TRIPLE-S MANAGEMENT CORP
Form 10-K
March 10, 2017

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2016

TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____ to _____

COMMISSION FILE NUMBER 001-33865

Triple-S Management Corporation

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

1441 F.D. Roosevelt Avenue, San Juan, PR 00920
(787) 749-4949

Securities registered pursuant to Section 12(b) of the Act:

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

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

Indicate by check mark if the registrant is well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
Yes No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.
Yes No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the

preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).
Yes No

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

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

| | |
|---|---|
| Large accelerated filer | Accelerated filer |
| Non-accelerated filer | Smaller reporting company |

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2016 was approximately $577,239,532 for the Class B common stock (the only stock of the registrant that trades in a public market) and $950,968 for the Class A common stock (valued at its par value of $1.00 since it is not publicly traded).

As of February 28, 2017, the registrant had 950,968 of its Class A common stock outstanding and 23,320,899 of its 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 on April 28, 2017 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, 2016

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Part I

Item 1. Business

General Description of Business and Recent Developments

Triple-S Management Corporation ("Triple-S", "TSM", the "Company", the "Corporation", "we", "us" or "our") is one of the l significant players in the managed care industry in Puerto Rico, serving approximately 1,017,000 members, with a 25% market share in terms of premiums written in Puerto Rico for the nine-month period ended September 30, 2016. We have the exclusive right to use the Blue Cross and Blue Shield ("BCBS") name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla and over 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the Commercial, Medicaid and Medicare markets. We market our managed care products through an extensive network of independent agents and brokers located throughout Puerto Rico as well as an internal salaried sales force. We provided administration services only or self insured ("ASO") managed care services to the Plan de Salud del Gobierno (similar to Medicaid) ("PSG" or "Medicaid") island-wide until March 31, 2015. Effective April 1, 2015, the government changed the Medicaid delivery model from an ASO to a risk-based model and we elected to participate in this sector as a fully-insured provider in only two of the eight regions of Puerto Rico. PSG is funded by the Government of Puerto Rico and the U.S. Government.

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

A substantial majority of our premiums are from customers within Puerto Rico. In addition, most of all of our long-lived assets, other than financial instruments, including deferred policy acquisition costs and value of business acquired, goodwill and other intangibles, and the deferred tax assets are related to Puerto Rico.

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 of the audited consolidated financial statements for the years ended December 31, 2016, 2015 and 2014.

On October 12, 2016, the Centers for Medicare & Medicaid Services ("CMS") published the STAR Ratings for payment year 2018. Our Health Maintenance Organization ("HMO") contract, scored 4.0 overall on a 5.0 star rating system, increasing 1.0 versus the prior year, and achieved 5 stars in Part D, demonstrating our dedication to providing the highest quality of care for our members as well as the investments we have made in technology and systems. Our Preferred Provider Organization ("PPO") contract, scored 3.5 overall, maintaining the rating from the previous year and achieved 4.5 stars in Part D. No Medicare Advantage plan in Puerto Rico has achieved more than a 4 overall star rating. Star ratings are calculated annually and are subject to change each year.

In February our subsidiary Triple-S Salud, Inc. ("TSS") was granted Utilization Review Accreditation Commission ("URAC") effective March 1, 2017. This was a new requirement for the Federal Employees Program representing over $175 million in premiums. The accreditation is extensive to the whole Commercial and Medicaid lines of business since they are managed in the same operational platforms as the Federal Employees Program. These achievements evidence the corporate commitment to quality in health services for our members and affiliates.

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.

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Industry Overview

Managed Care

In response to an increasing focus on health care costs by employers, the government and consumers, there has been a increase in alternatives to traditional indemnity health insurance, such as HMOs and PPOs. Through the introduction of these alternatives the managed care industry has attempted to contain the cost of health care by negotiating contracts with hospitals, physicians and other providers to deliver health care to plan members at favorable rates. These products usually feature medical management and other quality and cost optimization measures such as pre-admission review and approval for certain non-emergency services, pre-authorization of certain outpatient surgical procedures, network credentialing to determine that network doctors and hospitals have the required certifications and expertise, and various levels of care management programs to help members better understand and navigate the medical system. In addition, providers may have incentives to achieve certain quality measures or may share medical cost risk. Members generally pay co-payments, coinsurance and deductibles when they receive services. While the distinctions between the various types of plans have lessened over recent years, PPO products generally provide reduced benefits for out-of-network services, while traditional HMO products generally provide little to no reimbursement for non-emergency out-of-network utilization. An HMO plan may also require members to select one of the network primary care physicians ("PCPs") to coordinate their care and approve any specialist or other services.

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

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

Life Insurance

Total annual premiums in Puerto Rico for the year ended December 31, 2015 for the life insurance market approximated $1.5 billion. The main products in this market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are independent agents. Banks have established general agencies to cross sell life insurance products, such as term life and credit life.

Property and Casualty Insurance

The total property and casualty market in Puerto Rico in terms of gross premiums written for the nine months ended September 30, 2016 was approximately $1.3 billion. Property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi-peril, fire and allied lines and other general liabilities. Approximately 69% of the market is written by the top six companies in terms of market share, and approximately 88% of the market is written by companies incorporated under the laws of and which operate principally in Puerto Rico.

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

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Puerto Rico's Economy

The dominant sectors of the Puerto Rico economy in terms of production and income are manufacturing and services. The current manufacturing sector now places increased emphasis on higher wages, high technology industries, such as pharmaceuticals, biotechnology, computers, microprocessors, professional and scientific instruments, and certain high technology machinery and equipment with almost 90% of manufacturing generated by chemical and electronic products. The services sector, which includes finance, insurance, real estate, wholesale and retail trade, transportation, communications and public utilities, and other services, plays a major role in the economy. It ranks second to manufacturing in contribution to the gross domestic product and leads all sectors in providing employment.

The economy of Puerto Rico is affected by external factors determined by the U.S. economy and the policies and results of the U.S. government. These external factors include exports, direct investment, the amount of federal transfer payments, the level of interest rates, the rate of inflation, and revenues derived from tourism coming from the U.S. Generally, the economy of Puerto Rico has followed the economic trends of the U.S. economy. However, recently the economic growth in Puerto Rico has not been consistent with the performance of the United States economy. The government of Puerto Rico has faced a number of fiscal challenges, including an imbalance between its general fund revenues and expenditures, reaching its highest level in fiscal year 2009 with a deficit of $3.3 billion. Recurrent budget deficits have substantially increased the amount of public sector debt. The total outstanding public sector debt amounted to $68.7 billion as of July 31, 2016. In 2016, Puerto Rico defaulted on various types of debt, which included General Obligation bonds, after a local debt moratorium provision was evoked.

On June 30, 2016, the President of the United States signed the Puerto Rico Oversight, Management, and Economic Stability Act ("PROMESA"), which grants the Commonwealth of Puerto Rico (the "government" or the "Commonwealth") and its component units, access to an orderly mechanism to restructure their debts in exchange for significant federal oversight over the Commonwealth's finances. In general, PROMESA seeks to provide Puerto Rico with fiscal and economic discipline through the creation of a control board, relief from creditor lawsuits through the enactment of a temporary stay on litigation, and two alternative methods to adjust unsustainable debt.

See "Item 1A. Risk Factors—Risks Related to Our Business – Our business is geographically concentrated in Puerto Rico and weakness in the economy and the fiscal health of the government has adversely impacted and may continue to adversely impact us.''

Products and Services

Managed Care

Through our subsidiaries TSS and Triple-S Advantage, Inc. ("TSA"), we offer a broad range of managed care products, including HMO plans, PPO plans, Medicare Supplement, Medicare Advantage, and Medicaid plans. Managed care products represented approximately 92% of our consolidated premiums earned before elimination, net for each of the years ended December 31, 2016, 2015 and 2014. We design our products to meet the needs and objectives of a wide range of customers, including employers, professional and trade associations, individuals and government entities. Our customers either contract with us to assume underwriting risk or they self-fund underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members' access to providers is subject to referral or preauthorization requirements.

Managed care generally refers to a method of integrating the financing and delivery of health care within a system that manages the cost, accessibility and quality of care. Managed care products can be further differentiated by the types of provider networks offered, the ability to use providers outside such networks and the scope of the medical

management and quality assurance programs. Our members receive medical care from our networks of providers in exchange for premiums paid by the individuals or their employers, including governmental entities, and, in some instances, a cost-sharing payment between the employer and the member. We reimburse network providers according to pre-established fee arrangements and other contractual agreements.

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We currently offer the following managed care plans:

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

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

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

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

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

Life Insurance

We offer a wide variety of life, accident, disability and health and annuity products in Puerto Rico through our subsidiary Triple-S Vida, Inc. ("TSV"). Life insurance premiums represented approximately 6% of our consolidated premiums earned, net before elimination for the years ended December 31, 2016 and 2015, and 7% for the year ended December 31, 2014. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases ("Cancer" line of business), and pre-need life products are marketed through independent agents. TSV is the leading distributor of life products in Puerto Rico. We are the only home service company in Puerto Rico and offer guaranteed issue, funeral and cancer policies to the lower and middle income market segments directly to people in their homes. We also market our group life and disability coverage through our independent producers.

Property and Casualty Insurance

We offer a wide range of property and casualty insurance products through our subsidiary Triple-S Propiedad, Inc. ("TSP"). Property and casualty insurance premiums represented approximately 4% of our consolidated premiums earned, net before elimination for each of the years ended December 31, 2016, 2015 and 2014. Our predominant insurance products are commercial multi-peril package, personal package, commercial auto, hospital malpractice, commercial liability, and commercial property. This segment's commercial products target small to medium size accounts.

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

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Our policy is to enter into reinsurance agreements with reinsurers considered to be financially sound. Practically all our reinsurers have an A.M. Best rating of ''A-'' or better, or an equivalent rating from other rating agencies. During the year ended December 31, 2016, 36.2% of the premiums written in the property and casualty insurance segment were ceded to reinsurers. Although these reinsurance arrangements do not relieve us of our direct obligations to our insured, we believe that the risk of our reinsurers not paying balances due to us is low.

Marketing and Distribution

Our marketing activities concentrate on promoting our strong brands, quality care, customer service efforts, size and quality of provider networks, flexibility of plan designs, financial strength and breadth of product offerings. We distribute and market our products through several channels, including our salaried and commission-based internal sales force, direct mail, independent brokers and agents, telemarketing staff, traditional media (TV, Press, Billboards, Radio and Cinema) and Digital Media.

Branding and Marketing

Our branding and marketing efforts include “brand advertising”, which focuses on the Triple-S name and the BCBS mark for our managed care products and services, “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 strong name recognition and comfort level that many existing and potential customers associate with this brand. Acquisition marketing consists of business-to-business marketing efforts to generate leads for brokers and our sales force as well as direct-to-consumer marketing efforts which are used to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall company image. We believe these efforts support and further our competitive brand advantage. We will continue to utilize the Triple-S name and the BCBS mark for all managed care products and services in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla.

Sales and Marketing

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

Distribution

Managed Care Segment. We rely principally on our internal sales force and a network of independent brokers and agents to market our products. Individual policies are sold entirely through independent agents who exclusively sell our individual products, and Medicare Advantage and group products are sold through our 320 person internal sales force (promotors and sales representatives) as well through approximately 150 independent brokers and agents. We believe that each of these marketing methods is optimally suited to address the specific needs of the customer base to which it is assigned.

Strong competition exists among managed care companies for brokers and agents with proven 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.

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Life Insurance Segment In our life insurance segment, we offer our insurance products through our own network of both company-employed and independent agents. The majority of our premiums (64% in 2016 and 59% in 2015) were placed through our home service distribution channel selling directly to customers in their homes. TSV employs approximately 645 full-time active agents and managers and utilizes approximately 400 independent agents and brokers. For individual policies, we advance first year commissions upon issuance and for group policies, we pay commissions on a monthly basis based on premiums received.

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is exclusively subscribed through approximately 13 general agencies, including our insurance agency, Triple-S Insurance Agency, Inc. ("TSIA"), where business is placed by independent insurance agents and brokers. During the years ended December 31, 2016, 2015 and 2014 TSIA placed approximately 73%, 73% and 69% of TSP's total premium volume, respectively. General agencies contracted by TSP remit premiums net of their respective commission.

Customers

Managed Care

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico. The following table sets forth enrollment information with respect to each sector at December 31, 2016:

| Market Sector | Enrollment at December 31, 2016 | Percentage of Total Enrollment | |
|---|---|---|---|
| Commercial | 509,157 | 50.1 | % |
| Medicare | 110,297 | 10.8 | % |
| Medicaid | 397,918 | 39.1 | % |
| Total | 1,017,372 | 100.0 | % |

Commercial Sector

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

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

Federal Government Employees. For over 40 years, we have maintained our leadership in providing managed care services to federal government employees in Puerto Rico. We provide our services to these employees under the Federal Employees Health Benefits Program pursuant to a direct contract with OPM and through the Federal Employee Program of the BCBSA. We are one of two companies in Puerto Rico that has such a contract with OPM. Every year, OPM allows other insurance companies to compete for this business, provided such companies comply with the applicable requirements for service providers. This contract is subject to termination in the event of a noncompliance that is 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 through our network of independent brokers. We provide individual and family contracts.

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Local Government Employees. We provide full risk managed care services to the local government of Puerto Rico employees through a government-sponsored program. Annually, the government qualifies the managed care companies that participate in this program and sets the coverage, including benefits, co-payments and amount to be contributed by the government. Employees then select from one of the authorized companies and pays for the difference between the premium of the selected carrier and the amount contributed by the government.

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

Medicare Advantage Sector

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

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

Medicare also provides a prescription drug program ("Medicare Part D"). Medicare beneficiaries are given the opportunity to select a Medicare Part D prescription drug plan provided by MCOs or other Part D sponsors. TSS offered a stand-alone Medicare Part D prescription drug benefits product until December 31, 2014.

Medicaid

The government of Puerto Rico has privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into eight geographical areas. Each of the eight geographical areas is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2016, this program provided healthcare coverage to over 1.3 million people.

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

We currently serve two geographical regions on an at-risk basis pursuant to an agreement that will expire on June 30, 2017. TSS provides healthcare services in the Metro North and West regions to approximately 398,000 subscribers. See "Item 1. Business Customers – Medicaid Sector". Our agreement with the government of Puerto Rico is subject to termination in the event of a non-compliance that is not corrected or cured to the satisfaction of the government entity overseeing Medicaid, or in the event that the government determines that there is an insufficiency of funds to finance the program.

Life Insurance

Our life insurance customers consist primarily of individuals, who hold approximately 607,000 policies. We also insure approximately 1,560 groups.

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Property and Casualty Insurance

Our property and casualty insurance segment targets small to medium size accounts with low to average exposures to catastrophic losses. The auto physical damage and auto liability customer bases are primarily of commercial accounts. Personal business are primarily generated with sales of our personal package product, ProPack, that includes coverage for residences, personal property, and automobile. Also, professional liability coverage is offered with hospital and medical malpractice products.

Underwriting and Pricing

Managed Care

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

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

We have been able to maintain relatively high retention rates, which is the percentage of existing clients retained in the renewal process, in the corporate accounts sector of our managed care business. For 2016 and 2015 our corporate accounts retention factor was 88% and 93%, respectively.

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

Life Insurance

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

Property and Casualty Insurance

The property and casualty insurance sector is experiencing a soft market in Puerto Rico, principally as a result of economic conditions and reinsurance capacity. Notwithstanding these conditions, our property and casualty segment

has maintained its leadership position in the property insurance sector by following prudent underwriting and pricing practices.

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

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Quality Initiatives and Medical Management

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

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

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

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Provider Arrangements

Approximately 99% of member services are provided through one of our contracted provider networks and the remainder is provided by out-of-network providers. Our relationships with managed care providers, physicians, hospitals, other facilities and ancillary managed care providers are guided by standards established by applicable regulatory authorities for network development, reimbursement and contract methodologies.

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

We promote the use of electronic claims billing by our providers. Approximately 93% of claims are submitted electronically through our fully automated claims processing system, and our “first-pass rate”, or rate at which a claim is approved for payment when first processed by our system without human intervention, for provider claims has averaged 92% in 2016.

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

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

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

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

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

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

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## Competition

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

### Managed Care

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

Competitors in the managed care segment include national and local managed care plans. At December 31, 2016 we had approximately 1,017,000 members enrolled in our managed care segment. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 27% for the nine-month period ended September 30, 2016.

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

### Life Insurance

We are one of the leading providers of life insurance products in Puerto Rico. In 2015, we were the second largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 10.5%. We are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines. Excluding annuities, we are the largest company in the life insurance and cancer lines of business, with market shares of approximately to 20% and 21% respectively.

### Property & Casualty Insurance

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

In the nine-month period ended September 30, 2016, we were the fourth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 8%.

## Blue Cross and Blue Shield License

We have license agreements with BCBSA that permit us the exclusive use of the BCBS name and marks for the sale, marketing and administration of managed care plans and related services in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. We believe that the BCBS name and marks are valuable brands of our products and services in the marketplace. The license agreements, which have a perpetual term (but which are

subject to termination under circumstances described below), contain certain requirements and restrictions regarding our operations and our use of the BCBS name and marks.

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Upon the occurrence of any event causing the termination of our license agreements, we would cease to have the right to use the BCBS name and marks. We also would no longer have access to the networks of providers of the different plans that are members of the Association nor the BlueCard Program. We would expect to lose a significant portion of our membership if we lose these licenses. Loss of these licenses could significantly harm our ability to compete in our markets and could require payment of a significant fee to the BCBSA. Furthermore, if our licenses were terminated, the BCBSA would be free to issue a new license to use the BCBS name and marks to another entity, which could have a material adverse effect on our business, financial condition and results of operations. See "Item 1A Risk Factors Risks Related to Our Business – The termination or modification of our license agreements to use the BCBS name and marks could have a material adverse effect on our business, financial condition and results of operations."

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

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

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

- failure to satisfy state-mandated statutory net worth requirements;

- impending financial insolvency; and

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

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

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

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

Pursuant to the rules and license standards of the BCBSA, TSM guarantees TSS and Triple-S Blue, Inc. ("TSB") contractual and financial obligations to their respective customers. Also, TSS guarantees TSA's contractual and

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

Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the BCBS name and marks. The annual BCBSA fee for the year 2017 is $1,444,069. During the years ended December 31, 2016 and 2015, we paid fees to the BCBSA in the amount of $2,395,808 and $2,470,783, respectively. The BCBSA is a national trade association of 37 independent Primary Licensees (Plans), including TSM, the primary function of which is to promote and preserve the integrity of the BCBS name and marks, as well as to provide certain coordination other entities licensed by the BCBSA (the “Member Plans”). Each Member Plan is an independent legal organization and is not responsible for obligations of other BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the BCBS name and marks outside our BCBS licensed territory.

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

Trademarks

We consider our trademarks Triple-S and SSS to be very important and material to all segments in which we are engaged. All our trademarks which we consider important have been duly registered with the Department of State of Puerto Rico and the United States Patent and Trademark Office. It is our policy to register all our important and material trademarks in order to protect our rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the BCBS name and marks in Puerto Rico, Costa Rica, U.S. Virgin Islands, British Virgin Islands, and Anguilla. See ''—Blue Cross and Blue Shield License''.

Regulation

Our business operations are subject to comprehensive and detailed regulation in all the jurisdictions we conduct business. Regulatory agencies include the Commissioner of Insurance of Puerto Rico (the "Commissioner of Insurance"), the Health Department of Puerto Rico and the Puerto Rico Health Insurance Administration ("ASES" by its Spanish acronym), which administers Medicaid, including the Medicare dual-eligible beneficiaries program, the Division of Banking and Insurance of the Office of the Lieutenant Governor of the U.S. Virgin Islands, the General Superintendence of Insurance of Costa Rica, the Insurance Division of the Financial Service Commission of British Virgin Islands and the Financial Services Commission of Anguilla. Federal regulatory agencies that oversee our operations include the U.S. Department of Health and Human Services ("HHS")—directly and through the Office of the Inspector General ("OIG"), the Office of Civil Rights ("OCR") and Centers for Medicare and Medicaid Services ("CMS")—, the U.S. Department of Justice ("DOJ"), the U.S. Department of Labor ("DOL"), and the U.S. Office of Personnel Management ("OPM"). These government agencies have the right to:

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

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

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- initiatives to provide greater access to coverage for uninsured and under-insured populations without adequate funding to health plans or to be funded through taxes or other negative financial levies on health plans;

- other efforts or specific legislative changes to the Medicare or Medicaid program, including changes in the bidding process or other means that materially reduce premiums;

- local government regulatory changes;

- increased government enforcement, or changes in interpretation or application of fraud and abuse laws; and

- regulation that increase the operational burden on health plans or laws that increase a health plan's exposure to liabilities, including efforts to expand the tort liability of health care plans.

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 on contracts to administer government programs;

- transactions with affiliated entities;

- limitations on the ability to pay dividends;

- payment rates to healthcare providers;

- rate review and approval;
- transactions resulting in a change of control;

- member rights and responsibilities;
- fraud and abuse;
- sales and marketing activities;
- quality assurance procedures;
- privacy of medical and other information and permitted disclosures;
- surcharges on payments to providers;
- provider contract forms;
- delegation of financial risk and other financial arrangements in rates paid to healthcare providers;
- agent licensing;
- financial condition (including reserves);
- reinsurance;
- issuance of new capital stock shares;
- corporate governance;
- permissible investments; and
- guaranteed issue and renewability.

