted for separately; therefore no segment allocation is necessary. However, certain operating expenses are centrally managed, therefore requiring an allocation to each segment. Most of these expenses are distributed to each segment based on different parameters, such as payroll hours, processed claims, or square footage, among others. In addition, some depreciable

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assets are kept by one segment, while allocating the depreciation expense to other segments. The allocation of the depreciation expense is based on the proportion of asset used by each segment. Certain expenses are not allocated to the segments and are kept within TSM s operations.

The following tables summarize the operations by operating segment for each of the years in the three-year period ended December 31, 2007, 2006, and 2005.

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	2007	2006	2005
Operating revenues:			
Managed care:			
Premiums earned, net	$ 1,298,776	1,337,070	1,276,307
Fee revenue	14,018	14,089	14,445
Intersegment premiums/fee revenue	6,229	5,531	4,274
Net investment income	19,673	18,852	16,958
Total managed care	1,338,696	1,375,542	1,311,984
Life:			
Premiums earned, net	88,505	86,595	17,130
Intersegment premiums	356	293	
Net investment income	15,016	13,749	3,018
Total life	103,877	100,637	20,148
Property and casualty:			
Premiums earned, net	96,267	87,961	86,767
Intersegment premiums	616	591	
Net investment income	11,849	9,589	8,706
Total property and casualty	108,732	98,141	95,473
Other segments intersegment service revenues *	44,971	53,375	50,004
Total business segments	1,596,276	1,627,695	1,477,609
TSM operating revenues from external sources	656	467	456
Elimination of intersegment premiums	(7,201)	(6,415)	(4,274)
Elimination of intersegment service revenue	(44,971)	(53,375)	(50,004)
Consolidated operating revenues	$ 1,544,760	1,568,372	1,423,787

*

Includes segments that are not required to be reported separately. These segments include the data processing services organization as well as the third-party administrator of health insurance services.

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	2007	2006	2005
Operating income:			
Managed care	$ 57,392	45,472	16,112
Life	10,716	11,196	3,045
Property and casualty	10,740	11,250	12,244
Other segments *	891	1,115	543
Total business segments	79,739	69,033	31,944
TSM operating revenues from external sources	656	467	456
TSM unallocated operating expenses	(7,846)	(6,648)	(5,271)
Elimination of TSM charges	10,903	10,474	6,588
Consolidated operating income	83,452	73,326	33,717
Consolidated net realized investment gains	5,931	837	7,161
Consolidated net unrealized gain (loss) on trading securities	(4,116)	7,699	(4,709)
Consolidated interest expense	(15,839)	(16,626)	(7,595)
Consolidated other income, net	3,217	2,323	3,732
Consolidated income before taxes	$ 72,645	67,559	32,306

	2007	2006	2005
Depreciation expense:			
Managed care	$ 4,277	3,788	3,640
Life	677	750	439
Property and casualty	1,488	775	62
Total business segments	6,442	5,313	4,141
TSM depreciation expense	1,120	1,130	1,089
Consolidated depreciation expense	$ 7,562	6,443	5,230

* Includes segments that are not required

to be reported separately. These segments include the data processing services organization as well as the third-party administrator of health insurance services.

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	2007	2006
Assets:		
Managed care	$ 762,422	600,948
Life	430,807	407,994
Property and casualty	375,415	326,894
Other segments *	11,255	7,807
Total business segments	1,579,899	1,343,643
Unallocated amounts related to TSM:		
Cash, cash equivalents, and investments	82,980	11,879
Property and equipment, net	22,523	23,792
Other assets	2,280	4,096
	107,783	39,767
Elimination entries intersegment receivables and others	(28,140)	(37,901)
Consolidated total assets	$ 1,659,542	1,345,509

	2007	2006
Significant noncash items:		
Net change in unrealized gain on securities available for sale:		
Managed care	$ 2,928	(1,560)
Life	3,253	(1,457)
Property and casualty	3,085	(183)
Total business segments	9,266	(3,200)
Amount related to TSM	283	(12)
Consolidated net change in unrealized gain on securities available for sale	$ 9,549	(3,212)
Net change in liability for pension benefits:		

Managed care	$ 2,838	3,795
Life	35	212
Property and casualty	275	197
Other segments *	844	614
Total business segments	3,992	4,818
Amount related to TSM	98	134
Consolidated net change in liability for pension benefits	$ 4,090	4,952
Adjustment to initially apply SFAS No. 158, net of tax:		
Managed care	$	(10,959)
Life		(1,145)
Property and casualty		(144)
Other segments *		(3,278)
Total business segments		(15,526)
Amount related to TSM		(555)
Consolidated net change in liability for pension benefits	$	(16,081)

* Includes segments that are not required to be reported separately. These segments include the data processing services organization as well as the third-party administrator of health insurance services.