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

Puerto Rico Insurance Laws

Our insurance subsidiaries are subject to the regulations and supervision of the Commissioner of Insurance. The regulations and supervision of the Commissioner of Insurance consist primarily in the approval of certain policy forms, solvency standards, 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 the financial reports, among others. In general, such regulations are for the protection of policyholders rather than security holders.

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Puerto Rico insurance laws prohibit any person from offering to purchase or sell voting stock of an insurance company with capital contributed by stockholders (a stock insurer) that constitutes 10% or more of the total issued and outstanding stock of such company or of the total issued and outstanding stock of a company that controls an insurance company, without the prior approval of the Commissioner of Insurance. The proposed purchaser or seller must disclose any changes proposed to be made to the administration of the insurance company and provide the Commissioner of Insurance with any information reasonably requested. The Commissioner of Insurance must make a determination within 30 days. Such determination will be based on the evaluation of the transaction's impact on the public interest, taking into account the experience, moral character and financial stability of the proposed purchaser; and whether the change of control could jeopardize the interests of insured, claimants or the company's other stockholders.

Puerto Rico insurance laws also require that stock insurers obtain the Commissioner of Insurance's approval prior to any merger or consolidation. The Commissioner of Insurance cannot approve any such transaction unless it determines that such transaction is fair, equitable, consistent with law, and that no reasonable objection exists. The reinsurance of all or substantially all of the insurance of an insurance company by another insurance company is deemed to be a merger or consolidation.

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

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

Privacy of Financial and Health Information

Puerto Rico law requires that companies which manage individual financial, insurance and health information maintain the confidentiality of such information. The Commissioner of Insurance has promulgated regulations relating to the privacy of such information. As a result, our managed care subsidiaries must periodically inform our clients of our privacy policies, and in the case of our property and casualty and life insurance subsidiaries, allow our clients to opt-out if they do not want their financial information to be shared. Also, Puerto Rico law requires that managed care providers provide patients with access to their health information within a specified time and that they not charge more than a predetermined amount for such access. The law imposes various sanctions on managed care providers that fail to comply with these provisions.

Managed Care Provider Services

Participating managed care providers of the dual-eligible sector of the population, administered by ASES, are required to provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialty services. In addition, the Patient's Solicitor Office (the "Solicitor") is authorized to review and supervise the operations of entities contracted by the government of Puerto Rico to provide services to the dual-eligible sector of the population. The Solicitor may investigate and adjudicate claims filed by Medicaid

beneficiaries against the various service providers contracted by the government of Puerto Rico. See “Business – Customers-Medicare Supplement and Medicare Advantage Sector” sections included in this Item for more information.

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Capital and Reserve Requirements

Local insurers and health organizations are required by the Insurance Code to submit to the Puerto Rico Commissioner of Insurance Risk Based Capital ("RBC") reports following the NAIC RBC Model Act, and accordingly are subject to certain regulatory actions if their capital levels do not meet the 200% minimum specific risk based capital requirement, for the entities within the managed care segment and 300% for the entities within the property and casualty and life insurance segment.

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

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company's risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the company's total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. At the "company action level", occurring when a company's total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. When a company's adjusted capital is between 200% and 300% and it has a combined ratio greater than 150%, a "company action level" is triggered only if the Puerto Rico Commissioner of Insurance has implemented the health trend test. As of December 31, 2016, the Commissioner of Insurance has not enacted the health trend test in its regulations. 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.

As of December 31, 2016, our insurance subsidiaries met and exceeded the minimum capital requirements established by the Commissioner of Insurance and the BCBSA, as applicable, except for TSA for which we expect to remediate and implement corrective actions plans to comply with such requirements.

In addition to its catastrophic reinsurance coverage, TSP is required by local regulatory authorities to establish and maintain a reserve supported by a trust fund (the "Trust") to protect policyholders against their dual exposure to hurricanes and earthquakes. The funds in the Trust are solely to be used to pay catastrophic losses whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust, and accordingly additions to the reserve, are determined by a rate, imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. At December 31, 2016 and 2015, the reserve for catastrophes is $44.7 million and $43.0 million, respectively. The supporting trust fund has assets of $47.1 million and $46.2 million as of December 31, 2016 and 2015, respectively. Assets consist primarily of investment in securities available for sale, securities held for maturity, accrued investment income, cash and cash equivalents. The income generated by investment securities deposited in the Trust becomes part of the Trust fund

balance and are therefore considered an addition to the reserve. For additional details see note 16 of the audited consolidated financial statements.

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Dividend Restrictions

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

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

Guaranty Fund Assessments

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

Federal Regulation

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

Medicare Generally

Medicare is the federal health insurance program created in 1965 for all people aged 65 and older (regardless of income or medical history), qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by CMS, with the day-to-day operations of the program (e.g., provider enrollment, claims payment) handled by private contractors under contract with CMS. There are approximately 55 million Medicare beneficiaries.

Medicare is divided into 4 distinct parts:

- Part A covers, among other things, inpatient hospital stays, skilled nursing facility stays, home health visits (also covered under Part B), and hospice care.

- Part B covers physician visits, outpatient services, laboratory services, durable medical equipment, certain preventive services, and home health visits. Enrollment in Part B is voluntary and subject to an annual deductible.

- Part C, also known as Medicare Advantage, allows beneficiaries to enroll in private health plans and receive Medicare-covered benefits. Currently, about 17 million Medicare beneficiaries are enrolled in the United States in a Medicare Advantage plan. Under the Patient Protection and Affordable Care Act of 2010 (Pub. L No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), on March 30, 2010 (referred to herein as "ACA"), payments to Medicare Advantage plans are generally being reduced over time, and bonus payments are available to certain plans based on quality ratings. Medicare Advantage plans are required to maintain a

medical loss ratio ("MLR") of at least 85%, meaning, very basically, that if Medicare Advantage plans do not spend at least 85% of their revenue on patient care costs, may face various sanctions, including refunds, prohibition on enrolling new members, and contract termination. The Part C premium varies by plan.

- Part D is the voluntary, subsidized outpatient prescription drug benefit created under the Medicare Modernization Act of 2003 (the "MMA"). Part D includes subsidies for beneficiaries with low incomes that do not apply to Puerto Rico. Part D is offered through private plans that contract with Medicare, including stand-alone prescription drug plans and Medicare Advantage prescription drug plans. Part D plans are also subject to MLR requirements and their premium varies by plan.

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

Since the 1980’s, as an alternative to the traditional fee-for-service Medicare program, Medicare has also offered Medicare managed care benefits provided through contracted private health plans, currently known as Medicare Advantage plans. Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans’ members. Beginning in 1997, CMS gradually phased in a risk adjustment payment methodology that based its monthly premium payments to plans on various clinical and demographic factors. Beginning in 2003, Congress introduced a Medicare managed care approach, which itself has subsequently undergone several changes, and beginning in 2006, Congress introduced the Medicare Part D program, which offered a voluntary outpatient prescription drug benefit to fee-for-service as well as Medicare Advantage beneficiaries.

Among other things, the ACA mandated several changes, implemented by CMS, to the Medicare Advantage and Medicare Part D programs, including strengthening CMS’ ability to remove poor performers from the Medicare Advantage and Part D programs beginning in 2015. Beginning with Medicare contract year 2015, CMS has the authority to terminate its contract with any Medicare Advantage or Part D plan for substantial contract non-compliance, or refuse to renew such plan, if the plan fails to achieve an overall Star Rating of 3.0 stars (out of 5.0) for any consecutive three (3) year period. Although CMS has issued annual Star Ratings for Part D plans since 2007 and for Medicare Advantage plans since 2008, CMS uses Star Ratings issued for Medicare contract years 2013 and beyond in implementing this provision. In April 2015, CMS announced that it would for the first time exercise its authority to terminate low performing Medicare Advantage and Part D plans beginning in 2016. CMS issues Star Ratings on a prospective basis, typically in the fall preceding the contract year. CMS has the authority to use the lower Star Ratings as a means to invoke its existing authority under Section 1857(c)(2) of the Social Security Act to terminate a contract when CMS determines that the Medicare Advantage or Part D plan has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage or Part D program.

Payments to Medicare Advantage Participating Plans

Since 2006, Medicare Advantage has used a bidding system by which plans submit bids based on costs per enrollee for Part A and Part B covered services. Medicare Advantage also pays plans for providing prescription drug benefits under Part D. Bids are based on estimated costs per enrollee for the Medicare-covered services. The bids are then analyzed against a benchmark established by federal statute, and which vary by county or region. A Medicare Advantage plan’s actual payment rate is based on a complex statutory formula that takes into account a number of factors, including the relationship between the plan’s bid and the applicable benchmark. When a bid is higher than the benchmark, enrollees generally pay the difference (through an additional premium) between the benchmark and the bid, in addition to any other Medicare premiums. If the bid is lower than the benchmark, the plan and Medicare generally share the difference, and the plan must use its share (known as a “rebate”) to provide additional benefits to enrollees.

In addition, under the ACA, Medicare Advantage plan payment rates are subject to transitionally phased-in reductions intended to bring Medicare Advantage rates more in line with Medicare fee-for-service rates. These reductions are being phased in between 2012 and 2017. CMS generally will rebate a portion of the amount by which the benchmark amount exceeded the accepted bid for certain plans. For plans achieving star rating of at least 3.5 stars, the portion of the savings retained by the plan is higher. For plans achieving star ratings of at least 4 stars, the starting benchmark amount from which the savings is computed is also higher. Rebates will be reduced for all plans, but plans with higher quality ratings will keep a larger proportion of the rebate. Plans attaining at least 4.0 stars are also eligible for direct bonus payments.

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Medicaid Generally

Medicaid is a public insurance program intended for low-income individuals and families. Medicaid provides coverage to almost 65 million Americans, including children, pregnant women, and individuals with disabilities. To participate in Medicaid, states must cover certain groups but have the flexibility to cover other population groups. States may apply to CMS for waivers to provide coverage to populations beyond what is normally covered under the program. States are able to establish eligibility criteria within federal minimum standards. States are allowed to set Medicaid provider payment rates, and may reimburse providers through fee-for-service or managed care. They also have the flexibility to determine the type, amount, duration, and scope of services of their respective Medicaid programs, so long as within federal guidelines, although states are required to cover certain mandatory benefits. In Puerto Rico, the Medicaid program is administered locally by ASES.

Medicaid is jointly funded by the federal government and the states with the federal government paying states for a specified percentage of program expenditures known as the Federal Medical Assistance Percentage ("FMAP"). The FMAP varies by state based on factors such as per capita income. The FMAP for Puerto Rico is 55%. FMAPs are adjusted based on a 3 year cycle. Generally, during economic recessions such as the one that began in 2008, state revenues fall while Medicaid enrollment and spending rise. To help alleviate the shortfall, the federal government temporarily increased its share of Medicaid costs through the American Recovery and Reinvestment Act of 2009. However, that temporary fix ended in 2012, and while many states have enacted cost containment initiatives to help control costs, states continue to wrestle with falling revenue while Medicaid enrollment and spending increase.

The ACA expands Medicaid to an eligibility floor of 138% of the federal poverty level ("FPL") beginning in 2014. A 2012 U.S. Supreme Court decision regarding health care reform limited the federal government's ability to enforce Medicaid expansion—meaning that the issue of Medicaid expansion is effectively left to each individual state. Puerto Rico and the other U.S. territories were not included in the Medicaid expansion, instead Congress approved one billion in federal funding for Puerto Rico and the other U.S. territories to establish local affordable insurance exchanges or expand their Medicaid programs, at their option. Puerto Rico elected to use the approximately $925 million made available by Congress to Puerto Rico for expanding its Medicaid program. Although the funds would be available until 2019, the government has estimated that, given the current burn rate of the approved funding, funds would be fully utilized before the start of 2018.

Dual-Eligible Beneficiaries

A "dual-eligible" beneficiary is a person who is eligible for both Medicare, because of age or other qualifying status, and Medicaid, because of economic status. Dual-eligibles are a high cost population that account for a disproportionate share of government health care expenditures. According to a 2011 report issued by the Kaiser Commission on Medicaid and the Uninsured, there are approximately 9 million dual-eligibles, including 5.5 million low-income seniors and 3.4 million people with disabilities under age 65, receiving both Medicare and Medicaid benefits nationwide. Given the disproportionately high cost of treating dual-eligibles, there has been a spate of initiatives designed to address the issue. The government of Puerto Rico established a model that wraps-around benefits included in Medicaid that were not included in Medicare Advantage benefits. Dual-eligible beneficiaries in Puerto Rico have the option to participate in this model called Platino. Health plans that offer Platino products receive premiums from CMS and the government of Puerto Rico. In this plan the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dual-eligible members. The MMA established subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid program. Companies offering Medicare Part D stand-alone prescription drug plans with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the

dual-eligible beneficiaries within the applicable region.

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Additionally, ACA created the Medicare-Medicaid Coordination Office to better integrate Medicare and Medicaid benefits and improve coordination between federal and state governments, which has, among other things implemented initiatives such as demonstration projects and limited coordinated care contracts, intended to improve quality and lower costs with respect to dual eligible beneficiaries. Under authority of the ACA, a number of states (not including Puerto Rico) have been awarded contracts to support the design of demonstration projects that aim to improve the coordination of care for people with Medicare and Medicaid coverage.

Special Needs Plans

Special Needs Plans are intended to address Medicare beneficiaries with special care needs, particularly those with chronic conditions. In addition, the ACA created Fully Integrated Dual Eligible (FIDE) special needs plans, designed to promote the full integration and coordination of Medicare and Medicaid benefits for dual eligible beneficiaries by a single managed care organization, Essentially, Medicare Advantage Special Needs Plans ("SNPs") are a type of Medicare Advantage Plan for people with certain chronic diseases and conditions or who have specialized needs (such as people who have both Medicare and Medicaid or people who live in certain institutions). SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies (list of covered drugs) to best meet the specific needs of the groups they serve.

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

Fraud and Abuse Laws. Insurance providers in Puerto Rico are subject to local and federal laws that prohibit fraud and abuse, and are required to have anti-fraud units in place. In addition, entities, such as TSS and TSA, that receive federal funds from government health care programs, such as Medicare and Medicaid, are subject to a wide variety of federal fraud and abuse laws and enforcement activities. Such laws include, among others, the federal anti-kickback laws and the False Claims Act.Anti-kickback Laws. Insurance providers in Puerto Rico are subject to local and federal anti-kickback laws. These anti-kickback laws prohibit the payment, solicitation, offering or receipt of any form of remuneration (including kickbacks, bribes, and rebates) in exchange for business, and under federal law, the referral of federal healthcare program patients or any item or service that is reimbursed by any federal health care program. In addition, the federal regulations include certain safe harbors that describe relationships that have been determined by CMS not to violate the federal Anti-Kickback Statute. Relationships that do not fall within one of the enumerated safe harbors are not a per se violation of the federal law, but will be subject to enhanced scrutiny by regulatory authorities. The ACA amended the intent requirement of the federal Anti-Kickback Statute, and other healthcare criminal fraud statutes, so that a person or entity no longer needs to have actual knowledge of the federal Anti-Kickback Statute, or the specific intent to violate it, to have violated the statute. The ACA also provided that a violation of the federal Anti-Kickback Statute is grounds for the government or a whistleblower to assert that a claim for payment of items or services resulting from such violation constitutes a false or fraudulent claim for purposes of the federal False Claims Act. Failure to comply with the anti-kickback provisions may result in civil damages and penalties, criminal sanctions, and administrative remedies, such as exclusion from the applicable federal health care program.

Federal False Claims Act. Federal regulations also strictly prohibit the presentation of false claims or the submission of false information to the federal government. Under the federal False Claims Act, any person or entity that has knowingly presented or caused to be presented a false or fraudulent request for payment from the federal government or who has made a false statement or used a false record in the submission of a claim may be subject to treble damages and penalties of up to $21,562.80 per claim. The ACA codified federal government's prior position that claims presented in relationships that violate the federal Anti-Kickback Statute may also be considered to be violations of the federal False Claims Act. Furthermore, the federal False Claims Act permits private citizen "whistleblowers" to bring actions on behalf of the federal government for violations of the False Claims Act and to share in the settlement or judgment that may result from the lawsuit. Financial recoveries from civil health care matters

brought under the False Claims Act are significant.

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HIPAA, HITECH, and Gramm-Leach-Bliley Act

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

HHS also sets standards relating to the privacy of individually identifiable health information. In general, these regulations restrict how covered entities and business associates may use and disclose medical records and other individually identifiable health information in any form, whether communicated electronically, on paper or orally, subject only to limited exceptions. In addition, the regulations provide patients' rights to understand and control how their health information is used. HHS has also published security regulations designed to protect member health information from unauthorized use or disclosure and require notification to members, the Secretary of HHS, and in certain cases the media, in the event of a breach of unsecured individually identifiable health information.

In 2015 we entered into two agreements with federal and Puerto Rican regulators to resolve investigations in connection with privacy incidents at our Managed Care segment. The agreements include the payment of a combined amount of $5 million and the adoption of a three year corrective action plan. See, "Item 3. Legal Proceedings–Unauthorized Disclosure of Protected Health Information" for more information.

HHS has released rules mandating the use of standard formats in electronic health care transactions (for example, health care claims submission and payment, plan eligibility, precertification, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules mandating the use of standardized code sets and unique identifiers for employers and providers. Our managed care subsidiary believes that it is in material compliance with these requirements. In addition, the federal government required healthcare organizations, including health insurers, upgrade to updated and expanded standardized code sets used for describing health conditions by converting from the ICD-9 diagnosis and procedure code set to the ICD-10 diagnosis and procedure code by October 1, 2015. Our conversion from the ICD-9 code set to the ICD-10 code set, which required a substantial investment, was successfully completed.

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

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Employee Retirement Income Security Act of 1974

The services we provide to certain employee welfare benefit plans maintained by private sector employers are subject to regulation under 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, the U.S. Department of Labor, and federal courts. ERISA regulates certain aspects of the relationships between us, private sector employers who maintain employee welfare benefit plans subject to ERISA, and the participants and beneficiaries in such plans. Some of our administrative services and other activities may also be subject to regulation under ERISA and its regulations. In addition, certain states require licensure or registration of companies providing third-party claims administration services for benefit plans. We provide a variety of products and services to employee welfare benefit plans that are covered by ERISA and its regulations. 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 federal and state courts.

Dodd-Frank Act

In 2010, Congress enacted the Dodd-Frank Wall-Street Reform and Consumer Protection Act (the "Dodd-Frank Act") which provides for a number of reforms and regulations in the corporate governance, financial reporting and disclosure, investments, tax and enforcement areas that affect our subsidiaries. Among other things, the Dodd-Frank Act creates a Federal Insurance Office ("FIO") within the U.S. Department of the Treasury with powers that include information-gathering and subpoena authority. In 2013, as part of its initial task to study the state of the insurance industry, the FIO issued a report recommending that Congress consider direct federal involvement should the states fail to accomplish necessary modernization reforms in the near term. The FIO continues to support the current state-based regulatory regime, but may consider federal regulation should the states fail to take steps to greater uniformity.

In addition, the Dodd-Frank Act gives the Federal Reserve supervisory authority over a number of financial services companies, including insurance companies, if they are designated by the Financial Stability Oversight Council as "systemically important." In such a case, the Federal Reserve's supervisory authority could include the ability to impose heightened financial regulation upon that insurance company and could impact its capital, liquidity and leverage requirements as well as its business and investment conduct. We have not been designed as "systemically important" by the Financial Stability Oversight Council.

Although the FIO does not have authority over health insurance, it may have authority over other parts of our business, primarily life and property and casualty insurance. The 2016 presidential and congressional election results have created additional uncertainty regarding the future of the Dodd-Frank Act and increased the potential for changes to the law that may affect our business.

Legislative and Regulatory Initiatives

Puerto Rico Initiatives

The Commissioner of Insurance adopted Rule No. 83, titled ''Standards and Procedures to Regulate the Insurance Holding Company Systems and Criteria for Evaluating Changes in Control''. Rule No. 83 requires insurers and health services organizations authorized to do business in Puerto Rico and which are members of an insurance holding company system to register and file with the Commissioner of Insurance certain reports describing capital structure, ownership, financial condition, enterprise risks and general business operations. In addition, Rule No. 83 establishes the criteria to be used to approve or refuse to approve any transaction that may constitute a change in control of a domestic insurer or health services organization. Rule No. 83 also requires prior notice and approval of certain intercompany transactions, as well as payments of extraordinary dividends or distributions.

Federal Initiatives

On March 23, 2010, the federal health reform legislation, known as the Affordable Care Act, was enacted. Most of the provisions of ACA with more significant effects on the health insurance marketplace went into effect on or before January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, and the assessment of new taxes and fees, including annual Health Insurance Providers Fee ("HIP Fee"), on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The total HIP fee levied on the health insurance industry was $11.3 billion for 2016 and 2015, with increasing annual amounts thereafter, growing to $14.3 billion by 2018. The HIP Fee has been waived for 2017. After 2018, the HIP Fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S health insurers in the year preceding the assessment. We incurred $44.2 million, $34.6 million, and $27.7 million for the HIP fee in 2016, 2015 and 2014, respectively.

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On July 16, 2014, HHS notified the Commissioner of Insurance of Puerto Rico that the guarantee issue, community rating, single risk pool, rate review, MLR, and essential health benefits provisions under the ACA do not apply to U.S. territories, however they continue to apply to Puerto Rico by virtue of an amendment to the Health Insurance Code of Puerto Rico passed on July 22, 2013 to enact similar provisions in Puerto Rico. ACA affects all aspects of the health care delivery and reimbursement system in the United States, including health insurers, managed care organizations, healthcare providers, employers, and U.S. states and territories.

The current debate in Washington surrounding the repeal and replacement of the ACA injects a new degree of uncertainty into important aspects related to the profitability or marketability of our business, financial condition and results of operations. Various federal agencies, including, but not limited to, HHS, DOL, and the U.S. Department of the Treasury have issued and continue to issue Executive Orders and regulations related to the stabilization of the individual insurance market as well as their intentions to repeal the ACA in whole or in part. With regard to specifics, under the Consolidated Appropriations Act 2016, Congress placed a one year moratorium on the implementation on the annual fees on health insurers, which will now go into effect in 2017. Continuation of that moratorium, as well as permanent repeal of the Health Insurance Tax, remains an active legislative priority for lawmakers. As a result of the complexity of ACA, its impacts on health care in the United States and the uncertainty of its future, we cannot currently estimate the ultimate impact of ACA on our business, cash flows, financial condition and results of operations. We will continue to assess ACA's impact on us as additional regulations and guidance are issued.

As we think about the future of the ACA, or what may replace it, some of the more significant ACA issues that currently affect our managed care business, or may in the future, include:

- Provisions requiring greater access to coverage for certain uninsured and under-insured populations and the elimination of certain underwriting practices without adequate funding to health plans or with negative financial levies on health plans such as restrictions in the ability to charge additional premium for additional risk. These include, among others, (i) extending dependent coverage for unmarried individuals until age 26 under their parents' health coverage, (ii) limiting a health plan's ability to rescind coverage and restricting the plan's ability to establish annual and lifetime financial caps, (iii) eliminating the use of gender as a ratings factor, and (iv) limiting a health plan's ability to deny or limit coverage on grounds of a person's pre-existing medical condition;

- Provisions restricting medical loss ratios and requiring premium refunds for non-compliance;

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

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

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

- Other efforts or specific legislative changes to the Medicare and Medicaid programs, including changes in the bidding process, authority of CMS to deny bids, or other means of materially reducing premiums such as through further adjustments to the risk adjustment methodology;

- Increased federal funding to the Medicaid program;

- Funding provided to the government of Puerto Rico to enable it to fund the expansion of its Medicaid program, rather than establish a health insurance exchange;

- Provisions that impose annual fees on health insurers;

- Increased government funding to enforcement agencies and/or changes in interpretation or application of fraud and abuse laws;

- Expanded scope of authority and/or funding to audit Medicare Advantage health plans and recoup premiums or other funds by the government or its representatives; and the increase in persons eligible for coverage under the Medicaid program in Puerto Rico, which may result in some persons currently insured by us in our commercial programs becoming eligible for, and thus moving to, the Medicaid program.

While all aspects of the ACA are expected to undergo significant changes throughout the repeal and replace process, some of the specific provisions we will be tracking include the following: The ACA mandates significant changes to the rules regarding private health insurance to facilitate competition for market efficiency, promote prevention and wellness, increase pooling of risk, and prohibit discrimination for pre-existing conditions and/or health statues. For example, HHS has issued rules specifically related to health insurance market reforms, essential benefits, and standards for wellness programs by employers who sponsor group health plans. The market reform rules concerns the sale, pricing, and renewability of health insurance. These rules apply to the individual and small group health insurance markets (whether or not in the health insurance exchanges). The rules do not generally apply to grandfathered health plans. The essential benefits rule establishes the standards for covered benefits under private health insurance coverage. Under the rule, states have the ability to select a benchmark plan from ten popular private health plans. Popularity is based on enrollment figures for the plans. Should a state not select a plan, the default becomes the largest small group health plan. A covered benefit under the benchmark plan will be considered an essential health benefit. The Government of Puerto Rico selected one of our Medicare Advantage products, supplemented with additional benefits currently provided under the federal employee health plan, as the benchmark plan. Under the ACA, health plans that are not grandfathered in the individual and small group market are required to cover essential health benefits. While essential benefits are not specifically defined, the ACA outlines 10 categories of benefits that are required to be covered by plans, including: a) emergency services; b) ambulatory patient services; c) hospitalization; and d) preventive and wellness services and chronic disease management. The wellness rule amends an earlier regulation regarding the design and implementation of wellness programs offered by employers in group health plans. See Part I, Item 1A “Risk Factors The health care reform law and the implementation of the law could have a material effect on our business, financial condition, cash flows, or results of operations” for more information.

Budget Control Act

The Budget Control Act of 2011 was enacted to reduce the deficit and avoid default on the national debt. When a joint committee of Congress established to develop debt reduction legislation failed to cut at least $1.5 trillion over the coming 10 years, an automatic process of across-the-board cuts (“sequestration”) split equally between defense and non-defense programs was triggered. Under the sequestration, automatic spending cuts became effective beginning

April 1, 2013, and these cuts have been extended through at least 2024 unless additional Congressional action is taken. This resulted in cuts of 2% to Medicare funding. Medicaid programs are not subject to automatic spending cuts.

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Employees

As of December 31, 2016, we had 3,414 full-time employees and 332 temporary employees. TSS has a collective bargaining agreement with the "Unión General de Trabajadores", which represents approximately 33% of one of our managed care subsidiaries' approximately 1,177 regular employees. The collective bargaining agreement expires on November 30, 2019. The Corporation considers its relations with employees to be good.

Available Information

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

Special Note Regarding Forward-Looking Statements

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

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

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

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- competitor pricing below market trends of increasing costs;
- re-estimates of our policy and contract liabilities;
- changes in government regulation of managed care, life insurance or property and casualty insurance;
- significant acquisitions or divestitures by major competitors;
- introduction and use of new prescription drugs and technologies;
- a downgrade in our financial strength ratings;
- litigation or legislation targeted at managed care, life insurance or property and casualty insurance companies;
- ability to contract with providers and government agencies consistent with past practice;
- ability to successfully implement our disease management and utilization management programs;
- volatility in the securities markets and investment losses and defaults; and
- 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 at the time the statements are made. Further, forward-looking statements speak only as of the date they are made, and, other than as required by applicable law, including the securities laws of the United States, we do not intend to update or revise any of them in light of new information or future events.

Item 1A. Risk Factors

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

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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 our reorganization in 1999, when SSS was merged into a newly-formed entity having authorized capital of 25,000 $40-par-value shares, or twice the number of authorized shares of SSS. SSS's shareholders did not, however, authorize the issuance of the newly formed entity's shares to providers or any other third party. In addition, subsequent to the reorganization, our shareholders did not approve attempts to increase our share capital in 2002 and 2003.

Notwithstanding the fact that TSS and its predecessor, SSS, were never in a position to issue new shares to providers as contemplated by the share acquisition agreements because shareholder approval for such issuance was never obtained, and the fact that SSS on several occasions in the 1990s offered providers the opportunity to purchase shares of its treasury stock and such offers were accepted by very few providers, providers who entered into share acquisition agreements may claim that the share acquisition agreements entitled them to acquire our or TSS's shares at a subscription price equivalent to that provided for in the share acquisition agreements. SSS entered into share acquisition agreements with approximately 3,000 providers, the substantial majority of whom never came to own shares of SSS. Such share acquisition agreements provide for the purchase and sale of approximately 15,000 shares of SSS. If we or TSS were required to issue a significant number of shares in respect of these agreements, the interest of our existing shareholders would be substantially diluted. As of the date of this Annual Report on Form 10-K, only one judicial claim to enforce any of these agreements has been brought against the Company. The case was settled by the parties and, on August 2013, dismissed by the court with prejudice. Additionally, we have received several inquiries with respect to 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 the 3,000-for-one stock split effected by us on May 1, 2007. However, we cannot provide assurances that claimants will not successfully seek to increase the size of their claims by reference to the stock split.

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

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

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

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

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

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

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

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

In the event that claimants acquire shares of our managed care subsidiary, TSS, at less than fair value, we will not be able to prevent dilution of the value of the Class B shareholders' ownership interest in us to the extent that the net value received by such claimants exceeds the value of our outstanding shares of Class A common stock. Finally, the anti-dilution protection afforded by the dual class structure may cease to be of further effect at any time because all remaining shares of Class A common stock may, at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted into shares of Class B common stock. On November 12, 2015, the Company converted 1,426,721 shares of Class A common stock to Class B common stock.

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. As of December 31, 2016 there were 23,321,163 shares of Class B common stock and 950,968 shares of Class A common stock. Our Class A common stock is no longer subject to contractual lockup; thus, such shares are freely tradable without restriction or further registration under the Securities Act by persons other than our ‘‘affiliates’’ within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the NYSE and will not be fungible with our listed shares of Class B common stock. 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.

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

Our 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. In recent years some groups of providers have been pressing for legislation that would allow them to collectively negotiate certain contract terms through cooperatives. As a result, Puerto Rico enacted legislation authorizing providers to collectively negotiate the services fees through cooperatives, on a voluntary basis, with health insurance companies and other healthcare-related organizations. This legislation requires that the Public Corporation for the Supervision and Insurance of Cooperatives adopt regulation that may have a material adverse effect in our business. If collective negotiations with providers become mandatory or we are otherwise required to enter into collective negotiations with providers, it could become more difficult to maintain cost-effective managed care provider contracts, which could adversely affect our business.

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

Our managed care business participates in government contracts that generate a significant amount of our consolidated operating revenues, including:

- Medicare: We provide services through our Medicare Advantage products pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is cancellable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if the process for bidding materially changes or if any of these contracts are terminated, our business could be materially impaired. During each of the years ended December 31, 2016, 2015 and 2014, contracts with CMS represented 35.4%, 39.4% and 47.6% of our consolidated premiums earned, net, respectively.

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- Commercial: One of our managed care subsidiaries is a qualified contractor to provide managed care coverage to federal government employees within Puerto Rico. Such coverage is provided pursuant to a contract with the OPM that is subject to termination in the event of noncompliance not corrected to the satisfaction of the OPM. During each of the years ended December 31, 2016, 2015 and 2014 premiums generated under this contract represented 5.8%, 5.6% and 7.2% of our consolidated premiums earned, net, respectively.

Under the commercial business, we also provide health coverage to certain employees of the Government of Puerto Rico and its instrumentalities. Earned premium revenue related to such health plans represented 3.1%, 3.3% and 5.8% of our consolidated premiums earned, net, respectively.

- Medicaid: We participate in the government of Puerto Rico Health Reform Program (similar to Medicaid) to provide health coverage to medically indigent citizens in Puerto Rico. Under the current agreement, which was effective April 1, 2015, TSS offers healthcare services on a fully-insured basis to Medicaid subscribers in the Metro North and West regions. TSS is also responsible for providing medical, mental, pharmacy and dental healthcare services to Medicaid subscribers in the Service Regions on an at-risk basis. The agreement has a three-year term ending June 30, 2018. Premiums were renegotiated until June 30, 2017 ,at which time we will renegotiate new rates until the end of the three year term. The current agreement with ASES contains certain termination rights for both TSS and ASES, including ASES's right to terminate the agreement as a result of insufficient government funds to pay ASES's obligations under the contract and TSS's right to terminate the agreement within 45 days before the end of each fiscal year if TSS and ASES have not agreed to the per member per month rate. For the years ended December 31, 2016 and 2015, premiums generated under our current agreement represented 27.1% and 21.8% of our consolidated premiums earned, net, respectively.

If any of these contracts is terminated for any reason, including by reason of any noncompliance by us, or not renewed or replaced by a comparable contract, our consolidated premiums and profitability earned could be materially adversely affected. See also "Risks Relating to the Regulation of our Industry—As a Medicare Advantage program participant, we are subject to complex regulations."

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

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than ASO products and those managed care products where employer groups retain the risk, such as self-funded financial arrangements. There has been a trend in recent years among our Commercial customers of moving from fully-insured plans to ASO, or self-funded arrangements. As of December 31, 2016 and 2015, 66% and 64% of our managed care commercial customers, respectively, had fully insured arrangements and 34% and 36%, respectively, had ASO arrangements. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

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

A portion of the claim liabilities recorded by our insurance segments represents an estimate of amounts needed to pay and adjust anticipated claims with respect to insured events that have occurred, including events that have not yet been reported to us. These amounts are based on estimates of the ultimate expected cost of claims and on actuarial estimation techniques. Judgment is required in actuarial estimation to ascertain the relevance of historical payment and claim settlement patterns under each segment's current facts and circumstances. Accordingly, the ultimate liability may be in excess of or less than the amount provided. We regularly compare prior period liabilities to re-estimate claim liabilities based on subsequent claims development; any difference between these amounts is adjusted in the operations of the period determined. Additional information on how each reportable segment determines its claim liabilities, and the variables considered in the development of this amount, is included elsewhere in this Annual Report

on Form 10-K under “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates”. Actual experience will likely differ from assumed experience, and to the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

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

We are a party to license agreements with the BCBSA that entitle us to the exclusive use of the BCBS name and mark in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. These license agreements contain certain standards, requirements and restrictions regarding our operations and our use of the BCBS name and mark which may be modified in certain instances by the BCBSA. Changes to the terms of our license agreements may restrict various potential business activities. Failure to comply with the standards, requirements and restrictions established could result in the termination of a license agreement. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Upon termination of a license agreement, the BCBSA would impose a re-establishment fee upon us, which would allow the BCBSA to entitle another managed care company to use the BCBS name and marks in the service areas we currently serve. This re-establishment fee is currently $98.33 per licensed enrollee. If the re-establishment fee were applied to our total BCBS enrollees as of December 31, 2016, we would be assessed approximately $99.6 million by the BCBSA.

We believe that the BCBS name and mark are valuable identifiers of our products and services in the marketplace. Termination of these license agreements, including modifications to the current term and conditions, could have a material adverse effect on our business, financial condition and results of operations. See “Item 1. Business Blue Cross and Blue Shield License” for more information.

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

Reinsurance is the practice of transferring part of an insurance company’s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. During 2016, 34.6%, or $46.0 million, of the premiums written in the property and casualty insurance segment and 5.5%, or $8.8 million, of the premiums written in the life insurance segment were ceded to reinsurers. Total premiums ceded, on a consolidated basis, represent 1.9%, or $54.8 million of our premiums. The premiums ceded and the availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

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

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

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

pay on a timely basis, we will continue to be liable to our policyholders notwithstanding such defaults or delays. If our reinsurers are not capable of fulfilling their financial obligations to us, our insurance losses would increase, which would negatively affect our financial condition and results of operations.

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A downgrade in 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 2016, A.M. Best maintained our property and casualty insurance subsidiary's rating of "A-" (the fourth highest of A.M. Best's 16 financial strength ratings) with a stable outlook. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary's rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings.

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

We are subject to strong competition in each line of business in which we operate. 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 in our profitability. The industry in which we operate has unique characteristics that, if we are unable to manage adequately, may adversely affect our business, financial conditions and results of operations. Some of the trends and characteristics related to the competition we face in our different lines of business include the following:

- The managed care market in Puerto Rico is mature. According to the U.S. Census Bureau, Puerto Rico's population decreased by 2.2% between 2000 and 2010; however, the national population rate grew 9.7% during the same period. According to the US Census Bureau, the older population is an important and growing segment of the United States population. Between 2000 and 2010, the population 65 years and older increased at a faster rate (15.1%) than the total U.S. population. In Puerto Rico, for the same period, the population 65 years and older increased by 27.5 %. As a result, in order to increase our profitability we believe that we must increase our membership in the Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically.

- Local economy is in a downturn. Challenging economic conditions in Puerto Rico continue to produce conditions that are adverse to the generation of new sources of business in this segment. As a result, insurance companies compete for the same customers through pricing, policy terms and quality of services. Also, our industry is also subject to aggressive marketing and sales practices that target our current and prospective customers. We may not be successful in attracting and retaining our customers.

- Our industry is highly regulated. Future legislation at the federal and local levels may also result in increased competition, especially in the managed care segment. 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.

- Market concentration. Concentration in our industry 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 companies, which can create downward price pressures on premium rates.

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

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

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

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

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

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

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

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Our business also is dependent on our ability to have qualified personnel in highly specialized areas, including actuarial, medical and financial professionals to successfully attain our financial and operational goals. In addition, in order to market our products effectively, we must continue to recruit, retain and establish relationships with qualified independent agents and brokers. Such 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. Our inability to retain, attract and manage qualified employees, or independent agents and brokers that help us to maintain our current or increase our customers base, could have a material adverse effect on our business, financial condition and results of operations.

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

We have exposure to market risk and credit risk in our investment activities. The fair values of our investments vary from time to time depending on economic and market conditions. Fixed maturity securities expose us to interest rate risk as well as credit risk. Equity securities expose us to equity price risk. Interest rates are highly sensitive to many factors, including governmental monetary policies and domestic and international economic and political conditions. These and other factors also affect the equity securities owned by us. The outlook of our investment portfolio depends on the future direction of interest rates, fluctuations in the equity markets and the amount of cash flows available for investment. For additional information, see "Item 7A. Quantitative and Qualitative Disclosures About Market Risk" for an analysis of our exposure to interest and equity price risks and the procedures in place to manage these risks. Our investment portfolios may lose money in future periods, which could have a material adverse effect on our financial condition.

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, and real estate and equity investments, among others, which could generate higher returns on our investments. If we fail to comply with these laws and regulations, any investments exceeding regulatory limitations would be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital.

The securities and credit markets could experience extreme volatility and disruption.

Adverse conditions in the U.S. and global capital markets could significantly and adversely affect the value of our investments in debt and equity securities, other investments, our profitability and our financial position.

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

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

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

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

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- Reducing our ability to issue other securities.

We evaluate our investment securities for other-than-temporary impairment on a quarterly basis. This review is subjective and requires a high degree of judgment. It also requires us to make certain assessments about the potential recovery of the assets we hold. For the purpose of determining gross realized gains and losses, the cost of investment securities is based upon specific identification.

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

For additional information, see "Item 7A. Quantitative and Qualitative Disclosures About Market Risk" for an analysis of our exposure to interest and equity price risks and the procedures in place to manage these risks. Our investment portfolios may lose money in future periods, which could have a material adverse effect on our financial condition.

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, and real estate and equity investments, among others, which could generate higher returns on our investments. Notwithstanding, the Insurance Code of Puerto Rico requires insurers to invest an amount equal to no less than half of the insurer's required capital in Puerto Rico Securities. Since February 2014, the credit ratings of bonds issued by the Government of Puerto Rico and most of Puerto Rico public corporations have been downgraded to below-investment grade. As a result, on March 2014, the Puerto Rico Legislative Assembly enacted legislation allowing insurance companies to hold investments that were acquired at an investment grade rating but subsequently downgraded below-investment grades for period not exceeding three years from the date of acquisition. This legislation also authorizes the Commissioner of Insurance, upon an insurer's request, to provide a three-year extension of the holding period, or an exemption to dispose of the downgraded investment. As of December 31, 2016, the Company's insurance subsidiaries, on a consolidated basis, hold approximately $12.3 million in bonds issued by the Government of Puerto Rico and its instrumentalities that are currently graded at below-investment grade. The Insurance Code requirement that insurers invest in Puerto Rico securities may affect our ability to invest in other securities with a higher investment credit rating, the overall value of our investment portfolio and our financial condition. 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 may adversely affect our financial condition and results of operations.

Our business is geographically concentrated in Puerto Rico and weakness in the economy and the fiscal health of the government has adversely impacted and may continue to adversely impact us.

Our principal lines of business are concentrated in Puerto Rico, which is currently in the midst of a severe fiscal and economic crisis resulting primarily from a continuing economic recession, significant and recurrent budget deficits, accelerated outmigration, a high debt-to-revenue ratio, unfunded pension liabilities and the loss of access to the capital markets, among other factors. We also have direct government exposure through our contract with the Puerto Rico Health Services Administration, which administers the government health plan, and certain other business relationships with the Government of Puerto Rico and its instrumentalities.

Puerto Rico's gross national product contracted in real terms every year between fiscal years (from July 1 to June 30) 2007 and 2015 (inclusive), with the exception of fiscal year 2012, when the economy grew 0.5% due to the large amount of stimuli and deficit spending injected into the Puerto Rico economy during the period. According to the Puerto Rico Planning Board, for fiscal years 2016 and 2017, gross national product is projected to decrease by 1.8% and 2.3% in constant dollars. This persistent contraction or minimal growth has had an adverse effect on employment and tax revenues, and has significantly contributed to central government budget deficits.