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(27) Quarterly Financial Information (Unaudited)

The results of operations of GA Life are included in the quarterly financial information for the period following January 31, 2006.

	2007				
	March 31	June 30	September 30	December 31	Total
Revenues:					
Premiums earned, net	$ 348,465	377,346	375,803	381,934	1,483,548
Administrative service fees	3,509	3,617	3,908	2,984	14,018
Net investment income	11,121	11,047	11,229	13,797	47,194
Total operating revenues	363,095	392,010	390,940	398,715	1,544,760
Net realized investment gains (losses)	1,196	3,784	1,183	(232)	5,931
Net unrealized investment gain (loss) on trading securities	(1,925)	573	588	(3,352)	(4,116)
Other income (loss), net	209	2,158	(525)	1,375	3,217
Total revenues	362,575	398,525	392,186	396,506	1,549,792
Benefits and expenses:					
Claims incurred	297,318	308,023	310,033	308,401	1,223,775
Operating expenses	56,137	59,358	57,944	64,094	237,533
Total operating costs	353,455	367,381	367,977	372,495	1,461,308
Interest expense	3,952	4,058	3,938	3,891	15,839
Total benefits and expenses	357,407	371,439	371,915	376,386	1,477,147
Income before taxes	5,168	27,086	20,271	20,120	72,645
Income tax expense (benefit):					
Current	1,060	5,938	4,575	4,333	15,906

Deferred	(397)	343	206	(1,931)	(1,779)
Total income taxes	663	6,281	4,781	2,402	14,127
Net income	$ 4,505	20,805	15,490	17,718	58,518
Basic net income per share	$ 0.17	0.78	0.58	0.62	2.15
Diluted net income per share	$ 0.17	0.78	0.58	0.62	2.15

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	2006				
	March 31	June 30	September 30	December 31	Total
Revenues:					
Premiums earned, net	$ 380,531	387,637	390,431	353,027	1,511,626
Administrative service fees	3,429	3,202	3,725	3,733	14,089
Net investment income	10,050	10,766	10,509	11,332	42,657
Total operating revenues	394,010	401,605	404,665	368,092	1,568,372
Net realized investment gains (losses)	528	433	363	(487)	837
Net unrealized investment gain (loss) on trading securities	2,556	(2,245)	3,407	3,981	7,699
Other income (loss), net	1,199	(1,286)	1,295	1,115	2,323
Total revenues	398,293	398,507	409,730	372,701	1,579,231
Benefits and expenses:					
Claims incurred	324,707	332,210	317,388	284,676	1,258,981
Operating expenses	57,730	56,932	55,810	65,593	236,065
Total operating costs	382,437	389,142	373,198	350,269	1,495,046
Interest expense	3,798	4,095	4,493	4,240	16,626
Total benefits and expenses	386,235	393,237	377,691	354,509	1,511,672
Income before taxes	12,058	5,270	32,039	18,192	67,559
Income tax expense (benefit):					
Current	2,636	779	6,130	5,862	15,407
Deferred	41	(128)	1,079	(3,373)	(2,381)
Total income taxes	2,677	651	7,209	2,489	13,026

Net income	$ 9,381	4,619	24,830	15,703	54,533
Basic net income per share	$ 0.35	0.17	0.93	0.59	2.04
Diluted net income per share	$ 0.35	0.17	0.93	0.59	2.04

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TRIPLE-S MANAGEMENT CORPORATION
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(With Independent Auditors Report Thereon)

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Triple-S Management Corporation:

Under date of March 7, 2008, we reported on the consolidated balance sheets of Triple-S Management Corporation and Subsidiaries (the Company) as of December 31, 2007 and 2006, and the related consolidated statements of earnings, stockholders equity and comprehensive income, and cash flows for each of the years in the three-year period ended December 31, 2007 as contained in the 2007 annual report to stockholders. Our report refers to the adoption of the recognition and disclosure provisions of Statement of Financial Accounting Standards No. 158, *Employer s Accounting for Defined Benefit Pension and Other Postretirement Plans,* as of December 31, 2006. These consolidated financial statements and our report thereon are included in the annual report on Form 10-K for the year 2007. In connection with our audits of the aforementioned consolidated financial statements, we also audited the related financial statement schedules as listed in Item 15. These financial statement schedules are the responsibility of the Company s management. Our responsibility is to express an opinion on these financial statement schedules based on our audits.