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The weakness of Puerto Rico's economy has adversely affected employment. Total employment in Puerto Rico decreased from 1,244,425 to 1,001,525 from fiscal year 2007 to fiscal year 2016. The reduction in total employment began in the fourth quarter of fiscal year 2007 and continued consistently through the first half of fiscal year 2015 due to the current recession and the fiscal adjustment measures implemented by the government. Since then, total employment has mostly stabilized. According to the Household Survey, during fiscal year 2016, total employment increased by 1.8% when compared to the prior fiscal year, and the unemployment rate averaged 11.7% compared to 13.0% for the prior fiscal year. Additionally, for the first five months of fiscal year 2017, total employment decreased by 0.4% with respect the first five months of fiscal year 2016.

The Government's structural deficit, coupled with the continuing recession, decreasing employment, lack of capital market access, and a drastic reduction in the liquidity of Government Development Bank for Puerto Rico, have resulted in the government being unable to pay scheduled debt service payments while continuing to provide essential services.

The Government has implemented a number of extraordinary liquidity management measures in order to continue operating, which include significantly delaying the payment of income tax refunds and accounts payable to government contractors and suppliers. The Government has also enacted several extraordinary revenue raising measures, including the imposition of a 4.5% surcharge on the sales and use tax and a 4% sales and use tax on certain business to business services that had been previously exempt from the sales and use tax. In addition, pursuant to a local moratorium law, the Government suspended the payment of debt service on its debts and that of several of its public corporations and is retaining certain revenues assigned to particular public corporations and redirecting the same for the funding of operational expenses. The Government has stated that certain of these emergency measures are unsustainable and could have significantly adverse economic consequences. Also, the Commonwealth has indicated that absent additional liquidity or other emergency measures, it may experience significant cash shortfalls during the fourth quarter of the current fiscal year.

In response to the Commonwealth's fiscal and economic crisis, on June 30, 2016, the U.S. Congress enacted the Puerto Rico Oversight, Management and Economic Stability Act ("PROMESA"), which, among other things, established a Federally-appointed oversight board (the "Oversight Board"), comprised of seven members, that has ample powers over the finances of the Commonwealth and its instrumentalities. PROMESA also established a temporary stay on litigation to enforce rights or remedies related to financial liabilities of the Commonwealth, its instrumentalities and municipalities, which was initially scheduled to expire on February 15, 2017 but was extended by the Oversight Board until May 1, 2017. Finally, PROMESA established two separate mechanisms to restructure the debts of the Commonwealth, its public corporations and municipalities. The first mechanism permits modifications of financial indebtedness with the consent of a supermajority of affected financial creditors. The second mechanism is a court-supervised debt-adjustment process, which is modeled after Chapter 9 of the U.S. Bankruptcy Code.

Pursuant to PROMESA, the Oversight Board required the Commonwealth to submit a fiscal plan in October 2016. The fiscal plan submitted by the Commonwealth projected that, under current policies, consolidated expenditures (including required pension payments and debt service on tax-supported debt) would, in the aggregate, exceed consolidated resources by approximately $58.7 billion from fiscal year 2017 to fiscal year 2026 (later revised based on feedback from the Oversight Board to approximately $67.5 billion over such period). The plan estimated that, even assuming the successful implementation of the measures set forth therein, there would still be a material cumulative financing gap before the payment of debt service during the ten-year period covered by the fiscal plan in the absence of federal Affordable Care Act funding for the Government's health programs. The Oversight Board rejected the prior Administration's plan in November 2016 and requested that the new Administration of Governor Ricardo Rosselló Nevares deliver a new fiscal plan by January 15, 2017, which was later extended until February 28, 2017. In a letter dated January 18, 2017, the Oversight Board recommended to the Governor a series of measures for inclusion in the fiscal plan, including: (i) a $1.0 billion reduction in health care spending by fiscal year 2019, (ii) the elimination of budgetary subsidies to municipalities and (iii) significant reductions in payroll expenditures and pension and/or

pension-related benefits. On February 28, 2017, the Governor of Puerto Rico submitted a 10-year fiscal plan to the Fiscal Oversight Board established by PROMESA, for its review and approval. As part of the proposed plan, the Puerto Rico government intends to make significant changes to the Government Health Plan, including a cost take-out of around $300 million over the first two years and $2.5 billion over the ten-year plan period.

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Our insureds' financial capacity is affected by, among other things, the general economic conditions in Puerto Rico and other adverse conditions affecting Puerto Rico consumers and businesses. The effects of the prolonged recession are reflected in a decrease in insured customers in our commercial lines of business and premiums earned, net. The measures taken to address the fiscal crisis and those that may have to be taken in the near future, including higher taxes and lower governmental expenditures, will likely affect many of our insureds, which could result in a lower amount of insureds, insureds moving to lower premium plans among others. The Commonwealth's fiscal projections suggest that the level of fiscal adjustment of any fiscal plan approved by the Oversight Board, and its resulting impact on the local economy, will be significant. Such fiscal adjustment may also result in significant resistance from different stakeholders, and may negatively affect consumer confidence. The foregoing could result in decreased demand for our insurance products or migration to less profitable products.

If global or local economic conditions worsen or the Government of Puerto Rico is unable to manage its fiscal and economic challenges, including consummating an orderly restructuring of its debt obligations while continuing to provide essential services, the conditions described above could continue or worsen in ways that are unpredictable and outside of our control. While PROMESA provides the Commonwealth with tools to restructure the debt obligations of the Commonwealth and its instrumentalities, these restructuring tools are new and untested. Furthermore, the size of the fiscal gaps suggested by the Commonwealth's projections indicates the possibility of significant creditor losses. Both of these factors may make any debt restructuring process a lengthy and highly adversarial process. These factors could have a material adverse impact on our earnings and financial condition.

Continued weakness in the Puerto Rican economy or the failure of the Puerto Rico government to manage its fiscal problems in a orderly manner could have an adverse effect on our insured customers, which may be required to forego insurance coverage or scale back on the amount of insurance coverage purchased. In turn, if this trend continues or worsens, our results of operations or financial condition may be adversely impacted.

Actions taken by the Commonwealth government or the PROMESA Oversight Board to address the ongoing fiscal and economic challenges in Puerto Rico could materially affect the value of our portfolio of Puerto Rico government securities.

We have direct exposure to the Puerto Rico government, its public corporations and municipalities that amounted to a book value of approximately $17.9 million and a corresponding market value of approximately $20.1 million. The exposure consists of escrowed bonds which are backed by US government securities (with a book value and market value of approximately $7.8 million) and of senior lien bonds issued by the Puerto Rico Sales Tax Financing Corporation, also known as Cofina (with a book value of approximately $10.1 million and a market value of approximately $12.3 million). Our Cofina holdings are currently at an unrealized gain of approximately $2.2 million as these positions have been impaired in previous periods. Cofina has been designated as a covered entity under PROMESA and the automatic stay on litigation imposed by PROMESA applies to these holdings. Currently the government continues to deposit sales tax revenues into the Cofina trust and debt service is being paid on the bonds. Deterioration of the Commonwealth's fiscal and economic situation, including any negative ratings implications, could further adversely affect the value of our Puerto Rico government obligations, resulting in losses to us.

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

Our business and operations may be affected if we do not maintain and upgrade our information systems and the integrity of our proprietary information. We are materially dependent on our information systems, including Internet-enabled products and information, for all aspects of our business operations. Monitoring utilization and other factors, supporting our managed care management techniques, processing provider claims and providing data to our regulators, and our ability to compete depends on adopting technology on a timely and cost-effective basis. Malfunctions in our information systems, fraud, error, communication and energy disruptions, security breaches or the failure to maintain effective and up-to-date information systems could disrupt our business operations, alienate

customers, contribute to customer and provider disputes, result in regulatory violations and possible liability, increase administrative expenses or lead to other adverse consequences. The use of member data by all of our businesses is regulated at federal and local levels. These laws and rules change frequently and developments require adjustments or modifications to our technology infrastructure.

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

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

We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches. Because of the confidential health information we store and transmit, security breaches could expose us to a risk of regulatory action, litigation, possible liability and loss. We are taking all needed security measures to prevent security breaches, and ensure our business operations won’t be adversely affected by potential security breaches.

We face risks related to litigation.

We are subject 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 are subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services, claims relating to the denial of benefits or coverage, medical malpractice actions, medical malpractice actions, allegations of anti-competitive and unfair business activities, provider disputes, broker and agent disputes, and claims by regulatory actions by agencies for non-compliance, among others. Legal proceedings are inherently unpredictable and we cannot ascertain their outcome. We have insurance to cover liabilities relating to litigation; however, insurance coverage may not be sufficient to cover any such liability or our insurers could deny or dispute coverage. Results of regulatory actions could require us to change our business practices and may affect our profitability. Substantial liability relating to legal or regulatory actions could adversely affect our cash flow, results of operations, and financial conditions. 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 managed care, property and casualty and life insurance segments would likely increase and our properties may incur substantial damage, which could have a material adverse effect on our business, financial condition and results of operations.

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

The secured term loan and the note purchase agreements governing the notes contain financial and non-financial covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These non-financial covenants could restrict our operations. In addition, if we fail to make any required payment under our secured term loans or note purchase agreements governing the notes or to comply with any of the non-financial covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our secured term loans or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the secured term loans, cease to make further extensions of credit. If the indebtedness under our secured term loans or note purchase agreements is accelerated, we may be unable to repay or re-finance the amounts due and our business may be materially adversely affected.

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

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

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

If we do not effectively manage the growth of our operations and our acquisitions, 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 growth strategy exposes us to additional risks, including our ability to:

- identify profitable growth opportunities in current and additional markets;
- transact successful acquisitions, capital investments and other growth initiatives;
- determine the correct value of assets and investments;

- implement adequate pricing and operational structure, including underwriting and claim management processes;
- design attractive and profitable insurance and health products and services;
- recruit required personnel for expanded operations, including officers, agents, brokers, medical providers, and other key personnel;
- obtain regulatory permission required to operate in other jurisdictions or lines of business;

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- comply with regulatory requirements;

- integrate acquired business to our operations, including integration of information technology, management and personnel, and administrative systems;

- create the expected return over time; and

- implement new, or modify existing internal monitoring and control systems.

Additionally, our management and other key personnel may expend considerable time and effort which may distract them from their core activities. We may face risk associated to unknown or unidentified liabilities resulting from our investments or acquisitions. We may also be subject to changes in trade protection laws, policies and measures, and other regulatory requirements affecting our business, including the Foreign Corrupt Practices Act and laws prohibiting corrupt payments. Deterioration of social, political, labor or economic conditions in a specific country or region and difficulties in managing foreign operations may also adversely affect our operations or financial results. Also, fluctuations in foreign currency rates could affect our financial results.

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

As of December 31, 2016 we had approximately $25.4 million and $4.9 million of goodwill and intangible assets recorded on our balance sheet, primarily related to the TSA acquisition, that represent 1.4% of our total consolidated assets and 3.5% of our consolidated stockholders’ equity. If we make additional acquisitions it is likely that we will record additional goodwill and intangible assets on our consolidated balance sheet.

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

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

In addition, the estimated value of our reporting units may be impacted as a result of the implementation of various Health Care Reform regulations. Such regulations could have significant effects on our future operations, which in turn could unfavorably affect our ability to support the carrying value of certain goodwill and other intangible assets and result in significant impairment charges in future periods. See “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates Goodwill and Other Intangible Assets”.

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Risks Relating to Taxation

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

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

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

Based on our current business assets and operations, we do not expect that we will be considered a ''passive foreign investment company'' (a "PFIC") for U.S. federal income tax purposes. However, because PFIC status depends upon the composition of our income and assets and the market value of our assets (including, among others, less than 25 percent owned equity investments) in each year, which may be uncertain and may vary substantially over time, there can be no assurance that we will not be considered a PFIC for any taxable year. Our belief that 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 our shares of Class B common stock.

Legislative and other measures that may be taken by Puerto Rico governmental authorities could materially increase our tax burden.

In July 2015, Puerto Rico enacted legislation increasing the aggregate sales and use tax rate from 7% to 11.5% (10.5% payable to the Puerto Rico Department of the Treasury (the "Central Government SUT") and 1% payable to the municipality (the "Municipal SUT")) and imposing a 4% sales and use tax payable to the Puerto Rico Department of the Treasury on certain services previously covered by the business to business exemption and designated professional services. The increase from 7% to 11.5% became effective in July 1, 2015 and the 4% tax became effective October 1, 2015. Under the approved legislation the sales and use tax does not apply to Medicare and Medicaid services. Moreover, in light of Puerto Rico's current fiscal and economic challenges, it is uncertain whether further tax-related legislation affecting the heath care or insurance industry may be enacted in an effort to increase Puerto Rico's tax revenues. Any increase in the amount of taxes we pay and the taxation of the customers we serve may have a material adverse effect to our financial condition, results of operations and cash flows.

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Risks Relating to the Regulation of Our Industry

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

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

- initiatives to provide greater access to coverage for uninsured and under-insured populations without adequate funding to health plan or to be funded through taxes or other negative financial levy on health plans;
- payments to health plans that are tied to achievement of certain quality performance measures and by health plans that do not satisfy applicable medical loss ratio requirements;
- other efforts or specific legislative changes to the Medicare or Medicaid programs, including changes in the bidding process or other means of materially reducing premiums;
- local government regulatory changes;
- increased government enforcement, or changes in interpretation or application, of fraud and abuse and health information privacy laws; and
- regulations that increase the operational burden on health plans that increase a health plan's exposure to liabilities, including efforts to expand the tort liability of health plans.

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

Future regulatory actions by the Commissioner of Insurance or other governmental agencies, including federal regulations, could have a material adverse effect on the profitability or marketability of our business, financial condition and results of operations, which in turn could impact the value of our business model and result in potential impairments of our goodwill and other intangible assets.

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

Continued implementation of the ACA provides comprehensive changes to the U.S. health care system, which are being phased in at various stages through 2018. The legislation imposed an annual insurance industry assessment of $8 billion in 2014, which will increase to $14.3 billion by 2018, with increasing annual amounts thereafter based on premium growth. Such assessment may not be deductible for income tax purposes. If the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this new tax, our results of operations, financial position and liquidity may be materially adversely affected. Also, health plans serving the individual market are subject to the guaranteed issue provisions under which the plans are required to issue coverage to individuals without regard to their health status of pre-existing conditions, which could lead to adverse selection by consumers. On July 16, 2014, the Department of Health and Human Services sent a letter to the Commissioner of Insurance of Puerto Rico notifying that guarantee issue provisions under ACA are not applicable to U.S. territories. However, on July 22, 2013, similar guarantee issue and other market reforms provisions were enacted in Puerto Rico as part of amendments made to the Health Insurance Code of Puerto Rico. Although the Puerto Rico legislature is considering additional legislation to provide insurance companies more flexibility to comply with the additional requirements enacted in 2013, it is uncertain whether such legislation will in fact be enacted or the effect of any such additional legislation may have on our business. If we are unable to adapt our premium structure to address the guaranteed issue requirement, our results of operations, financial position and liquidity may be materially adversely affected.

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On January 20, 2017, President Trump signed an Executive Order directing federal agencies with authorities and responsibilities under the ACA to waive, defer, grant exemptions from, or delay the implementation of any provision of the ACA that would impose a fiscal or regulatory burden on states, individuals, healthcare providers, health insurers, or manufacturers of pharmaceuticals or medical devices. Further, in January 2017, Congress voted to adopt a budget resolution for fiscal year 2017, or the Budget Resolution, that authorizes the implementation of legislation that would repeal portions of the ACA. Following the passage of the Budget Resolution, on March 6, 2017, the U.S. House of Representatives introduced legislation known as the American Health Care Act, which, if enacted, would amend or repeal significant portions of the ACA. Among other changes, the American Health Care Act would sunset the annual insurance industry assessment as of December 31, 2017, essentially eliminate the individual and employer mandates by eliminating penalties and providing retroactive relief for failing to maintain or provide minimum essential coverage, and permit insurers to charge individuals a 30% surcharge on premiums for failing to demonstrate continuous coverage. The American Health Care Act would also make significant changes to Medicaid by, among other things, making the ACA Medicaid expansion optional for states, repealing the ACA requirement that state Medicaid plans provide the same essential health benefits that are required by plans available through the exchanges, implementing a per capita cap on federal payments to states beginning in fiscal year 2020, and changing certain eligibility requirements. While it is uncertain when or if the provisions in the American Health Care Act will become law, or the extent to which any such changes may impact our business, it is clear that Congress is taking concrete steps to repeal and replace certain aspects of the ACA.

Further, various health insurance reform proposals are also emerging at the state level. This legislation could impact us through potential disruption to the employer-based market, potential cost shifting in the health care delivery system to insurance companies and limitations on the ability to increase premiums to meet costs. Because of the unsettled nature of these reforms, the numerous steps required to implement them, and the potential repeal of certain aspects of these reforms we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities.

Although we believe the legislation may provide us with significant opportunities to grow our business, the implementation of enacted reforms, such as the continued cuts in the effective Medicare Advantage rates applicable to our plans which are expected to be phased in for our plans through 2017, and the expected sunset in 2019 of the additional federal funding of Medicaid granted to Puerto Rico and the other US Territories under ACA, as well as future regulations and legislative changes, may in fact have a material adverse effect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our business may be materially adversely affected.

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

The laws and regulations governing Medicare Advantage program participants are complex, subject to interpretation and frequent change 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. In addition, maintaining compliance with such laws and regulations as they change may, in some cases, entail substantial direct costs.

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Under CMS regulations to implement certain ACA requirements that became effective on June 1, 2012, CMS has the authority not to renew our contracts beginning in 2015 based solely on the Star Ratings of our Medicare Advantage plans if their respective ratings do not achieve three or more stars (out of 5.0 stars) for three consecutive contract years. See the subcaption "Federal regulations" in Item 1 of this annual report on Form 10-K for detailed information of the Stars Ratings. In the final call letter to Medicare Advantage organizations dated April 6, 2015, CMS stated that it would not delay contract terminations based on a plan's Star Ratings

Historically, the TSA plans have received annual Star Ratings of three or more stars. CMS provides a quality bonus to plans with Star Ratings of 3.5 or more. As of December 31, 2016, TSA's HMO plan achieved 4.0 overall on a 5.0 star rating system, and achieved 5 stars in Part D and TSA's PPO plan maintained its 3.5 stars and achieved 4.5 stars in Part D.

The Company is subject, and will likely continue to be subject, to audits from CMS in connection with the Medicare Advantage contracts. CMS audit may review the effectiveness of multiple matters, including the performance of the benefit administration, coverage determinations, process of appeals and grievances, dismissals, oversight of agents and brokers, and enrollment process. CMS may impose civil monetary penalties as a result of their findings or require changes to our business practices that may adversely affect our profitability. CMS may also terminate any of our Medicare Advantage contracts if it determines that any of these plans has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage program. Compliance with CMS requirements may require us to divert resources that may affect the results of our operations and financial condition. Any termination or non-renewal of our Medicare Advantage plans would have a material adverse effect on our business and financial results.

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

Federal, Puerto Rico, and Costa Rica government authorities, including but not limited to the Commissioner of Insurance, ASES, CMS, the OIG, the Office of the Civil Rights of HHS, the U.S. Department of Justice, the U.S. Department of Labor, and the OPM, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations. In addition, beginning in Medicare contract year 2016, CMS will have the right to require Medicare Advantage plan sponsors such as us to hire an independent auditor, working in accordance with CMS specifications, to validate if the deficiencies that were found during a CMS full or partial program audit have been corrected and provide CMS with a copy of the audit findings. If, in the future, we were required by CMS to hire an independent auditor, such audit would entail direct costs to us, in addition to potential penalties in the event of negative audit findings. We may also become the subject of non-routine regulatory or other investigations or proceedings brought by these or other authorities, and our compliance with and interpretation of applicable laws and regulations may be challenged. In addition, our regulatory compliance may also be challenged by private citizens under the "whistleblower provisions" of applicable laws. The defense of any such challenge could result in substantial cost, diversion of resources, and a possible material adverse effect on our business.

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

- recoupment of amounts we have been paid pursuant to our government contracts;
- mandated changes in our business practices;
- imposition of significant civil or criminal penalties, fines or other sanctions on us and/or our key employees;
- additional reporting requirements and oversight and mandated corrective action or remediation plans;

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- loss or non-renewal of our government contracts or loss of our ability to participate in Medicare or other federal or local governmental payor programs; damage to our reputation;
- increased difficulty in marketing our products and services;
- inability to obtain approval for future services or geographic expansions; and
- loss of one or more of our licenses to act as an insurance company, preferred provider or managed care organization or other licensed entity or to otherwise provide a service.

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

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

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

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

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

The collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information are regulated at the federal, state, international and industry levels and requirements are imposed on us by contracts with customers. HIPAA regulations also provide access rights and other rights for health plan beneficiaries with respect to their health information. These regulations include standards for certain electronic transactions, including encounter and claims information, health plan eligibility and payment information. Health plans are also subject to beneficiary notification and remediation obligations in the event of an authorized use or disclosure of personal health information. HIPAA also requires business associates as well as covered entities to comply with certain privacy and security requirements. Even though we provide for appropriate protections through our contracts with our third-party service providers and in certain cases assess their security controls, we still have limited oversight or control over their actions and practices.