In our opinion, such financial statement schedules, when considered in relation to the basic consolidated financial statements taken as a whole, present fairly, in all material respects, the information set forth therein.

/s/ KPMG LLP
San Juan, Puerto Rico
March 7, 2008
Stamp No 2222075 of the Puerto Rico
Society of Certified Public Accountants
was affixed to the record copy of this report.

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TRIPLE-S MANAGEMENT CORPORATION
(Parent Company Only)
Balance Sheets
December 31, 2007 and 2006
(Dollar amounts in thousands, except per share data)

	2007	2006
Assets		
Current assets:		
Cash and cash equivalents	$ 47,772	1,224
Receivables:		
Due from subsidiaries*	597	360
Other	25	29
Total receivables	622	389
Investment in securities	35,208	9,655
Prepaid income tax	111	
Net deferred tax assets	367	218
Accrued interest	173	79
Other assets	198	523
Total current assets	84,451	12,088
Notes receivable from subsidiaries*	57,000	79,000
Investment in securities		1,000
Accrued interest on note receivable from subsidiaries	8,151	4,001
Net deferred tax assets	543	574
Investments in wholly owned subsidiaries*	448,579	377,341
Property and equipment, net	22,523	23,792
Other assets	863	912
Total assets	$ 622,110	498,708
Liabilities and Stockholders Equity		
Current liabilities:		
Current portion of long-term debt	$ 1,640	12,140
Due to subsidiary*	6,015	15,159
Accounts payable and accrued expenses	8,045	6,465
Income taxes payable		291
Total current liabilities	15,700	34,055
Long-term debt	119,306	120,947
Liability for pension benefits	4,566	1,107
Total liabilities	139,572	156,109

Stockholders equity:		
Common stock Class A, $1 par value. Authorized 100,000,000 shares; issue and outstanding 16,042,809 and 26,733,000 shares at December 31, 2007 and 2006, respectively	16,043	26,733
Common stock Class B, $1 par value. Authorized 100,000,000 shares; issue and outstanding 16,266,554 at December 31,2007	16,266	
Additional paid-in capital	188,935	124,031
Retained earnings	267,336	211,266
Accumulated other comprehensive loss, net	(6,042)	(19,431)
	482,538	342,599
Commitments and contingencies		
Total liabilities and stockholders equity	$ 622,110	498,708

* Eliminated in consolidation.

See accompanying independent registered public accounting firm s report and notes to financial statements.

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TRIPLE-S MANAGEMENT CORPORATION
(Parent Company Only)
Statements of Earnings
Years ended December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

	2007	2006	2005
Rental income*	$ 7,096	6,897	6,724
Management fees	3,880	3,650	
General and administrative expenses	(7,846)	(6,648)	(5,271)
Operating income	3,130	3,899	1,453
Other revenue (expenses):			
Equity in net income of subsidiaries	57,980	53,632	27,604
Interest expense, net of interest income of $5,477, $6,088, and $1,809 in 2007, 2006, and 2005, respectively*	(2,557)	(2,078)	(336)
Other income	397		
Total other revenue, net	55,820	51,554	27,268
Income before income taxes	58,950	55,453	28,721
Income tax expense (benefit):			
Current	520	772	208
Deferred	(88)	148	80
Total income tax expense, net	432	920	288
Net income	$ 58,518	54,533	28,433

* Eliminated in consolidation.
See accompanying independent registered public accounting firm s report and notes to financial statements.