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

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Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain our ability to manage our business model. In addition, HHS has expanded its HIPAA audit program to assess compliance efforts not only by covered entities, but also business associates. Although we are not aware of HHS plans to audit any of our covered entities or business associates, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows. We are also subject to Puerto Rico Act No. 194 of August 25, 2000, also known as the Patient's Rights and Responsibilities Act, including provisions more stringent than HIPAA. There is uncertainty regarding many aspects of such state requirements which make compliance with applicable health information laws more difficult. For these reasons, our total compliance costs may increase in the future.

We are subject, and will likely continue to be subject, to regulatory audits and investigations relating to our compliance with HIPAA and other related privacy requirements. On November 20, 2015, we entered into a resolution agreement with the HHS Office of Civil Rights ("OCR") in connection with investigations conducted by OCR involving privacy incidents at our managed care business, which includes a three-year corrective action plan. Also, on November 20, 2015, we entered into a settlement agreement with ASES in connection with privacy incidents relating to beneficiaries of the government health plan. See, "Item 3. Legal Proceedings–Unauthorized Disclosure of Protected Health Information" for more information.

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

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

Medicare Advantage managed care plans are paid based off of a CMS-calculated "benchmark" amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. A Medicare Advantage plan's actual payment rate is based on a complex statutory formula that takes into account a number of factors, including the relationship between the plan's bid and the benchmark. In addition, under the ACA, Medicare Advantage plan payment rates are subject to transitionally phased in reductions intended to bring Medicare Advantage rates more in line with Medicare fee-for-service rates, which are being phased in between 2012 and 2017. Medicare generally will rebate a portion of the amount by which the benchmark amount exceeded the accepted bid for certain plans. For plans achieving star rating of at least 3.5 stars, the portion of the savings retained by the plan is higher. For plans achieving star ratings of at least 4 stars, the starting benchmark amount from which the savings is computed is also higher (a "quality bonus"). However, Medicare's three year Quality Bonus Payment Demonstration, under which bonuses for some plans were higher than required by the ACA, and under which Medicare would also rebate a quality bonus to certain plans achieving star ratings of 3.0 or 3.5 stars, ended in 2014. 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. CMS also could administratively seek to implement certain methodological changes to the Medicare Advantage rate calculations that could result in functionally lower payment rates. The implementation of the proposed Medicare Advantage rates, if adopted, as well as the continued implementation of the ACA reduction of Medicare Advantage funding, which is expected to continue to be phased in through 2017, may have a material adverse effect on our revenue, financial

position, results of operations or cash flow.

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

We 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, our ability to participate in the Medicare Advantage program is affected by the pricing and design of our competitors' bids. Moreover, we may in the future be required to reduce benefits or charge our members an additional premium in order to maintain our current level of profitability, either of which could make our health plans less attractive to members and adversely affect our membership.

In February 2017, CMS released its draft Advance Notice and Call Letter for Medicare Advantage reimbursement in 2018. This draft notice contains a number of provisions that will have a significant effect on the operations of Puerto Rico's MA program. These proposals include provisions that may increase certain payments made to plans in Puerto Rico, including an adjustment to physician reimbursement reflecting the GPCI payment update made in last year's physician payment rule. The draft call letter does not adequately address problems with the benchmark for treatment of end stage renal disease (ESRD) patients in the Medicare Advantage program. In addition, the draft letter does not commit to including the zero claims adjustment, embedded in last year's rate, in determining Puerto Rico's 2018 MA benchmark; failure to include the adjustment would result in a significant reduction in payment. The call letter will be finalized in early April. Until then, it is uncertain whether any of CMS's proposals will be implemented or, if implemented, the effect in our Medicare Advantage business.

CMS's risk adjustment payment system and other Medicare Advantage funding pressures make our revenue and profitability difficult to predict and could result in material retroactive adjustments to our results of operations.

CMS has implemented a risk adjustment payment system for Medicare Advantage plans to improve the accuracy of payments and establish incentives for such plans to enroll and treat less healthy Medicare beneficiaries. CMS phased in this payment methodology with a risk adjustment model that bases a portion of the total CMS reimbursement payments mainly on demographic and the health severity of enrollees. The risk adjusted premiums we receive are based on claims and encounter data that we submit to CMS within prescribed deadlines. We develop our estimates for risk-adjusted premiums utilizing historical experience, or other data, and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which are possible as additional diagnosis code information is reported to CMS, when the ultimate adjustment settlements are received from CMS, or we receive notification of such settlement amounts. CMS adjusts premiums on two separate occasions on a retrospective basis. The first retrospective adjustment for a given plan year generally occurs during the third quarter of that year. This initial settlement represents the update of risk scores for the current plan year based on the severity of claims incurred in the prior plan year. CMS then issues a final retrospective risk adjusted premium settlement for that plan year in the following year. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur, which may result in the refund of premiums to CMS. The result of these audits could materially reduce premium revenue in the year in which CMS determines a refund is required and could be material to our result of operations, financial position and cash flows.

CMS may make changes to the manner in which it determines risk adjustment payments. As a result of the risk adjustment process and CMS's ability to modify the manner in which it applies such risk adjustments, 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 adjustment to payment from CMS and our Medicare payment revenue.

One particular risk adjustment problem that we have identified is the lack of adequate risk adjustment for ESRD. The end-stage renal disease (ESRD) population in Puerto Rico is significantly underfunded in the proposed benchmark. The ESRD benchmark in Puerto Rico is $4,238 in 2017, compared to a national average of $6,628 and $5,800 in the US Virgin Islands. There are 3,500 ESRD patients in the MA program in Puerto Rico and these patients have a clinical profile even more complicated than ESRD patients on the mainland. 40 percent of our ESRD patients have three additional comorbidities. Puerto Rico has only two dialysis providers; the average dialysis fee in Puerto Rico is $180 through Medicare Advantage, compared to a national average of around $225. Puerto Rico faces a disproportionately large ESRD burden, in part because of the high incidence of diabetes among our population. Diabetes is the third leading cause of death in Puerto Rico, with a death rate of 87 per 100,000, compared to 23.9 per 100,000 on the mainland.

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Finally, we generally rely on providers, including certain network providers who are our employees, to appropriately document all medical data, including the diagnosis codes submitted with claims, as the basis for our risk scores under the program. Thus, our ability to meet our premium revenue estimates depends largely on the success of third party efforts to collect and properly reflect medical data, including diagnosis codes that must be submitted with claims. There is no assurance that our providers will be successful in accurately collecting such medical data and diagnosis codes and, to the extent their efforts are not successful, such failure may have a material adverse effect on our premium revenues. Further, the continued implementation of the ACA reduction of Medicare Advantage funding, which is expected to continue to be phased in through 2017, may have a material adverse effect on our premium revenues.

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

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

Medicare and Medicaid spending by the federal government could be decreased as part of the spending cuts associated with the debt ceiling or the repeal and replacement of the Affordable Care Act.

The Sequestration Transparency Act of 2012 (P.L. 112-155) requires the President of the United States to submit to Congress a report on the potential sequestration triggered by the failure of the Joint Selective Committee on Deficit Reduction to propose, and Congress to enact, a plan to reduce the deficit by $1.2 trillion, as required by the Budget Control Act of 2011. Under the sequestration, automatic spending cuts became effective beginning April 1, 2013, and, following passage of the Bipartisan Budget Act of 2015, these cuts have been extended through at least 2025 unless additional Congressional action is taken. This resulted in cuts of 2% to Medicare funding. Medicaid programs are not subject to automatic spending cuts. In addition, in January 2013, President Obama signed into law the American Taxpayer Relief Act of 2012, which, among other things, reduced Medicare payments to several categories of healthcare providers and increased the statute of limitations period for the government to recover overpayments to providers from three to five years. Congress will have to confront another debt ceiling debate this summer which could result in additional cuts to entitlement programs.

Legislation under development in Congress to repeal and replace the Affordable Care Act has the potential to significantly alter the Medicaid program. In addition to the more general programmatic uncertainty, Puerto Rico confronts a cliff in the availability of its Medicaid funding by late 2017. Congress has a number of opportunities to address Puerto Rico's Medicaid challenges over the next several months and we are optimistic that action will be taken to provide bridge funding to avoid the cliff.

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own a seven story building located at 1441 F.D. Roosevelt Avenue, in San Juan, Puerto Rico, and two adjacent buildings, as well as the adjoining parking lot, which is mainly used by the managed care segment. In addition, we own five floors of a fifteen-story building located at 1510 F.D. Roosevelt Avenue, in Guaynabo, Puerto Rico, which is mainly used by the property and casualty segment. We also own land and a multi-segment customer service center in the municipalities of Mayagüez and Ponce, Puerto Rico. 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. In addition, through a health clinic in which we have a controlling interest, we own land and a two-story medical facility in the municipality of Bayamón. These properties are subject to liens under our credit facilities. In connection with our entrance to the Costa Rican market, we acquired a two-story building located in the city of San José, Costa Rica, which is used by the life insurance segment, See "Item 7—Management's Discussion and Analysis of Financial Condition and Results of Operation – Liquidity and Capital Resources".

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.

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Item 3. Legal Proceedings

Our business is subject to numerous laws and regulations promulgated by Federal, Puerto Rico, USVI, Costa Rica, BVI, and Anguilla governmental authorities. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. The Commissioner of Insurance of Puerto Rico, as well as other Federal, Puerto Rico, USVI, Costa Rica, BVI, and Anguilla government authorities, regularly make inquiries and conduct audits concerning the Company's compliance with such laws and regulations. Penalties associated with violations of these laws and regulations may include significant fines and exclusion from participating in certain publicly funded programs and may require the Company to comply with corrective action plans or changes in our practices. For a description of our legal proceedings, see Note 24, Contingencies, of the Notes to Consolidated Financial Statements, included in Item 8, Financial Statements and Supplementary Data, of this Annual Report on Form 10-K.

Item 4. Mine Safety Disclosures

None.

Part II

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

Market Information

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

The following table presents high and low closing prices of our Class B common stock for each quarter of the years ended December 31, 2016 and 2015:

| | High | Low |
|---|---|---|
| 2016 | | |
| First quarter | $26.83 | $19.99 |
| Second quarter | 27.50 | 21.60 |
| Third quarter | 26.55 | 21.51 |
| Fourth quarter | 23.68 | 19.00 |
| 2015 | | |
| First quarter | $25.01 | $18.38 |
| Second quarter | 26.40 | 18.72 |
| Third quarter | 24.63 | 17.69 |
| Fourth quarter | 26.50 | 18.17 |

On February 28, 2017 the closing price of our Class B common stock on the NYSE was $18.67.

Holders

As of February 28, 2017, there were 950,968 and 23,321,013 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A common stock as of February 28, 2017 was

approximately 786. The number of our holders of Class B common stock as of February 28, 2017 was approximately 4,123.

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Dividends

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

Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Our subsidiaries are subject to regulatory surplus requirements and additional regulatory requirements, which may restrict their ability to declare and pay dividends or distributions to us. In addition, our secured term loan restricts our ability to pay dividends if a default thereunder has occurred and is continuing. Please refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources – Restriction on Certain Payments by the Corporation's Subsidiaries". Also, see note 17 of the audited consolidated financial statements for the years ended December 31, 2016, 2015 and 2014.

We did not declare any dividends during the two most recent fiscal years and do not expect to pay any cash dividends in the near 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

See note 20 of the audited consolidated financial statements for the years ended December 31, 2016, 2015 and 2014.

Performance Graph

The following graph compares the price performance of our Class B common stock for the period from January 1, 2012 through December 31, 2016, with the price performance over such period of (i) the Standard and Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's 500 Managed Health Care Index (the "S&P MHC Index"). The comparison assumes an investment of $100 on January 1, 2012 in each of our Class B common stock, the S&P 500 Index, and the S&P MHC 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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| Ticker | Name | 1/3/2012 | 12/31/2012 | 12/31/2013 | 12/31/2014 | 12/31/2015 | 12/31/2016 |
|---|---|---|---|---|---|---|---|
| GTS US Equity | TRIPLE-S MANAGEMENT CORP | 100.00 | 91.35 | 96.14 | 118.25 | 118.25 | 102.37 |
| SPX Index | S&P 500 INDEX | 100.00 | 111.68 | 144.74 | 161.22 | 160.05 | 175.31 |
| S5MANH Index | S&P MHC Index | 100.00 | 102.88 | 150.09 | 197.99 | 238.45 | 281.45 |

Recent Sales of Unregistered Securities

Not applicable.

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Purchases of Equity Securities by the Issuer

Not applicable.

Item 6. Selected Financial Data

Statement of Earnings Data

| (Dollar amounts in millions, except per share data) | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|
| Years ended December 31, | | | | | |
| Premiums earned, net | $2,890.6 | $2,783.2 | $2,128.6 | $2,203.0 | $2,253.4 |
| Administrative service fees | 17.9 | 44.7 | 119.3 | 108.7 | 110.1 |
| Net investment income | 48.9 | 45.2 | 47.5 | 47.3 | 46.8 |
| Other operating revenues | 3.5 | 3.7 | 4.2 | 4.8 | 4.3 |
| Total operating revenues | 2,960.9 | 2,876.8 | 2,299.6 | 2,363.8 | 2,414.6 |
| Net realized investments gains | 17.4 | 18.9 | 18.2 | 2.6 | 5.2 |
| Other income, net | 6.5 | 7.0 | 2.3 | 15.3 | 2.2 |
| Total revenues | 2,984.8 | 2,902.7 | 2,320.1 | 2,381.7 | 2,422.0 |
| Benefits and expenses: | | | | | |
| Claims incurred | 2,472.2 | 2,318.7 | 1,747.6 | 1,836.2 | 1,919.8 |
| Operating expenses | 493.9 | 518.7 | 497.2 | 478.2 | 425.2 |
| Total operating costs | 2,966.1 | 2,837.4 | 2,244.8 | 2,314.4 | 2,345.0 |
| Interest expense | 7.6 | 8.2 | 9.3 | 9.5 | 10.6 |
| Total benefits and expenses | 2,973.7 | 2,845.6 | 2,254.1 | 2,323.9 | 2,355.6 |
| Income before taxes | 11.1 | 57.1 | 66.0 | 57.8 | 66.4 |
| Income tax (benefit) expense | (6.3) | 5.1 | 0.7 | 2.3 | 12.5 |
| Net income | 17.4 | 52.0 | 65.3 | 55.5 | 53.9 |
| Net loss attributable to non-controlling interest | - | (0.1) | (0.4) | (0.4) | (0.1) |
| Net income attributable to TSM | $17.4 | $52.1 | $65.7 | $55.9 | $54.0 |
| Basic net income per share (1): | $0.71 | $2.03 | $2.42 | $2.02 | $1.91 |
| Diluted net income per share: | $0.71 | $2.02 | $2.41 | $2.01 | $1.90 |

Balance Sheet Data

| Years ended December 31, | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|
| Cash and cash equivalents | $103.4 | $197.8 | $110.0 | $74.4 | $89.6 |
| Total assets | $2,219.0 | $2,206.1 | $2,145.7 | $2,047.6 | $2,059.3 |
| Long-term borrowings | $35.1 | $36.8 | $74.5 | $89.3 | $101.3 |
| Total stockholders' equity | $863.2 | $847.5 | $858.6 | $785.4 | $762.1 |

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Additional Managed Care Data (2)

| Years ended December 31, | 2016 | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|---|
| Medical loss ratio | 88.6 % | 86.2 % | 85.9 % | 86.7 % | 88.8 % |
| Operating expense ratio | 14.0 % | 15.1 % | 18.5 % | 17.0 % | 14.5 % |
| Medical membership (period end) | 1,017,372 | 1,094,444 | 2,139,484 | 2,187,939 | 1,721,114 |

(1) Further details of the calculation of basic earnings per share are set forth in notes 2 and 21 of the audited consolidated financial statements for the years ended December 31, 2016, 2015 and 2014.
(2) 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, 2016 and 2015, and consolidated results of operations for 2016, 2015 and 2014. References to the terms "we", "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations (“MD&A”), refer to TSM and unless the context otherwise requires, its direct and indirect subsidiaries. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

The structure of our MD&A is as follows:

VI. Recently Issued Accounting Standards

I. Overview

We are one of the most significant players in the managed care industry in Puerto Rico and have over 50 years of experience in this industry. We offer a broad portfolio of managed care and related products in the Commercial, Medicaid and Medicare Advantage markets. In the Commercial market we offer products to corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement. We also participate in the Government of Puerto Rico Health Reform (a managed care program for the medically indigent funded by the Puerto Rico and U.S. federal governments that is similar to the Medicaid program in the U.S.) (Medicaid). The Island is divided in eight regions and we served all of them on an administrative service only basis (ASO) until March 31, 2015. Effective April 1, 2015, the government changed the Medicaid delivery model from an ASO to a risk-based model and we elected to participate as a fully-insured provider in only two regions of Puerto Rico.

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We have the exclusive right to use the BCBS name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. As of December 31, 2016 we serve approximately 1,017,000 members across all regions of Puerto Rico. For the years ended December 31, 2016 and 2015 respectively, our managed care segment represented approximately 92% of our total consolidated premiums earned, net. We also have significant positions in the life insurance and property and casualty insurance markets in Puerto Rico.

We participate in the managed care market through our subsidiaries, TSS, TSB and TSA. TSS, TSA and TSB are BCBSA licensees, which provide us with exclusive use of the Blue Cross and Blue Shield name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla.

We participate in the life insurance market through our subsidiary, TSV, and in the property and casualty insurance market through our subsidiary, TSP.

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

2016 Consolidated Highlights

Key developments in our business during 2016 are described below:

- Consolidated premiums earned, net increased 2.9% year over year, to $2.9 billion, primarily reflecting higher Managed Care and Life Insurance premiums.

- The higher Managed Care premiums reflect the additional Medicaid premiums generated under the new at-risk contract that became effective April 1, 2015 and higher average premium rates in the Commercial business; partially offset by lower Commercial and Medicare membership. Total Medicaid premiums during this period were $783.2 million, $176.0 million higher than last year.

- Consolidated claims for the year were $2.5 billion, up 6.6% over last year, primarily reflecting the higher fully-insured Managed Care enrollment associated with the new Medicaid contract. The consolidated loss ratio was up 220 basis points, to 85.5%, and the Medical Loss Ratio ("MLR") increased 240 basis points, to 88.6%. Excluding the impact of prior-period reserve developments, and moving the Medicare risk score revenue adjustments to the corresponding period, the Managed Care MLR for the year was 88.1%, 110 basis points higher than the same metric from the prior year.

- Consolidated operating expenses for the year were $493.9 million and the operating expense ratio was 17.0%.

- Generated net income of $17.4 million in 2016, a decrease from a net income of $52.1 million in the prior year, reflecting the Managed Care segment's lower Commercial and Medicare enrollment combined with the segment's higher MLR.

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Overview details

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:

| | Years ended December 31, | | |
|---|---|---|---|
| (Dollar amounts in millions) | 2016 | 2015 | 2014 |
| Premiums earned, net: | | | |
| Managed care | $2,648.5 | $2,549.5 | $1,896.1 |
| Life insurance | 156.9 | 148.1 | 142.5 |
| Property and casualty insurance | 87.9 | 87.6 | 92.1 |
| Intersegment premiums earned | (2.7) | (2.0) | (2.1) |
| Consolidated premiums earned, net | $2,890.6 | $2,783.2 | $2,128.6 |
| Administrative service fees: | | | |
| Managed care | $22.4 | $49.3 | $123.6 |
| Intersegment administrative service fees | (4.5) | (4.6) | (4.3) |
| Consolidated administrative service fees | $17.9 | $44.7 | $119.3 |
| Operating (loss) income: | | | |
| Managed care | $(36.8) | $20.5 | $31.4 |
| Life insurance | 21.5 | 20.0 | 22.6 |
| Property and casualty insurance | 12.1 | 8.3 | 10.0 |
| Intersegment and other | (2.0) | (9.4) | (9.2) |
| Consolidated operating (loss) income | $(5.2) | $39.4 | $54.8 |

Revenue

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

Managed Care Premium Revenue. Our revenue primarily consists of premiums earned from the sale of managed care products to the Commercial, Medicare Advantage and Medicaid sectors. We receive a monthly payment from or on behalf of each member enrolled in our managed care plans (excluding ASO). We recognize all premium revenue in our managed care business during the month in which we are obligated to provide services to an enrolled member. Premiums we receive in advance of that date are recorded as unearned premiums.

Premiums are set prospectively, meaning that a fixed premium rate is determined at the beginning of each contract year and revised at renewal. We renegotiate the premiums of different groups as their existing annual contracts become due. Our Medicare Advantage contracts entitle us to premium payments from CMS on behalf of each Medicare beneficiary enrolled in our plans, generally on a per member per month (“PMPM”) basis. We submit rate proposals to CMS in June for each Medicare Advantage product that will be offered beginning January 1 of the subsequent year in accordance with the competitive bidding process under the MMA. Retroactive rate adjustments

are made periodically with respect to our Medicare Advantage plans based on the aggregate health status and risk scores of our plan participants. Premium rates for the Medicaid business are based on a bid contract with ASES and are revised each year to be effective each July 1, at which time rates are fixed for the plan year.

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

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

Investment Income. Investment income consists of interest and dividend income from investment securities. See note 4 of 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 forms: (1) fee-for-service contracts based on negotiated fee schedules; (2) capitation arrangements, generally on a fixed PMPM payment basis, whereby the provider generally assumes some of the medical expense risk; and (3) risk-sharing arrangements, whereby we advance a PMPM payment and share the risk of certain medical costs of our members with the provider based on actual experience as measured against pre-determined sharing ratios. Claims incurred also include claims incurred in our life insurance and property and casualty insurance businesses. Each segment's results of operations depend to a significant extent on our ability to accurately predict and effectively manage claims and losses. A portion of the claims incurred for each period consists of claims reported but not paid during the period, as well as a management and actuarial estimate of claims incurred but not reported during the period.

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

Operating Expenses. Operating expenses include commissions to external brokers, general and administrative expenses, cost containment expenses such as case and disease management programs, and depreciation and amortization. The operating expense ratio is calculated by dividing operating expenses by premiums earned, net and administrative service fees. A significant portion of our operating expenses are fixed costs. Accordingly, it is

important that we maintain certain level of volume of business in order to compensate for the fixed costs. 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.

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II. Membership

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

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

| | As of December 31, | | |
|---|---|---|---|
| | 2016 | 2015 | 2014 |
| Commercial [1] | 509,157 | 547,634 | 593,121 |
| Medicare [2] | 110,297 | 123,888 | 117,673 |
| Medicaid [3] | 397,918 | 422,922 | 1,428,690 |
| Total | 1,017,372 | 1,094,444 | 2,139,484 |

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

(2) Includes Medicare Advantage as well as stand-alone PDP plan membership in 2014.

(3) Membership for 2016 and 2015 is on at-risk basis and for 2014 on a self-insured basis. Effective April 1, 2015, membership decreased since we elected to provide services to only two regions when the delivery model changed to an at-risk basis.

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III. Results of Operations

Consolidated Operating Results

The following table sets forth our consolidated operating results for the years ended December 31, 2016, 2015 and 2014. Further details of the results of operations of each reportable segment are included in the analysis of operating results for the respective segments.

| (Dollar amounts in millions) | 2016 | 2015 | 2014 |
|---|---|---|---|
| Years ended December 31, | | | |
| Revenues: | | | |
| Premiums earned, net | $2,890.6 | $2,783.2 | $2,128.6 |
| Administrative service fees | 17.9 | 44.7 | 119.3 |
| Net investment income | 48.9 | 45.2 | 47.5 |
| Other operating revenues | 3.5 | 3.7 | 4.2 |
| Total operating revenues | 2,960.9 | 2,876.8 | 2,299.6 |
| Net realized investment gains | 17.4 | 18.9 | 18.2 |
| Other income, net | 6.5 | 7.0 | 2.3 |
| Total revenues | 2,984.8 | 2,902.7 | 2,320.1 |
| Benefits and expenses: | | | |
| Claims incurred | 2,472.2 | 2,318.7 | 1,747.6 |
| Operating expenses | 493.9 | 518.7 | 497.2 |
| Total operating costs | 2,966.1 | 2,837.4 | 2,244.8 |
| Interest expense | 7.6 | 8.2 | 9.3 |
| Total benefits and expenses | 2,973.7 | 2,845.6 | 2,254.1 |
| Income before taxes | 11.1 | 57.1 | 66.0 |
| Income tax (benefit) expense | (6.3) | 5.1 | 0.7 |
| Net income | 17.4 | 52.0 | 65.3 |
| Net loss attributable to non-controlling interest | - | (0.1) | (0.4) |
| Net income attributable to TSM | $17.4 | $52.1 | $65.7 |

Year ended December 31, 2016 compared with the year ended December 31, 2015

Operating Revenues

Premiums earned, net increased by $107.4 million, or 3.9%, to $2.9 billion. This increase primarily reflects higher premiums in the Managed Care segment by $99.0 million as a result of the change in the Medicaid service model effective April 1, 2015, from an ASO agreement to a fully insured model, and higher premium rates in the Commercial business. This increase was offset by lower member month enrollment in the Medicare and Commercial businesses and a decrease in the Medicare average premiums rates.

Administrative service fees decreased $26.8 million, or 60.0%, mostly as a result of the previously mentioned change in the Medicaid contract model. Total administrative fees related to the previous Medicaid ASO agreement during the 2015 period amounted to $24.3 million.

Net investment income increased $3.7 million, or 8.2%, to $48.9 million mostly as a result of higher invested balances.

Claims Incurred

Consolidated claims incurred increased by $153.5 million, or 6.6%, to $2.5 billion, mostly due to higher claims in the Managed Care segment. This increase primarily reflects higher claims incurred in the segment's Medicaid business by $150.7 million after the contract changed to a fully insured model and the impact of Managed Care prior period reserve developments. The consolidated loss ratio increased by 220 basis points to 85.5%. Excluding the impact of prior period development, as well as moving the 2015 risk score revenue adjustments to its corresponding period, consolidated loss ratio was 84.1%, 70 basis points higher than last year.

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Operating Expenses

Consolidated operating expenses decreased by $24.8 million, or 4.8%, to $493.9 million. The decrease reflects lower expenses following the change in the Medicaid membership after we elected to reduce the number of regions we serve, from eight regions under an ASO agreement to only two regions when the contract changed to a fully-insured model. The lower operating expenses also reflect a decrease in the provision for doubtful accounts, mostly due to the strengthening of the allowance for doubtful receivables in the 2015 period, lower payroll and related expenses resulting from accruals related to management changes and retirements impacting the 2015 period, as well as a $4.4 million expense related to settlement agreements entered with governmental agencies in 2015. These decreases were partially offset by a new business-to-business tax implemented in Puerto Rico at the end of the third quarter 2015 and an increase in the Health Insurance Providers Fee, reflecting the at-risk Medicaid enrollment after the model changed in 2015. For the year ended December 31, 2016, the consolidated operating expense ratio decreased 130 basis points to 17.0%, as the result of the increase in premiums and lower expenses.

Income Taxes

Consolidated income taxes resulted in a benefit of $6.3 million. The tax benefit primarily results from the net effect of the following:

- For the 2016 period the Managed Care segment, which has a higher effective tax rate than our other segments, incurred in a loss before taxes, resulting in the recording of a tax benefit during the period.

- During the 2015 period, the Company executed a Closing Agreement between TSM and its subsidiaries and the Puerto Rico Treasury Department in connection with a local law that provided a temporary preferential tax rate in capital asset transactions. These events allowed the Company to record a $3.1 million benefit in the 2015 period resulting from the enacted lower taxable rate and the reassessment of the realizability of some of its deferred taxes.

- The Property and Casualty segment reassessed the tax rate used to measure several temporary differences; as a consequence such rate was increased from 20% to 39%, resulting in an increase to its deferred tax expense of approximately $3.6 million in 2016.

Year ended December 31, 2015 compared with the year ended December 31, 2014

Operating Revenues

Premiums earned, net increased by $654.6 million, or 30.8%, to $2.8 billion during the year ended December 31, 2015 when compared to the year ended December 31, 2014. This increase primarily reflects higher premiums in the Managed Care segment by $653.4 million after the change in the Medicaid service model effective April 1, 2015, from an ASO agreement to a fully insured model as well as to higher premiums in the Medicare business. Higher Medicare premiums are the result of increased member month enrollment offset by lower average premiums rates. Offsetting the premium revenue increase is a lower premiums earned in our Commercial business due to lower fully insured membership offset by higher average per member per month premiums.

Administrative service fees decreased by $74.6 million, or 62.5%, to $44.7 million for the year ended December 31, 2015 when compared with the year ended December 31, 2014, mostly as a result of the previously mentioned change in the Medicaid contract model effective April 1, 2015.

Claims Incurred

Claims incurred during the year ended December 31, 2015 increased by $571.1 million, or 32.7%, to $2.3 billion when compared to the claims incurred during the year ended December 31, 2014, mostly due to higher claims in the Managed Care segment. This increase primarily reflects the claims incurred in the segment's Medicaid business after the change from an ASO model to a fully insured model as well to an increase in the Medicare business. Increase in claims in the Medicare business is the result of an increase in membership offset by lower MLR. These increases were partially offset by lower claims incurred in the Commercial business, which reflects the business's lower member month enrollment.

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Operating Expenses

Operating expenses during the year ended December 31, 2015 increased by $21.5 million, or 4.3%, to $518.7 million as compared to the year ended December 31, 2014. The higher operating expenses are mainly related to increases in the Health Insurance Providers Fee, the provision for doubtful receivables, and payroll and related expenses resulting from recent management changes and retirements, a $4.4 million expense related to settlement agreements entered with governmental agencies, as well as to higher professional services incurred during the year ended December 31, 2015. These increases were partially offset by the impact of the cost containment initiatives, including lower expenses related to the change in the Medicaid membership after we elected to decrease the number of regions we serve from eight regions under an ASO agreement to only two regions when the contract was changed to a fully-insured model. Despite the increase in operating expenses, the consolidated operating expense ratio decreased 380 basis points to 18.3% for the 2015 period, reflecting the higher premium revenue during this year.

Income Tax Expense

Income tax expense during the year ended December 31, 2015 increased by $4.4 million to $5.1 million when compared to the income tax expense during the year ended December 31, 2014. The higher income tax expense primarily results from the following:

- During the years ended December 31, 2014 and 2015, the Company executed in the fourth quarter of 2014 and the second quarter of 2015 Closing Agreements between TSM and its subsidiaries and the Puerto Rico Treasury Department that allowed the Company to take advantage of a temporary preferential tax rate window on capital gains. These events allowed the Company to record a tax benefit of $3.1 million and $17.0 million, in 2015 and 2014, respectively, resulting from the enacted lower taxable rate and the reassessment of the realizability of some of its deferred taxes.

- The 2014 period includes a one-time $6.3 million adjustment increasing the consolidated deferred tax liability related to investments classified as available for sale after the July 1, 2014 enactment of Puerto Rico tax legislation that increased the corporate tax rate over long-term capital gains, from 15% to 20%, for all transactions occurring after June 30, 2014.

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Managed Care Operating Results

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico: Commercial, Medicare Advantage and Medicaid. For the year ended December 31, 2016, the Commercial, Medicare and Medicaid sectors represented 29.0%, 35.4% and 27.1% of our consolidated premiums earned, net, respectively.

| (Dollar amounts in millions) | 2016 | 2015 | 2014 |
|---|---|---|---|
| Operating revenues: | | | |
| Medical premiums earned, net: | | | |
| Commercial | $841.4 | $844.6 | $882.4 |
| Medicare | 1,023.9 | 1,097.7 | 1,013.7 |
| Medicaid | 783.2 | 607.2 | - |
| Medical premiums earned, net | 2,648.5 | 2,549.5 | 1,896.1 |
| Administrative service fees | 22.4 | 49.3 | 123.6 |
| Net investment income | 15.1 | 11.8 | 15.0 |
| Total operating revenues | 2,686.0 | 2,610.6 | 2,034.7 |
| Medical operating costs: | | | |
| Medical claims incurred | 2,347.5 | 2,196.7 | 1,629.1 |
| Medical operating expenses | 375.3 | 393.4 | 374.2 |
| Total medical operating costs | 2,722.8 | 2,590.1 | 2,003.3 |
| Medical operating (loss) income | $(36.8) | $20.5 | $31.4 |
| Additional data: | | | |
| Member months enrollment: | | | |
| Commercial: | | | |
| Fully-insured | 4,209,920 | 4,492,395 | 5,025,284 |
| Self-funded | 2,144,621 | 2,221,327 | 2,408,967 |
| Total Commercial member months | 6,354,541 | 6,713,722 | 7,434,251 |
| Medicaid: | | | |
| Fully-insured | 4,829,729 | 3,855,945 | - |
| Self-funded | - | 4,229,082 | 16,912,990 |
| Total Medicaid member months | 4,829,729 | 8,085,027 | 16,912,990 |
| Medicare: | | | |
| Medicare Advantange | 1,394,272 | 1,447,420 | 1,274,441 |
| Stand-alone PDP | - | - | 163,707 |
| Total Medicare member months | 1,394,272 | 1,447,420 | 1,438,148 |
| Total member months | 12,578,542 | 16,246,169 | 25,785,389 |
| Medical loss ratio | 88.6% | 86.2% | 85.9% |
| Operating expense ratio | 14.1% | 15.1% | 18.5% |

Year ended December 31, 2016 compared with the year ended December 31, 2015

Medical Operating Revenues

Medical premiums earned increased by $99.0 million, or 3.9%, to $2.6 billion. This increase is principally the result of the following:

- Medical premiums generated by the Medicaid business increased by $176.0 million to $783.2 million, primarily as the result of the change in the Medicaid service model, from an ASO agreement to a fully-insured model effective April 1, 2015.

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- Medical premiums generated by the Medicare business decreased by $73.8 million, or 6.7%, to $1,000 million. This fluctuation primarily results from lower risk score revenue as compared with 2015, lower member months enrollment, and a reduction in 2016 Medicare reimbursement rates.

- Medical premiums generated by the Commercial business decreased by $3.2 million, or 0.4%, to $841.4 million primarily resulting from a decrease in fully-insured member months enrollment, partially offset by an approximately 5% year over year increase in average premium rates.

Administrative service fees decreased by $26.9 million, or 54.6%, to $22.4 million mainly due to the previously mentioned change in the Medicaid contract effective April 1, 2015.

Medical Claims Incurred

Medical claims incurred increased by $150.8 million, or 6.9%, to $2.3 billion. The MLR of the segment increased 240 basis points during the 2016 period, to 88.6%. These fluctuations are primarily attributed to the net effect of the following:

- The medical claims incurred of the Medicaid business increased by $150.7 million during the 2016 period reflecting the previously mentioned change in the Medicaid contract effective April 1, 2015.

- The medical claims incurred of the Commercial business increased by $4.3 million, or 0.6%, during 2016, mostly reflecting the impact of prior period reserve developments, partially offset by lower member months enrollment. The Commercial MLR was 85.2%, which is 100 basis points higher than the MLR for the prior year. Excluding the effect of prior period reserve developments in 2016 and 2015, the MLR would have decreased by 270 basis points, reflecting the continuity of our underwriting discipline and premium trends higher than claims trends.

- The medical claims incurred of the Medicare business decreased by $4.1 million, or 0.4%, during the 2016 period reflecting the previously mentioned decrease in membership and changes in benefit design included in 2016 products as the result of the decrease in reimbursement rates. This decrease is offset by unfavorable prior period reserve developments. The Medicare MLR was 90.3%, which is 570 basis points higher than the MLR for the perior year. Adjusting for the effect of prior period reserve developments, and moving the 2015 final risk score revenue adjustments to its corresponding period, our Medicare MLR would have been 90.0%, about 530 basis points higher than last year. The higher MLR primarily reflects higher Part B drug costs mainly related to cancer and rheumatoid arthritis, additional deterioration in the experience of End Stage Renal Disease (ESRD) and the effect of the decrease in 2016 Medicare reimbursement rates.

Medical Operating Expenses

Medical operating expenses decreased by $18.1 million, or 4.6%, to $375.3 million. The decrease mostly reflects lower expenses following the change in the Medicaid membership after we elected to decrease the number of regions we serve, from eight regions under an ASO agreement to only two regions when the contract was changed to a fully-insured model. The lower operating expenses also includes the effect of a decrease in the provision for doubtful accounts, mostly due to the strengthening of the allowance for doubtful receivables in the 2015 period, lower payroll and related expenses resulting from accruals related to management changes and retirements impacting the 2015 period, as well as to a $4.4 million expense related to settlement agreements entered with governmental agencies in 2015. These decreases were partially offset by a new business-to-business tax implemented in Puerto Rico at the end of the third quarter 2015 and an increase in the Health Insurance Providers Fee, reflecting the at-risk Medicaid enrollment after the model changed in 2015. The operating expense ratio increased 110 basis points to 14.0% in 2016 as a result of the increase in premiums and lower expenses.

Year ended December 31, 2015 compared with the year ended December 31, 2014

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Medical Operating Revenues

Medical premiums earned for the year ended December 31, 2015 increased by $653.4 million, or 34.5%, to $2.5 billion when compared to the year ended December 31, 2014. This increase is principally the result of the following:

- Medical premiums generated by the Medicaid business amounted to $607.2 million during the year ended December 31, 2015 after the change in the Medicaid service model, from an ASO agreement to a fully insured model effective April 1, 2015.

- Medical premiums generated by the Medicare business increased by $84.0 million, or 8.3%, to $1.1 billion during the year ended December 31, 2015 as compared to the year ended December 31, 2014. This fluctuation primarily results from higher member month enrollment in Medicare Advantage products, which carry a higher average premium rate, offset by our exit of stand-alone PDP product. In 2015 we also had a higher risk score revenue as compared with 2014. The increase in premiums resulting from the change in mix of our products was offset in part by a decrease in PMPM of our Medicare Advantage products by 3.0% during 2015.

- Medical premiums generated by the Commercial business decreased by $37.8 million, or 4.3%, to $844.6 million during the year ended December 31, 2015 as compared to the year ended December 31, 2014. This fluctuation is primarily the result of a decrease in fully-insured member month enrollment by 532,889, or 10.6%, mainly in our rated groups and individual accounts products and reflecting cancellation of several commercial accounts and attrition in existing accounts as a result of Puerto Rico's challenging economic situation. The effect of the decreased membership is partially offset by a 7.1% year over year increase in average premium rates.

Administrative service fees decreased by $74.3 million, or 60.1%, to $49.3 million during the year ended December 31, 2015. This fluctuation is mainly due to the previously mentioned change in the Medicaid contract effective April 1, 2015.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2015 increased by $567.6 million, or 34.8%, to $2.2 billion, when compared to the prior year. The MLR of the segment was 86.2%, increasing by 30 basis points during the year ended December 31, 2015. These fluctuations are primarily attributed to the net effect of the following:

- Effective April 1, 2015, the Medicaid delivery model changed from an ASO contract to a fully insured model. The medical claims incurred related to this contract for year ended December 31, 2015 amounted $555.3 million. The medical loss ratio of this segment was 91.5%, in line with our bid.

- The medical claims incurred of the Medicare business increased by $53.8 million, or 6.2%, during the 2015 period due to higher enrollment and lower MLR in 2015 was 84.6%, which is 170 basis points lower than the MLR for the prior year. Excluding the effect of prior period reserve developments and risk-score adjustments in the 2015 and 2014 periods, the MLR presents a decrease of 260 basis points, largely reflecting the impact of initiatives implemented last year and a non-recurring adjustment in 2014.

- The medical claims incurred of the Commercial business decreased by $41.5 million, or 5.5%, during the 2015 period mostly reflecting a lower fully-insured member month enrollment. The 2015 Commercial MLR was 84.2%, which is 110 basis points lower than the prior year. Excluding the effect of prior period reserve developments in 2015 and 2014, the MLR would have decreased by 120 basis points, mostly reflecting premium trends that were higher than claims trends.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2015 increased by $19.2 million, or 5.1%, to $393.4 million when compared to the year ended December 31, 2014. The increase is mainly related to increases in the Health Insurance Providers Fee, the provision for doubtful receivables, and payroll and related expenses resulting from recent management changes and retirements, a $4.4 million expense recorded in 2015 related to settlement agreements entered with governmental agencies, as well as to higher professional services. These increases were partially offset by the impact of the cost containment initiatives, including lower expenses related to the change in the Medicaid membership after we elected to decrease the number of regions we serve from eight to only two regions when the contract was changed to a fully-insured model. Despite the increase in operating expenses, the medical operating expense ratio decreased 340 basis points, from 18.5% to 15.1% in the 2015 period, reflecting the higher premium revenue during this year.

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Life Insurance Operating Results

| (Dollar amounts in millions) | 2016 | 2015 | 2014 |
|---|---|---|---|
| Years ended December 31, | | | |
| Operating revenues: | | | |
| Premiums earned, net: | | | |
| Premiums earned | $161.3 | $153.8 | $151.8 |
| Assumed earned premiums | 4.4 | 3.9 | 1.6 |
| Ceded premiums earned | (8.8) | (9.6) | (10.9) |
| Premiums earned, net | 156.9 | 148.1 | 142.5 |
| Net investment income | 24.9 | 24.5 | 23.7 |
| Total operating revenues | 181.8 | 172.6 | 166.2 |
| Operating costs: | | | |
| Policy benefits and claims incurred | 86.9 | 82.6 | 74.8 |
| Underwriting and other expenses | 73.4 | 70.0 | 68.8 |
| Total operating costs | 160.3 | 152.6 | 143.6 |
| Operating income | $21.5 | $20.0 | $22.6 |
| | | | |
| Additional data: | | | |
| Loss ratio | 55.4 % | 55.8 % | 52.5 % |
| Expense ratio | 46.8 % | 47.3 % | 48.3 % |

Year ended December 31, 2016 compared with the year ended December 31, 2015

Operating Revenues

Premiums earned, net increased by $8.8 million, or 5.9% to $156.9 million, reflecting improved policy retention and higher sales in the segment's Individual Life and Cancer lines of business of $4.0 million and $2.7 million, respectively, as well as growth in the Costa Rica operations.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred increased by $4.3 million, or 5.2%, to $86.9 million, mostly reflecting a higher volume of business during the year, particularly in the Cancer line of business, which claims increased by $2.7 million, as well as to an increase of $2.6 million in actuarial reserves. The loss ratio for the period decreased 30 basis points to 55.4% in 2016.