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TRIPLE-S MANAGEMENT CORPORATION
(Parent Company Only)
Statements of Stockholders Equity and Comprehensive Income
Years ended December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

	Common stock Class A	Common stock Class B	Additional paid-in capital	Retained earnings	Accumulated other comprehensive income (loss)	Total
Balance, December 31, 2004	$ 26,712		124,052	134,531	16,138	301,433
Comprehensive income:						
Net income				28,433		28,433
Net unrealized change in fair value of available for sale securities					(18,832)	(18,832)
Net change in minimum pension liability					(2,788)	(2,788)
Net change in fair value of cash-flow hedges					457	457
Total comprehensive income						7,270
Balance, December 31, 2005	26,712		124,052	162,964	(5,025)	308,703
Dividends declared				(6,231)		(6,231)
Adjustment to initially apply SFAS No. 158, net of tax					(16,081)	(16,081)
Other	21		(21)			
Comprehensive income:						
Net income				54,533		54,533
Net unrealized change in fair value of available for sale securities					(3,212)	(3,212)
Net change in minimum pension liability					4,952	4,952
Net change in fair value of cash-flow hedges					(65)	(65)
Total comprehensive income						56,208
	26,733		124,031	211,266	(19,431)	342,599

Balance, December 31, 2006						
Dividends declared				(2,448)		(2,448)
Sale of stock in public offering	(10,813)	16,100	64,992			70,279
Grant of resticted Class B common stock		166				166
Share-based compensation			34			34
Other	123		(122)			1
Comprehensive income:						
Net income				58,518		58,518
Net unrealized change in fair value of available for sale securities					9,549	9,549
Defined benefit pension plan:						
Prior service cost, net					3,935	3,935
Actuarial loss					155	155
Net change in fair value of cash-flow hedges					(250)	(250)
Total comprehensive income						71,907
Balance, December 31, 2007	$ 16,043	16,266	188,935	267,336	(6,042)	482,538

See accompanying independent registered public accounting firm s report and notes to financial statements.

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TRIPLE-S MANAGEMENT CORPORATION
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Statements of Cash Flows
Years ended December 31, 2007, 2006, and 2005
(Dollar amounts in thousands, except per share data)

	2007	2006	2005
Cash flows from operating activities:			
Net income	$ 58,518	54,533	28,433
Adjustments to reconcile net income to net cash provided by (used in) operating activities:			
Equity in net income of subsidiaries*	(57,980)	(53,632)	(27,604)
Depreciation and amortization	1,120	1,130	1,090
Share-based compensation	200		
Provision for obsolescence		(83)	(25)
Deferred income tax (benefit) expense	(88)	148	80
Other	(394)		
Changes in assets and liabilities:			
Receivables*	(233)	1,062	(583)
Accrued interest*	(4,244)	(1,842)	(1,354)
Prepaid income tax and other assets	(146)	517	(2,553)
Accounts payable, accrued expenses, liability for pension benefit and due to subsidiary*	(3,945)	6,807	3,948
Income taxes payable	(291)	291	
Net cash (used in) provided by operating activities	(7,483)	8,931	1,432
Cash flows from investing activities:			
Acquisition of investment in securities classified as available for sale	(28,202)		(3,000)
Proceeds from sale and maturities of investment in securities classified as available for sale	4,393	335	
Notes receivable from subsidiaries*	22,000	4,000	(57,000)
Acquisition of business		(38,196)	
Net retirement (acquisition) of property and equipment	149	(162)	(273)
Net cash used in investing activities	(1,660)	(34,023)	(60,273)
Cash flows from financing activities:			
Dividends	(2,448)	(6,231)	
Repayments of long-term borrowings	(12,141)	(2,503)	(5,140)
Proceeds from long-term borrowings		35,000	60,000
Net proceeds from initial public offering	70,279		
Other	1		
Net cash provided by financing activities	55,691	26,266	54,860
Net increase (decrease) in cash and cash equivalents	46,548	1,174	(3,981)
Cash and cash equivalents, beginning of year	1,224	50	4,031

Cash and cash equivalents, end of year	$ 47,772	1,224	50
Supplemental information:			
Income taxes paid	$ 922	402	170
Interest paid	7,751	7,809	2,093
Noncash activities:			
Change in net unrealized gain on securities available for sale, including deferred income tax liability of $67, $2, and $805 in 2007, 2006 and 2005, respectively	$ 9,549	(3,212)	(18,832)
Change in cash-flow hedges, including deferred tax liability of $37 and $196,$236 in 2007, 2006 and 2005, respectively	(250)	(65)	457
Change in liability for pension benefits and deferred income tax asset of $9,502, $2,340, and $5,303, in 2007, 2006, and 2005, respectively	4,090	4,952	(2,788)
Adjustment to initially apply SFAS No. 158, including deferred income tax effect of $10,152 in 2006		(16,081)	

* Eliminated in consolidation.

See accompanying independent registered public accounting firm s report and notes to financial statements.

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(1) Organization

Triple-S Management Corporation (the Company or TSM) was incorporated under the laws of the Commonwealth of Puerto Rico on January 17, 1997 to engage, among other things, as the holding company of entities primarily involved in the insurance industry.

The Company has the following wholly owned subsidiaries that are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance): (a) Triple-S, Inc. (TSI) a managed care organization, that provides health benefits services to subscribers through contracts with hospitals, physicians, dentists, laboratories, and other organizations located mainly in Puerto Rico; (b) Triple-S Vida, Inc. (TSV), which is engaged in the underwriting of life and accident and health insurance policies and the administration of annuity contracts; and (c) Seguros Triple-S, Inc. (STS), which is engaged in the underwriting of property and casualty insurance policies. The Company and TSI are members of the Blue Cross and Blue Shield Association (BCBSA).

Effective January 31, 2006, the Company completed the acquisition of 100% of the common stocks of Great American Life Assurance Company of Puerto Rico (GA Life) (now Triple-S Vida, Inc.) and effective June 30, 2006, the Company merged the operations of its former life and accident and health insurance subsidiary, Seguros de Vida Triple-S, Inc. (SVTS), into the GA Life. The results of operations and financial position of GA Life are included as part of equity in net income of subsidiaries in the accompanying statements of earnings for the period following January 31, 2006. Effective November 1, 2007 GA Life changed its name to Triple-S Vida, Inc., after receiving required regulatory approvals.

The Company also has two other wholly owned subsidiaries, Interactive Systems, Inc. (ISI) and Triple-C, Inc. (TC). ISI is mainly engaged in providing data processing services to the Company and its subsidiaries. TC is mainly engaged as a third party administrator for TSI in the administration of the Commonwealth of Puerto Rico Health Care Reform business (the Reform). Also, TC provides health care advisory services to TSI and other health insurance-related services to the health insurance industry.

A substantial majority of the Company s business activity through its subsidiaries is with insureds located throughout Puerto Rico and, as such, the Company is subject to the risks associated with the Puerto Rico economy.

(2) Significant Accounting Policies

The significant accounting policies followed by the Company are set forth in the notes to the consolidated financial statements of the Company referred to in Item 15 to the Annual Report on Form 10-K.

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(3) Property and Equipment, Net

Property and equipment as of December 31 are composed of the following:

	2007	2006
Land	$ 6,531	6,531
Buildings and leasehold improvements	27,778	27,927
	34,309	34,458
Less accumulated depreciation and amortization	(11,786)	(10,666)
Property and equipment, net	$ 22,523	23,792

(4) Investment in Wholly Owned Subsidiaries

Summarized combined financial information for the Company s wholly owned subsidiaries as of and for the years ended December 31, 2007 and 2006 is as follows:

	2007	2006
Assets		
Cash, cash equivalents, and investments	$ 1,168,182	943,784
Receivables, net	216,525	186,919
Other assets	195,192	212,940
Total assets	$ 1,579,899	1,343,643
Liabilities and Equity		
Claim liabilities	$ 353,830	314,682
Future policy benefits related to funds withheld reinsurance	194,131	180,420
Unearned premiums	132,599	113,582
Annuity contracts	46,083	45,509
Accounts payable and other liabilities	404,677	312,109
Total liabilities	1,131,320	966,302
Stockholders equity	448,579	377,341
Total liabilities and equity	$ 1,579,899	1,343,643

The net income of the subsidiaries during the three-year period ended December 31, 2007 was $57,980, $53,632, and $27,604. The Company allocates to its subsidiaries certain expenses incurred in the administration of their operations. Total charges including other expenses paid on behalf of the subsidiaries amounted to $4,989, $4,346 and $3,828, in the three-year period ended December 31, 2007.