Underwriting and Other Expenses

Underwriting and other expenses increased by $3.4 million, or 4.9%, primarily reflecting an increase in commissions expense following the segment's premium growth mentioned above. In addition, the segment has incurred in higher development and marketing expenses related to the development of the Costa Rica operations. The segment's operating expense ratio decreased 50 basis points to 46.8% in 2016, reflecting the increase in premiums during the period.

Year ended December 31, 2015 compared with the year ended December 31, 2014

Operating Revenues

Premiums earned, net for the year ended December 31, 2015 increased by $5.6 million, or 3.9%, to $148.1 million as compared to the year ended December 31, 2014, mostly reflecting combined premium growth in the segment's Individual Life, Cancer, and Major Medical Health lines of business of $4.5 million, as well as to an increase of $2.3 million of new premiums assumed on retrocession reinsurance agreements entered during the second quarter of 2014.

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Policy Benefits and Claims Incurred

Policy benefits and claims incurred for the year ended December 31, 2015 increased by $7.8 million, or 10.4%, to $82.6 million when compared to the year ended December 31, 2014 mostly reflecting $4.9 million of benefits increase in the Cancer and Major Medical Health line of business claims, and an increase of $1.8 million of claims assumed under retrocession reinsurance agreements, which carry a higher loss ratio.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $1.2 million, or 1.7%, to $70.0 million during the year ended December 31, 2015, mostly related to increased commissions and general expenses, expenses related to the development of the Costa Rica operations, partially offset by a lower DAC and VOBA amortization reflecting improved portfolio persistency when compared to the same period of last year. As a result of the increase in premiums during this period, the segment's operating expense ratio improved 100 basis points from 48.3% in 2015 to 47.3% in 2015.

Property and Casualty Insurance Operating Results

| (Dollar amounts in millions) | 2016 | 2015 | 2014 |
|---|---|---|---|
| Years ended December 31, | | | |
| Operating revenues: | | | |
| Premiums earned, net: | | | |
| Premiums written | $133.1 | $134.4 | $141.1 |
| Premiums ceded | (46.0 ) | (48.7 ) | (52.1 ) |
| Change in unearned premiums | 0.8 | 1.9 | 3.1 |
| Premiums earned, net | 87.9 | 87.6 | 92.1 |
| Net investment income | 8.9 | 8.7 | 8.6 |
| Total operating revenues | 96.8 | 96.3 | 100.7 |
| Operating costs: | | | |
| Claims incurred | 40.8 | 42.6 | 46.3 |
| Underwriting and other operating expenses | 43.9 | 45.4 | 44.4 |
| Total operating costs | 84.7 | 88.0 | 90.7 |
| Operating income | $12.1 | $8.3 | $10.0 |
| | | | |
| Additional data: | | | |
| Loss ratio | 46.4 % | 48.6 % | 50.3 % |
| Expense ratio | 49.9 % | 51.8 % | 48.2 % |

Year ended December 31, 2016 compared with the year ended December 31, 2015

Operating Revenues

Total premiums written decreased by $1.3 million, or 1.0%, to $133.1 million, mostly resulting from lower sales of Commercial Package, offset by higher sales in the Compulsory Vehicle Liability insurance products.

The premiums ceded to reinsurers decreased by $2.7 million, or 5.5%, mostly reflecting favorable pricing in the market for nonproportional reinsurance treaties.

Claims Incurred

Claims incurred decreased by $1.8 million, or 4.2%, to $40.8 million. The loss ratio decreased 220 basis points, to 46.4%, during this period, primarily as a result of favorable loss experience in the Commercial Package insurance products.

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Underwriting and Other Expenses

Underwriting and other operating expenses decreased by $1.5 million, or 3.3%, to $43.9 million mostly due to lower net commission expenses driven by a decrease in net premiums earned. The operating expense ratio decreased by 190 basis points, to 50.0% in 2016.

Year ended December 31, 2015 compared with the year ended December 31, 2014

Operating Revenues

Total premiums written during the year ended December 31, 2015 decreased by $6.7 million, or 4.7%, to $134.4 million, mostly resulting from lower sales of commercial products, primarily package and auto insurance products.

Premiums ceded to reinsurers during the year ended December 31, 2015 decreased by approximately $3.4 million, or 6.5%, to $48.7 million. The ratio of premiums ceded to premiums written decreased by 70 basis points, from 36.9% in 2014 to 36.2% in 2015. The lower amount of premiums ceded primarily results from favorable pricing in the reinsurance market.

The change in unearned premiums results from the lower volume of premiums written in the current year.

As a result of the above fluctuations net premiums earned for the year ended December 31, 2015 decreased by $4.5 million, or 4.9%, to $87.6 million.

Claims Incurred

Claims incurred during the year ended December 31, 2015 decreased by $3.7 million, or 8.0%, to $42.6 million. The loss ratio decreased by 170 basis points, to 48.6% in 2015, primarily as a result of a favorable loss experience, mostly in the Commercial Multi-peril, Commercial Auto and Medical Malpractice lines of business, which was offset with an unfavorable loss experience in the Personal Auto line of business. Loss ratio improved with better experience in comercial multiperil, medical malpractice and general liability.

Underwriting and Other Expenses

Underwriting and other operating expenses for the year ended December 31, 2015 increased by $1.0 million, or 2.3%, to $45.4 million mostly due to an increase in net commissions primarily resulting from a higher amortization and lower capitalization of deferred acquisition costs due to lower premium written. The operating expense ratio increased by 360 basis points, to 51.8% in 2015.

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IV. 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) | 2016 | 2015 | 2014 |
|---|---|---|---|
| Sources (uses) of cash: | | | |
| Cash provided by operating activities | $6.5 | $229.1 | $38.0 |
| Net (purchases) proceeds of investment securities | (80.9) | (41.6) | 34.0 |
| Net capital expenditures | (4.8) | (9.1) | (4.8) |
| Payments of long-term borrowings | (1.7) | (37.6) | (14.8) |
| Proceeds from policyholder deposits | 18.2 | 16.5 | 9.6 |
| Surrenders of policyholder deposits | (21.9) | (18.8) | (10.1) |
| Repurchase and retirement of common stock | (21.4) | (48.3) | (11.3) |
| Other | 11.6 | (2.4) | (4.9) |
| Net (decrease) increase in cash and cash equivalents | $(94.4) | $87.8 | $35.7 |

Year ended December 31, 2016 compared to year ended December 31, 2015

Cash flow from operating activities decreased by $222.6 million for the year ended December 31, 2016 as compared to the year ended December 31, 2015, principally as a result of higher claims paid by $257.4 million and an increase cash paid to suppliers and employees by $34.3 million, offset in part by an increase in premiums collections of $67.5 million. The increase in claims paid and premiums collected is principally the result of the change in the Medicaid delivery model from an ASO agreement to a fully insured model effective April 1, 2015.

Increase in net purchases of investments in securities are part of our asset/liability management strategy using cash on hand.

Payments of long-term borrowings decreased by $35.9 million during the year ended December 31, 2016, primarily due to the payment of a repurchase agreement of $25.0 million that matured and a $11.0 million repayment of principal of certain senior unsecured notes during the 2015 period.

Repurchase and retirement of common stock amounted to $21.4 million reflecting the repurchase and retirement of 951,831 shares of common stock during the year ended December 31, 2016 under the Corporation’s Class B common stock repurchase programs.

The increase in other sources of cash for the year ended December 31, 2016 is attributed to changes in the amount of outstanding checks in excess of bank balances.

Year ended December 31, 2015 compared to year ended December 31, 2014

Cash flow from operating activities increased by $191.1 million for the year ended December 31, 2015 as compared to the year ended December 31, 2014, principally due to an increase in premium collections by $634.4 million, offset in part by higher claims paid by $432.2 million. The increase in premiums collected and claims paid is principally the result of the change in the Medicaid delivery model from ASO agreement to a fully insured model.

Net purchases of sales of investment securities were $41.6 million during the year ended December 31, 2015, primarily resulting from the net cash flows received from the purchases and sales of investment securities during the

2015 period following our asset/liability management strategy. During the year ended December 31, 2014 we had net proceeds of investments of $34.0 million.

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Repayments of long-term borrowings of $37.6 million during the year ended December 31, 2015, primarily due to the payment of a repurchase agreement of $25.0 million that matured during the period and an $11.0 million repayment of the senior unsecured notes principal.

Repurchase and retirement of common stock amounted to $48.3 million reflecting the repurchase and retirement of 2,241,086 shares of common stock during the year ended December 31, 2015 under the Corporation's Class B common stock repurchase programs.

The decrease in other uses of cash is attributed to the changes in the amount of outstanding checks over bank balances in the 2015 period.

Share Repurchase Program

The Company repurchases shares through open market transactions, in accordance with Rule 10b-18 of the Securities Exchange Act of 1934, as amended, under repurchase programs authorized by the Board of Directors. Shares purchased under share repurchase programs are retired and returned to authorized and unissued status.

A summary of share repurchase programs in place during the three-year-period ended December 31, 2016 is as follows:

- In July 2013 the Company's Board of Directors authorized an $11.5 million repurchase program (2013 $11.5 million stock repurchase program) of its Class B common stock. This program was discontinued on October 28, 2014.

- In October 2014 the Company's Board of Directors authorized a $50.0 million repurchase program (2014 $50.0 million share repurchase program) of its Class B common stock. This program was completed on October 7, 2015.

- In November 2015 the Company's Board of Directors authorized a $25.0 million repurchase program (2015 $25.0 million share repurchase program) of its Class B common stock. This program was completed on September 14, 2016.

The stock repurchase activity under stock repurchase programs for the years ended December 31, 2016, 2015, and 2014 is summarized as follows:

| (Dollar amounts in millions, except per share data) | 2016 | | | 2015 | | | 2014 | | |
|---|---|---|---|---|---|---|---|---|---|
| | Shares Repurchased | Average Share Price | Amount Repurchased | Shares Repurchased | Average Share Price | Amount Repurchased | Shares Repurchased | Average Share Price | Amount Repurchased |
| 2015 $25.0 program | 951,831 | $ 22.54 | $ 21.4 | 154,554 | $ 23.72 | $ 3.6 | - | $ - | $ - |
| 2014 $50.0 program | - | - | - | 2,086,532 | 21.69 | 44.7 | 228,525 | 23.55 | 5.4 |
| 2013 $11.5 program | - | - | - | - | - | - | 367,700 | 16.32 | 6.0 |
| Total | 951,831 | $ 22.54 | $ 21.4 | 2,241,086 | $ 21.87 | $ 48.3 | 596,225 | $ 20.28 | $ 11.4 |

Financing and Financing Capacity

We have several short-term facilities available to address timing differences between cash collections and disbursements. These short-term facilities are mostly in the form of arrangements to sell securities under repurchase agreements. As of December 31, 2016, we had $60.0 million of available credit under these facilities. There are no outstanding short-term borrowings under these facilities as of December 31, 2016.

On December 21, 2005, we issued and sold $60.0 million of our 6.6% senior unsecured notes due December 2020 (the "6.6% notes"). The 6.6% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at par, in whole or in part, as determined by us. On October 1, 2010 and May 14, 2015 we repaid $25.0 million and $11.0 million, respectively, of the principal of these senior unsecured notes. Amount currently outstanding is $24.0 million. The 6.6% notes contain certain non-financial covenants. At December 31, 2016, we are in compliance with these covenants.

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On November 4, 2015, TSS entered into a $50.0 million revolving loan agreement with a commercial bank in Puerto Rico. This unused line of credit has an interest rate of LIBOR plus 250 basis points, matured on November 4, 2016.

On March 11, 2016, TSS entered into a $30.0 million revolving loan agreement with a commercial bank in Puerto Rico. This unused line of credit has an interest rate of LIBOR plus 220 basis points, matures on March 11, 2017, and contains certain financial and non-financial covenants that are customary for this type of facility.

On December 28, 2016, TSM entered into a $35.5 million credit agreement with a commercial bank in Puerto Rico. The agreement consists of three term loans: (i) Term Loan A in the principal amount of $11.2 million, (iii) Term Loan B in the principal amount of $20.1 million and (iii) Term Loan C in the principal amount of $4.1 million. Term Loan A matures in October 2023 while the Term Loans B and C mature in January 2024. Term Loan A was used to refinance the outstanding balance of the $41 million secured loan payable with the same commercial bank in Puerto Rico. Proceeds from Term Loans B and C were received on January 11, 2017 and were used to prepay the outstanding principal amount plus accrued interest of the 6.6% Senior Unsecured Notes due January 2021 ($24 million), and fund a portion of a debt service reserve for the Loan (approximately $0.2 million). Pursuant to the credit agreement, interest is payable on the outstanding balance of the Loan at the following annual rate: (1) 1% over LIBOR for Term Loan A, (ii) 2.75% over LIBOR for Term Loan B, and (iii) 3.25% over LIBOR for Term Loan C. Interest shall be payable commencing on January 1, 2017, in the case of Term Loan A, and on February 1, 2017, in the case of Term Loan B and Term Loan C. As of December 31, 2016, this loan had an outstanding balance of $11.2 million. This credit agreement is guaranteed by a first mortgage 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. The loan includes certain non-financial covenants, which are customary for this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control and dividends. As of December 31, 2016, we are in compliance with these covenants. Failure to meet these covenants may trigger accelerated payment of the secured loans outstanding balance. The Company may, at its option, upon notice, as specified in the credit agreement, redeem and prepay prior to maturity, all or any part of the Loan and from time to time upon the payment of a penalty fee of 3% during the first year, 2% during the second year and 1% during the third year, and thereafter, at par, as specified in the credit agreement, together with accrued and unpaid interest, if any, to the date of redemption specified by the Company.

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

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, but excludes an estimate of the future cash outflows related to the following liabilities:
  - Unearned premiums – This amount accounts for the premiums collected prior to the end of coverage period and does not represent a future cash outflow. As of December 31, 2016, we had $79.3 million in unearned premiums.
  - Policyholder deposits – The cash outflows related to these instruments are not included because they do not have defined maturities, such that the timing of payments and withdrawals is uncertain. There are currently no significant policyholder deposits in paying status. As of December 31, 2016, our policyholder deposits had a carrying amount of $179.4 million.
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Other long-term liabilities – Due to the indeterminate nature of their cash outflows, $84.2 million of other long-term liabilities are not reflected in the following table, including $31.0 million of liability for pension benefits, $18.8 million in deferred tax liabilities, and $34.4 million in liabilities to the Federal Employees' Health Benefits Plan Program.

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| | Contractual obligations by year | | | | | | |
|---|---|---|---|---|---|---|---|
| (Dollar amounts in millions) | Total | 2017 | 2018 | 2019 | 2020 | 2021 | Thereafter |
| Long-term borrowings (1) | $41.4 | $2.7 | $2.8 | $2.7 | $26.6 | $2.4 | $ 4.2 |
| Operating leases | 17.8 | 4.2 | 3.9 | 3.6 | 2.3 | 3.8 | - |
| Purchase obligations (2) | 223.8 | 210.3 | 5.5 | 3.1 | 2.5 | 2.1 | 0.3 |
| Claim liabilities (3) | 448.9 | 361.6 | 50.0 | 10.1 | 8.4 | 7.6 | 11.2 |
| Estimated obligation for future policy benefits (4) | 563.6 | 111.5 | 99.4 | 93.0 | 87.5 | 82.9 | 89.3 |
| | $1,295.5 | $690.3 | $161.6 | $112.5 | $127.3 | $98.8 | $ 105.0 |

(1) As of December 31, 2016, our long-term borrowings consist of our 6.6% senior unsecured notes payable. Also, total contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.6% senior unsecured notes, scheduled interest payments were included in the total contractual obligations for long-term borrowings until the maturity date of the note in 2020. We may redeem the senior unsecured note starting five years after issuance; however no redemption is considered in this schedule. 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 $4.0 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, 2016. The expected claims payments are an estimate and may differ materially from the actual claims payments made by us in the future. Also, claim liabilities are presented gross, and thus do not reflect the effects of reinsurance under which $39.0 million of reserves had been ceded at December 31, 2016.

(4) Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. A significant portion of the estimated obligation for future policy benefits to be paid included in this table considers contracts under which we are currently not making payments and will not make payments until the occurrence of an insurable event not under our control, such as death, illness, or the surrender of a policy. We have estimated the timing of the cash flows related to these contracts based on historical experience as well as expectations of future payment patterns. The amounts presented in the table above represent the estimated cash payments for benefits under such contracts based on assumptions related to the receipt of future premiums and assumptions related to mortality, morbidity, policy lapses, renewals, retirements, disability incidence and other contingent events as appropriate for the respective product type. All estimated cash payments included in this table are not discounted to present value nor do they take into account estimated future premiums on policies in-force as of December 31, 2016 and are gross of any reinsurance recoverable. The $556.7 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $321.2 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual experience and the assumptions used in the estimation of these payments.

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Off-Balance Sheet Arrangements

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

Restriction on Certain Payments by the Corporation's Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of 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. As of December 31, 2016, our insurance subsidiaries were in compliance with such minimum capital requirements.

These regulations are not directly applicable to TSM, as a holding company, since it is not an insurance company.

The new credit agreement of approximately $35.5 million, limits the amount of dividends or other distributions (including share repurchases) payable by the Corporation to $50 million per year.

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, TSS, TSA, and TSB 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, 2016, TSM and TSS estimated RBC ratio was above the minimum BCBSA RBC requirement of 200% and the 375% of RBC level required by the BCBSA to avoid monitoring. At December 31, 2016, TSA estimated RBC ratio was above the minimum BCBSA RBC requirement of 100% for smaller controlled affiliate.

Starting 2015, BCBSA's primary licensees could be subject to monitoring if, over a 6 or 12 month period, its RBC ratio declines by 80 or more points and which results in a level that is below 500%.

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, Puerto Rico, and Costa Rica government authorities, regularly make inquiries and conduct audits concerning our compliance with applicable insurance and other laws and regulations.

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. For a description of our legal proceedings, see Note 24, Contingencies, of the Notes to Consolidated Financial Statements, included in Item 8, Financial Statements and Supplementary Data, of this Annual Report on Form 10-K.

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Guarantee Associations and Other Regulatory Commitments

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 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. In accordance with insurance laws and regulations assessments are recoverable through policy surcharges. In 2014, the property and casualty segment has recorded recoveries of assessments for $0.5 million. It is the opinion of management that any possible future guarantee association assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

Pursuant to the Puerto Rico Insurance Code, our property and casualty insurance subsidiary is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED). The syndicate was organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the syndicate cannot meet their obligations. During 2016, 2015 and 2014, 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, 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 2016, 2015 and 2014, the Association distributed to the Company an amount based on the good experience of the business amounting to $0.5 million, $0.7 million and $0.9 million, respectively. In December 2015 the Association declared a special dividend of $21 million subject to a special tax of 15% that was retained upon distribution. This special dividend was paid in three installments during 2016. The share of the property and casualty segment in this special dividend was approximately $1.7 million, net of tax.

The property and casualty segment is also member of the Puerto Rico Fire and Allied Lines Underwriting Association and the Puerto Rico Auto Assign Plan. These entities periodically impose assessments to cover operations and other charges. The assessments recorded from these entities were $1 thousand in 2015 and 2014. There were no assessments during 2016.

V. 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.

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Claim Liabilities

Claim liabilities by segment as of December 31, 2016 were as follows:

(Dollar amounts in millions)

| | |
|---|---|
| Managed care | $348.1 |
| Property and casualty insurance | 97.0 |
| Life insurance | 42.8 |
| Consolidated | $487.9 |

Management continually evaluates the potential impact of changes in the factors considered for 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 including those caused by epidemic conditions, 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, 2016, claim liabilities for the managed care segment amounted to $348.1 million and represented 71.3% of our total consolidated claim liabilities and 25.7% of our total consolidated liabilities.

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

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

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Managed care claim liabilities also include a provision for adverse deviation, which is an estimate for known environmental factors that are reasonably likely to affect the required level of reserves. This provision for adverse deviation is intended to capture the potential adverse development from known environmental factors such as our entry into new geographical markets, changes in our geographic or product mix, the introduction of new customer populations, variation in benefit utilization, disease outbreaks, changes in provider reimbursement, fluctuations in medical cost trend, variation in claim submission patterns and variation in claims processing speed and payment patterns, changes in technology that provide faster access to claims data or change the speed of adjudication and settlement of claims, variability in claim inventory levels, non-standard claim development, and/or exceptional situations that require judgmental adjustments in setting the reserves for claims.

Circumstances to be considered in developing our best estimate of reserves include changes in enrollment, utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns, and claim submission patterns. A comparison or prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 90% of the claims are paid within three months after the last day of the month in which they were incurred and about 7% are within the next three months, for a total of 97% paid within six months after the last day of the month in which they were incurred.

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

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As described above, completion factors and claims trend factors can have a significant impact on determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2016 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 |
| -1.2 | % | $ 18.8 | 0.75 | % | $ 19.7 |
| -0.8 | % | 12.5 | 0.50 | % | 13.2 |
| -0.4 | % | 6.2 | 0.25 | % | 6.6 |
| 0.4 | % | (6.2) | -0.25 | % | (6.6) |
| 0.8 | % | (12.3) | -0.50 | % | (13.2) |
| 1.2 | % | (18.4) | -0.75 | % | (19.7) |

(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 93%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 7% related to claims incurred prior to the previous calendar year-end. Management has not noted any significant emerging trends in claim frequency and severity and the normal fluctuations in enrollment and utilization trends from year to year.