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TRIPLE-S MANAGEMENT CORPORATION
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(5) Long-Term Borrowings

A summary of the long-term borrowings entered by the Company at December 31, 2007 and 2006 follows:

	2007	2006
Secured note payable of $20,000, payable in various installments through August 31, 2007, with interest payable on a monthly basis at a rate reset periodically of 130 basis points over selected LIBOR maturity (which was 6.67% at December 31, 2006.)	$	10,500
Senior unsecured notes payable of $60,000 due December 2020. Interest is payable monthly at a fixed rate of 6.60%.	60,000	60,000
Senior unsecured notes payable of $35,000 due January 2021. Interest is payable monthly at a fixed rate of 6.70%.	35,000	35,000
Secured loan payable of $41,000, payable in monthly installments of $137 through July 1, 2024, plus interest at a rate reset periodically of 100 basis points over selected LIBOR maturity (which was 6.24% and 6.35% at December 31, 2007 and 2006, respectively).	25,946	27,587
	120,946	133,087
Less current maturities	(1,640)	(12,140)
Total loans payable to bank	$ 119,306	120,947

Aggregate maturities of the Company s long term borrowings as of December 31, 2007 are summarized as follows:

2008	$ 1,640
2009	1,640
2010	1,640
2011	1,640
2012	1,640
Thereafter	112,746
	$ 120,946

All of the Company s senior notes can be prepaid at par, in total or partially, five years after issuance as determined by the Company. The Company s senior unsecured notes contain certain covenants with which the

Company has complied with at December 31, 2007.

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Debt issuance costs related to each of the Company s senior unsecured notes were deferred and are being amortized over the term of its respective senior note. Unamortized debt issuance costs related to these senior unsecured notes as of December 31, 2007 and 2006 amounted to $768 and $828, respectively, and are included within the other assets in the accompanying balance sheets.

The secured loan note payable previously described is guaranteed by a first position held by the bank on the Company s and its subsidiaries land, building, and substantially all leasehold improvements, as collateral for the term of the loans under a continuing general security agreement. This secured loan contains certain covenants, which are customary in this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitation on changes in control. As of December 31, 2007, the Company is in compliance with these covenants.

The Company was also a party to another secured loan whose outstanding balance of $10,500 was repaid upon its maturity on August 1, 2007.

Interest expense on the above long-term borrowings amounted to $8,415, $8,545 and $2,018, in the three-year period ended December 31, 2007.

(6) Income Taxes

The Company is subject to Puerto Rico income taxes. Under Puerto Rico income tax law, the Company is not allowed to file consolidated tax returns with its subsidiaries. As of December 31, 2007, tax years 2003 through 2006 are subject to examination by Puerto Rico taxing authorities.

On January 1, 2007, the Company adopted the provisions of FASB Interpretation No.48, *Accounting for Uncertainty in income Taxes an Interpretation of FASB statement No.109;* no adjustment was required upon the adoption of this accounting pronouncement.

The income tax expense differs from the amount computed by applying the Puerto Rico statutory income tax rate to net income before income taxes as a result of the following:

	2007	2006	2005
Income tax expense at statutory rate of 39%	$ 22,990	21,626	11,201
Increase (decrease) in taxes resulting from:			
Equity in net income of wholly owned subsidiaries	(22,612)	(20,916)	(10,765)
Disallowances	154	37	(68)
Other, net	(100)	173	(80)
Total income tax expense	$ 432	920	288

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Deferred income taxes reflect the tax effects of temporary differences between carrying amounts of assets and liabilities for financial reporting purposes and income tax purposes. The net deferred tax asset at December 31, 2007 and 2006 is composed of the following:

	2007	2006
Deferred tax assets:		
Employee benefits plan	$ 388	292
Accumulated depreciation	356	379
Liability for pension benefits	344	406
Deferred compensation	155	121
Postretirement benefits		17
Unrealized loss on securities available for sales		60
Gross deferred tax assets	1,243	1,275
Deferred tax liabilities:		
Unamortized bond issue costs	(196)	(211)
Postretirement benefits	(54)	
Cash-flow hedges	(37)	(196)
Unrealized loss on securities available for sales	(7)	
Other	(39)	(76)
Gross deferred tax liabilities	(333)	(483)
Net deferred tax asset	$ 910	792

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management believes that it is more likely than not that the Company will realize the benefits of these deductible differences.

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(7) Transaction with Related Parties

The following are the significant related-party transactions made for the three-year period ended December 31, 2007, 2006 and 2005:

	2007	2006	2005
Rent charges to subsidiaries	$7,023	6,824	6,588
Interest charged to subsidiary on notes receivable	4,821	5,620	1,353

(8) Contingencies

At December 31, 2007 and 2006, the Company is defendant in various lawsuits in the ordinary course of business. In the opinion of management, with the advice of its legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the position and results of operations of the Company.

(9) Business Combinations

Effective January 31, 2006, the Company acquired 100% of the common stock of GA Life. As a result of this acquisition, the Corporation became one of the leading providers of life insurance policies in Puerto Rico. The acquisition was accounted by the Company in accordance with the provisions of SFAS No. 141, *Business Combinations*. The equity in net income of GA Life is included in the accompanying financial statements for the period following the effective date of the acquisition. The aggregate purchase price of the acquired entity amounted to $38,196; of this amount $37,500 was paid in cash on January 31, 2006 and $696 are direct costs related to the acquisition.

The following table summarizes the estimated fair value of the assets acquired and liabilities assumed at the date of acquisition.

Current assets	$ 219,747
Property and equipment	1,500
Value of business acquired	22,823
Total assets acquired	244,070
Total liabilities assumed	(205,874)
Net assets acquired	$ 38,196

The estimated fair value of the value of business acquired was actuarially determined by discounting after-tax profits at a risk rate of return equal to approximately 12%. After-tax profits were forecasted based upon models of the insurance in-force, actual invested assets as of acquisition date and best-estimate actuarial assumptions regarding premium income, claims, persistency, expenses and investment income accruing from invested assets plus reinvestment of positive cash flows. The best-estimate actuarial assumptions

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were based upon GA Life s recent experience in each of its major life and health insurance product lines. The amount of value of business acquired is to be amortized, considering interest, over the anticipated premium-paying period of the related policies in proportion to the ratio of annual premium revenue to the expected total premium revenue to be received over the life of the policies.

(10) Stockholders Equity

(a) Common Stock

On April 24, 2007, the Company s Board of Directors (the Board) authorized a 3,000-for-one stock split of its Class A common stock effected in the form of a dividend of 2,999 shares for every one share outstanding. This stock split was effective on May 1, 2007 to all stockholders of record at the close of business on April 24, 2007. The total number of authorized shares and par value per share were unchanged by this action. The par value of the additional shares resulting from the stock split was reclassified from additional paid in capital to common stock. All references to the number of shares and per share amounts in these consolidated financial statements are presented after giving retroactive effect to the stock split.

In May 2007, the Company cancelled 24,000 director qualifying shares. Since February 2007, Board members are no longer required to hold qualifying shares to participate in the Board of Directors of the Company.

In December 7, 2007, the Company completed the initial public offering (IPO) of its Class B common stock. In this public offering the Company sold 16,100,000 shares, 10,813,191 of which were shares previously owned by selling shareholders. Proceeds received under this public offering amounted to $70,279, net of $6,248 of expenses directly related to the offering.

For a period of five years after the completion of our IPO, subject to the extension or shortening under certain circumstances, each holder of Class B common stock will benefit from anti-dilution protections provided in our amended and restated articles of incorporation.

(b) Preferred Stock

Authorized capital stock includes 100,000,000 of preferred stock with a par vale of $1.00 per share. As of December 31, 2007 and 2006, there are no issued and outstanding preferred stock shares.

(c) Dividends

On March 12, 2007, the Board declared a cash dividend of $2,448 distributed pro rata among all of the Company s issued and outstanding Class A common shares, excluding those shares issued to the representatives of the community that are members of the Board (the qualifying shares). All stockholders of record as of the close of business on March 23, 2007, except those who only hold qualifying shares, received a dividend per share of $0.09 for each share held on that date.

On January 13, 2006, the Board declared a cash dividend of $6,231 distributed pro rata among all of the Company s issued and outstanding Class A common shares, excluding qualifying shares. All

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stockholders of record as of the close of business on January 16, 2006, except those who only hold qualifying shares, received a dividend per share of $0.23 for each share held on that date.

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Triple-S Management Corporation and Subsidiaries
Schedule III - Supplementary Insurance Information
For the years ended December 31, 2007, 2006 and 2005

nts in thousands)	Deferred Policy Acquisition Costs and Value of Business Acquired	Claim Liabilities	Liability for Future Policy Benefits	Unearned Premiums	Other Policy Claims and Benefits Payable	Premium Revenue	Net Investment Income	Claims Incurred	Amortization of Deferred Policy Acquisition Costs and Value of Business Acquired	Other Operating Expenses
	$	$ 201,604	$	$ 27,923	$	$ 1,301,792	$ 19,673	$ 1,133,241	$	$ 148,063
	93,564	35,485	194,131	2,931		88,861	15,016	45,669	16,033	31,459
casualty insurance	23,675	116,741		101,745		96,883	11,849	44,865	28,917	24,210
ortable segments,										
ny operations and										
ing entries.						(3,988)	656			(11,149)
	$ 117,239	$ 353,830	$ 194,131	$ 132,599	$	$ 1,483,548	$ 47,194	$ 1,223,775	$ 44,950	$ 192,583
	$	$ 185,249	$	$ 17,812	$	$ 1,339,807	$ 18,852	$ 1,173,622	$	$ 156,448
	88,590	35,164	180,420	1,960		86,888	13,749	43,619	16,339	29,483
casualty insurance	22,827	94,269		93,810		88,552	9,589	41,740	25,118	20,033
ortable segments,										
ny operations and										
ing entries.						(3,621)	467			(11,356)
	$ 111,417	$ 314,682	$ 180,420	$ 113,582	$	$ 1,511,626	$ 42,657	$ 1,258,981	$ 41,457	$ 194,608
	$	$ 178,978	$	$ 8,829	$	$ 1,279,511	$ 16,849	$ 1,155,878	$	$ 139,994
	61,677	22,478		181	118,635	17,130	3,018	8,902	264	7,937
casualty insurance	19,891	96,107		86,693		86,767	8,706	43,587	23,137	16,505

ortable segments, ny operations and ing entries.				(3,204)	456				(6,134)
	$ 81,568	$ 297,563	$	$ 95,703	$ 118,635	$ 1,380,204	$ 29,029	$ 1,208,367	$ 23,401	$ 158,302

See accompanying independent registered public accounting firm s report.

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Triple-S Management Corporation and Subsidiaries
Schedule IV - Reinsurance
For the years ended December 31, 2007, 2006 and 2005
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	Gross Amount	Ceded to Other Companies (1)	Assumed from Other Companies	Net Amount	Percentage of Amount Assumed to Net
2007					
Life insurance in force	$ 10,321,749	2,459,100		7,862,649	0.0%
Premiums:					
Life insurance	$ 97,700	8,839		88,861	0.0%
Accident and health insurance	1,305,141	3,349		1,301,792	0.0%
Property and casualty insurance	170,884	69,137		101,747	0.0%
Total premiums	$ 1,573,725	81,325		1,492,400	0.0%
2006					
Life insurance in force	$ 10,433,690	6,957,946		3,475,744	0.0%
Premiums:					
Life insurance	$ 89,736	9,397	4,413	84,752	5.2%
Accident and health insurance	1,341,952	2,145		1,339,807	0.0%
Property and casualty insurance	158,975	65,723		93,252	0.0%
Total premiums	$ 1,590,663	77,265	4,413	1,517,811	0.3%
2005					
Life insurance in force	$ 4,443,620	1,887,180		2,556,440	0.0%
Premiums:					
Life insurance	$ 24,195	7,465	400	17,130	2.3%
Accident and health insurance	1,285,805	6,294		1,279,511	0.0%
Property and casualty insurance	151,127	59,244		91,883	0.0%

Total premiums	$ 1,461,127	73,003	400	1,388,524	0.0%

(1) Premiums ceded on the life insurance business are net of commission income on reinsurance amounting to $258, $275 and $541 for the years ended December 31, 2007, 2006 and 2005.

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Triple-S Management Corporation and Subsidiaries
Schedule V - Valuation and Qualifying Accounts
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	Balance at Beginning of Period	Additions Charged to Costs and Expenses	Additions Charged to Other Accounts - Describe (1)	Deductions - Describe (2)	Balance at End of Period
2007					
Allowance for doubtful receivables	$ 18,230	6,661		(8,966)	15,925
2006					
Allowance for doubtful receivables	$ 12,240	8,570	1,380	(3,960)	18,230
2005					
Allowance for doubtful receivables	$ 11,173	3,829		(2,762)	12,240

(1) Represents amount of allowance for doubtful accounts acquired upon the purchase of GA Life and other adjustments.

(2) Deductions represent the write-off of accounts deemed uncollectible.

See accompanying independent registered public accounting firm s report.