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

| (Dollar amounts in millions) | 2015 | 2014 | 2013 |
|---|---|---|---|
| Years ended December 31, | | | |
| Total incurred claims: | | | |
| As reported [1] | $2,216.3 | $1,665.3 | $1,734.5 |
| On a retrospective basis | 2,207.3 | 1,645.6 | 1,698.3 |
| Variance | $9.0 | $19.7 | $36.2 |
| Variance to total incurred claims as reported | 0.4 % | 1.2 % | 2.1 % |

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

Management expects that substantially all of the development of the 2016 estimate of medical claims payable will be known during 2017.

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

- Through the management of our cash flows and investment portfolio.
- In the Commercial business we have the ability to increase the premium rates throughout the year in the monthly renewal process, when renegotiating the premiums for the following contract year of each group as they become due. We consider the actual claims trend of each group when determining the premium rates for the following contract year.
- We have available short-term borrowing facilities that from time to time address differences between cash receipts and disbursements.

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

Life Insurance Segment

At December 31, 2016, claim liabilities for the life insurance segment amounted to $42.9 million and represented 8.8% of total consolidated claim liabilities and 3.2% of our total consolidated liabilities.

The claim liabilities related to the life insurance segment are based on methods and underlying assumptions in accordance with GAAP. The estimate of claim liabilities for this segment is based on the amount of benefits contractually determined for reported claims, and on estimates based on past experience modified for current trends, for unreported claims. This estimate relies on observations of ultimate loss experience for similar historical events.

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

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

in the development of these estimates; however, in recent years our estimates have resulted in immaterial redundancies or deficiencies.

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Property and Casualty Insurance Segment

At December 31, 2016, claim liabilities for the property and casualty insurance segment amounted to $97.0 million and represented 19.9% of the total consolidated claim liabilities and 7.1% of our total consolidated liabilities.

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

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

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

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

At December 31, 2016, the actuarial reserve range determined by the actuaries was from $90 million to $105 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 $5.6 million.

Liability for Future Policy Benefits

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

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Liabilities for future policy benefits for whole life and term insurance products and active life reserves for accident and health products are computed by the net level premium method, using interest assumptions ranging from 4.50% to 5.75% and withdrawal, mortality, morbidity and maintenance expense assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health unpaid claim reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Deferred annuity reserves are carried at the account value.

For deferred annuities, the liability for future policy benefits is equal to total policy account values. The liabilities for all other products 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 deferred annuities, the basis for the liability for future policy benefits is established at the time of issuance of each contract and would only change if our experience deteriorates to the point that the level of the liability is not adequate to provide for future policy benefits. We do not currently expect that level of deterioration to occur.

Deferred Policy Acquisition Costs and Value of Business Acquired

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

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

The schedules of amortization of life insurance deferred policy acquisition costs ("DPAC") and VOBA are based upon actuarial assumptions regarding future events that are uncertain. For all products, other than universal life and deferred annuities, the most significant of these assumptions is the level of contract persistency and investment yield rates. For these products the basis for the amortization of DPAC and VOBA is established at the issue of each contract and would only change if our segment's experience deteriorates to the point that the level of the net 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 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 net of reinsurance commissions during the production of business and are deferred and amortized ratably over the terms of the policies. The method used in

calculating deferred acquisition costs limits the amount of such deferred costs to actual costs or their estimated realizable value, whichever is lower.

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Impairment of Investments

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

Management continues to review the investment portfolios under our impairment review policy. Given the current market conditions and the significant judgments involved, there is a continuing risk that further declines in fair value may occur and additional material other-than-temporary impairments may be recorded in future periods. Management from time to time may sell investments as part of its asset/liability management process or to reposition its investment portfolio based on current and expected market conditions.

During the year ended December 31, 2016, we recognized other-than-temporary impairments amounting to $1.4 million on equity securities classified as available for sale. The impairment analysis as of December 31, 2016 indicated that, other than those securities for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was considered other-than-temporarily impaired as of that date; however, several factors are beyond management's control, such as the following: financial condition of the issuers, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management's judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income.

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

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, 2016 and 2015 is included in note 3 to the audited consolidated financial statements.

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Allowance for Doubtful Receivables

We estimate the amount of uncollectible receivables in each period and establish an allowance for doubtful receivables considering, among other things, the continued deterioration of the local economy, the exposure to government accounts and the challenging business environment in the Island. The allowance for doubtful receivables amounted to $37.3 million and $37.2 million as of December 31, 2016 and 2015, respectively. As of December 31, 2016 and 2015, the Company had premiums and other receivables of $57.8 million and $78.2 million, respectively, from the Government of Puerto Rico, including its agencies, municipalities, and public corporations. The related allowance for doubtful receivables as of December 31, 2016 and 2015 was $18.9 million and $19.1 million, respectively. The amount of the allowance is based on the aging of unpaid accounts, information about the customer's creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

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

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

Goodwill and Other Intangible Assets

Our consolidated goodwill and other intangible assets at December 31, 2016 were $25.4 million and $4.9 million, respectively, primarily related to the acquisition TSA in 2011. At December 31, 2015 the consolidated goodwill and other intangible assets were $25.4 million and $6.6 million, respectively. The goodwill and other intangible assets balance for both years were primarily related to the acquisition of TSA in 2011. As of December 31, 2016 and 2015, the TSA goodwill was $25.0 million. As of December 31, 2016 and 2015 other intangible assets related to the TSA acquisition were $4.6 million and $6.2 million, respectively.

We account for goodwill and intangible assets with indefinite lives in accordance with ASC No. 350, Goodwill and Other Intangible Assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under this guidance, goodwill is not amortized but is tested for at least annually for impairment and 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.

Our impairment tests involve the use of estimates related to the fair value of the reporting unit and require a significant degree of management judgment and the use of subjective assumptions. The Company assesses qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, including goodwill. If determined to be necessary, the two-step impairment test is used to identify potential goodwill impairment and measure the amount of a goodwill impairment loss to be recognized (if any). 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. The

residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

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Our goodwill impairment test uses the income approach to estimate a reporting unit's fair value. Use of the income approach for our goodwill impairment test reflects our view that valuation methodology provides a reasonable estimate of fair value. The income approach is developed using assumptions about future premiums, expected claims, MLR, operating expenses and net income derived from our internal planning process and historical trends. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry's weighted average cost of capital. It assumes the effective implementation of measures to contain the utilization and cost trends. Events or changes in circumstances, including a decrease in membership, an increase in MLR and/or operating expenses, could result in goodwill impairment.

As required by Financial Accounting Standard Board ("FASB") guidance, we completed our annual impairment tests of existing goodwill during the fourth quarter of 2016 and 2015. Certain interim impairment tests are also performed when potential impairment indicators exist or other changes in our business occur. If we do not achieve our earnings objectives or the cost of capital rises significantly, the assumptions and estimates underlying these impairment evaluations could be adversely affected and result in future impairment charges that would negatively impact our operating results. On the other hand, in October 2016 the TSA HMO contract scored 4.0 overall on a 5.0 star rating system, increasing 1.0 versus the prior year, and achieved 5 stars in Part D, all of this is expected to generate additional premiums in 2018. The result of the impairment test performed in 2016 and 2015 indicated that the fair value of the TSA unit exceeded its carrying value by approximately 47% and 30%, respectively.

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

Other Significant Accounting Policies

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

VI. Recently Issued Accounting Standards

For a description of our recently issued accounting standards, see Note 2, Significant Accounting Policies, of the Notes to Consolidated Financial Statements, included in Item 8, Financial Statements and Supplementary Data, of this Annual Report on Form 10-K.

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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.

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

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

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

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

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

Interest Rate Risk

Our exposure to interest rate changes results from our significant holdings of fixed maturity securities. 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 price risks, for which potential losses could arise from adverse changes in the value of these investments.

Risk Measurement

Our available-for-sale and held-to-maturity securities are a source of market risk. As of December 31, 2016 approximately 80% and 100% of our investments in available-for-sale and held-to-maturity securities, respectively, consisted of fixed maturity securities. The remaining balance of the available-for-sale portfolio is comprised of equity securities and alternative investments. 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 our available-for-sale and held-to-maturity portfolios is exposed to both interest rate risk and equity price risk.

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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, 2016 and 2015. The analysis does not consider any action that management can take to mitigate the impact of changes in market rates.

(Dollar amounts in millions)

| Change in Interest Rates | Expected Fair Value | Amount of Decrease | % Change |
|---|---|---|---|
| December 31, 2016: | | | |
| Base Scenario | $ 1,154.6 | | |
| +100 bp | 1,102.0 | (52.6) | (4.6)% |
| +200 bp | 1,053.2 | (101.4) | (8.9)% |
| +300 bp | 1,007.1 | (147.5) | (13.0)% |
| December 31, 2015: | | | |
| Base Scenario | $ 1,136.8 | | |
| +100 bp | 1,084.9 | (69.7) | (6.1)% |
| +200 bp | 1,037.2 | (117.4) | (10.3)% |
| +300 bp | 991.5 | (163.1) | (14.3)% |

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 99.8% of our fixed maturity 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 of mutual funds whose underlying assets are comprised of domestic equity securities, international equity securities and higher risk fixed income instruments as well as certain alternative investments in the form of commitments to limited liability partnerships. The fixed income mutual funds invest in loan participations, high yield debt and emerging market debt. The fixed income funds invest primarily in debt securities issued or guaranteed by corporations, financial institutions and governmental entities that are either unrated or have non-investment grade ratings from either Standard & Poor’s or Moody’s.

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Our investments in mutual funds exposes us to equity price risk and, because of the underlying assets included in these mutual funds, result in an indirect exposure to credit risk. We manage this indirect exposure to credit risk by closely monitoring the performance of these mutual funds.

Our alternative investments in the available-for-sale portfolio are comprised of commitments to limited liability partnerships. These private funds call capital over time and invest in traditional private equity, infrastructure equity, real estate debt and corporate debt. The investments are unrated, illiquid and expose us to a variety of underlying risks. We manage these exposures by closely monitoring the performance of these funds.

Assuming an immediate decrease of 10% in the market value of our equity securities as of December 31, 2016 and 2015, the hypothetical loss in the fair value of these investments would have been approximately $27.0 million and $19.7 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.

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Item 8. Financial Statements and Supplementary Data

Financial Statements

For our audited consolidated financial statements as of December 31, 2016 and 2015 and for each of the three years ended December 31, 2016 see Index to financial statements in “Item 15. Exhibits and Financial Statements Schedules” to this Annual Report on Form 10-K.

Selected Quarterly Financial Data

| | 2016 | | | | |
|---|---|---|---|---|---|
| | March 31 | June 30 | September 30 | December 31 | Total |
| Revenues | | | | | |
| Premiums earned, net | $738,534 | $729,049 | $ 721,187 | $ 701,871 | $2,890,641 |
| Administrative service fees | 5,083 | 4,520 | 4,146 | 4,094 | 17,843 |
| Net investment income | 11,358 | 12,875 | 12,337 | 12,343 | 48,913 |
| Other operating revenues | 812 | 915 | 871 | 863 | 3,461 |
| Total operating revenues | 755,787 | 747,359 | 738,541 | 719,171 | 2,960,858 |
| Net realized investment gains (losses): | | | | | |
| Total other-than-temporary impairment losses on securities | - | (1,434) | - | - | (1,434) |
| Net realized gains, excluding other-than-temporary impairment losses on securities | 58 | 2,954 | 5,376 | 10,425 | 18,813 |
| Total net realized investment gains | 58 | 1,520 | 5,376 | 10,425 | 17,379 |
| Other income, net | 875 | 3,859 | 734 | 1,101 | 6,569 |
| Total revenues | 756,720 | 752,738 | 744,651 | 730,697 | 2,984,806 |
| Benefits and expenses | | | | | |
| Claims incurred | 626,694 | 622,087 | 629,169 | 594,241 | 2,472,191 |
| Operating expenses | 122,980 | 121,112 | 123,406 | 126,396 | 493,894 |
| Total operating costs | 749,674 | 743,199 | 752,575 | 720,637 | 2,966,085 |
| Interest expense | 1,882 | 1,954 | 1,893 | 1,906 | 7,635 |
| Total benefits and expenses | 751,556 | 745,153 | 754,468 | 722,543 | 2,973,720 |
| Income (loss) before taxes | 5,164 | 7,585 | (9,817) | 8,154 | 11,086 |
| Income tax expense (benefit) | 1,709 | 3,707 | (7,873) | (3,888) | (6,345) |
| Net income (loss) | 3,455 | 3,878 | (1,944) | 12,042 | 17,431 |
| Less: Net loss attributable to non-controlling interest | 1 | 2 | 3 | 1 | 7 |
| Net income (loss) attributable to TSM | $3,456 | $3,880 | $ (1,941) | $ 12,043 | $17,438 |
| Basic net income (loss) per share | $0.14 | $0.16 | $ (.08) | $ 0.49 | $0.71 |
| Diluted net income (loss) per share | $0.14 | $0.16 | $ (.08) | $ 0.49 | $0.71 |

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| | 2015 | | | | |
|---|---|---|---|---|---|
| | March 31 | June 30 | September 30 | December 31 | Total |
| Revenues | | | | | |
| Premiums earned, net | $532,558 | $754,107 | $ 746,718 | $ 749,771 | $2,783,154 |
| Administrative service fees | 29,123 | 4,549 | 6,163 | 4,870 | 44,705 |
| Net investment income | 10,918 | 10,998 | 10,618 | 12,640 | 45,174 |
| Other operating revenues | 1,153 | 641 | 862 | 1,063 | 3,719 |
| Total operating revenues | 573,752 | 770,295 | 764,361 | 768,344 | 2,876,752 |
| Net realized investment gains (losses): | | | | | |
| Total other-than-temporary impairment losses on securities | (1,202) | (1,660) | (1,627) | (723) | (5,212) |
| Net realized gains, excluding other-than-temporary impairment losses on securities | 7,415 | 12,267 | 66 | 4,405 | 24,153 |
| Total net realized investment gains (losses) | 6,213 | 10,607 | (1,561) | 3,682 | 18,941 |
| Other income, net | 1,759 | 1,083 | 2,289 | 1,912 | 7,043 |
| Total revenues | 581,724 | 781,985 | 765,089 | 773,938 | 2,902,736 |
| Benefits and expenses | | | | | |
| Claims incurred | 432,430 | 637,898 | 634,909 | 613,478 | 2,318,715 |
| Operating expenses | 127,375 | 126,824 | 125,887 | 138,635 | 518,721 |
| Total operating costs | 559,805 | 764,722 | 760,796 | 752,113 | 2,837,436 |
| Interest expense | 2,182 | 2,074 | 1,979 | 1,934 | 8,169 |
| Total benefits and expenses | 561,987 | 766,796 | 762,775 | 754,047 | 2,845,605 |
| Income before taxes | 19,737 | 15,189 | 2,314 | 19,891 | 57,131 |
| Income tax expense (benefit) | 4,931 | (3,712) | (1,850) | 5,730 | 5,099 |
| Net income | 14,806 | 18,901 | 4,164 | 14,161 | 52,032 |
| Less: Net loss attributable to non-controlling interest | 30 | 25 | 30 | 4 | 89 |
| Net income attributable to TSM | $14,836 | $18,926 | $ 4,194 | $ 14,165 | $52,121 |
| Basic net income per share | $0.56 | $0.73 | $ 0.17 | $ 0.57 | $2.03 |
| Diluted net income per share | $0.56 | $0.73 | $ 0.16 | $ 0.57 | $2.02 |

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

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

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited Triple-S Management Corporation and its subsidiaries (the "Company's") internal control over financial reporting as of December 31, 2016, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit 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 effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on the criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedules as of and for the year ended December 31, 2016 of the Company and our report dated March 9, 2017 expressed an unqualified opinion on those financial statements and financial statement schedules.

/s/ DELOITTE & TOUCHE LLP

San Juan, Puerto Rico
March 9, 2017

Stamp No. E242722
affixed to original.

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Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

In connection with the preparation of this Annual Report on Form 10-K, management, under the supervision and with the participation of the chief executive officer and the chief financial officer, conducted an evaluation of the effectiveness of our "disclosure controls and procedures" as of the end of this period (as such term is defined under Exchange Act Rule 13a-15(e)) of the Corporation and its subsidiaries. Disclosure controls and procedures are designed to ensure that information required to be disclosed by the issuer in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms and that such information is accumulated and communicated to management, including the chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility that judgments in decision-making can be faulty, and breakdowns as a result of simple errors or mistake. Accordingly, even effective disclosure controls and procedures can only provide reasonable assurance of achieving their control objectives. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions.

Based on this evaluation, our chief executive officer and chief financial officer have concluded that as of December 31, 2016, which is the end of the period covered by this Annual Report on Form 10-K, our disclosure controls and procedures are effective to a reasonable level of assurance.

There were no significant changes in our disclosure controls and procedures, or in factors that could significantly affect internal controls, subsequent to the date the chief executive officer and chief financial officer completed the evaluation referred to above.

Management's Report on Internal Control Over Financial Reporting

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

- pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the Company;
- provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and
- provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

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

Management, under the supervision and with the participation of the chief executive officer and chief financial officer, assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2016 based on criteria described in the "Internal Control—Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") on May 14, 2013. Based on that assessment and those criteria, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2016 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company's consolidated financial statements for external reporting purposes in accordance with GAAP.

The effectiveness of our internal control over financial reporting as of December 31, 2016 has been audited by Deloitte & Touche, LLP, an independent registered public accounting firm, as stated in their report which is included in this Annual Report on Form 10-K.

Changes in Internal Control Over Financial Reporting

No changes in our internal control over financial reporting (as such term is defined in the Exchange Act Rule 13a-15(f)) occurred during the fiscal quarter ended December 31, 2016 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

9B. Other Information

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 11. Executive Compensation

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 14. Principal Accountant Fees and Services

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2017 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 15. Exhibits and Financial Statements Schedules

Financial Statements and Schedules

| Financial Statements | Description |
|---|---|
| F-1 | Reports of Independent Registered Public Accounting Firm |
| F-2 | Consolidated Balance Sheets as of December 31, 2016 and 2015 |
| F-3 | Consolidated Statements of Earnings for the years ended December 31, 2016, 2015 and 2014 |
| F-4 | Consolidated Statements of Comprehensive Income for the years ended December 31, 2016, 2015 and 2014 |
| F-5 | Consolidated Statements of Stockholders' Equity for the years ended December 31, 2016, 2015 and 2014 |
| F-6 | Consolidated Statements of Cash Flows for the years ended December 31, 2016, 2015 and 2014 |
| F-7 | Notes to Consolidated Financial Statements – December 31, 2016, 2015 and 2014 |

| 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.

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Exhibits

| Exhibits | Description |
|---|---|
| 3(i)(a) | Amended and Restated Articles of Incorporation (incorporated herein by reference to Exhibit 3(i)(d) to TSM's Annual Report on Form 10-K for the Year Ended December 31, 2007 (File No. 001-33865). |
| 3(i)(b) | Amendment to Article Tenth of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation, incorporated by reference to Exhibit 3(i)(b) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865). |
| 3(i)(c) | Articles of Incorporation of Triple-S Management Corporation, as currently in effect, incorporated by reference to Exhibit 3(i)(c) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865). |
| 3(ii) | Amended and Restated Bylaws of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3.1 to TSM's Current Report on Form 8-K filed on June 11, 2010 (File No. 001-33865)). |
| 10.1 | Agreement between the Puerto Rico Health Insurance Administration and TSS for the provision of the physical & behavioral health services under the Government Health Plan Program (incorporated herein by reference to Exhibit 10.1 to TSM's Annual Report on Form 10-K for the year ended December 31, 2014 (File No. 001-33865)). |
| 10.2 | Amended and Restated Agreement between the Puerto Rico Health Insurance Administration and TSS to administer the provision of the physical health component of the Medicaid program in designated service regions (incorporated herein by reference to Exhibit 10.1 to TSM's Quarterly Report on Form 10-Q filed on August 8, 2013 (File No. 001-33865)). |
| 10.4 | Federal Employees Health Benefits Contract (incorporated herein by reference to Exhibit 10.5 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)). |
| 10.5 | Credit Agreement with FirstBank Puerto Rico in the amount of $41,000,000 (incorporated herein by reference to Exhibit 10.6 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)). |
| 10.6 | Credit Agreement with FirstBank Puerto Rico in the amount of $20,000,000 (incorporated herein by reference to Exhibit 10.7 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)). |
| 10.7 | Non-Contributory Retirement Program (incorporated herein by reference to Exhibit 10.8 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)). |
| 10.8 | Blue Shield License Agreement by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.11 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)). |
| 10.9 | Blue Shield Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.12 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)). |
| 10.10 | |

Blue Cross License Agreements by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.13 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).

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| Exhibits | Description |
|---|---|
| 10.11 | Blue Cross Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.14 to TSM's Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)). |
| 10.12 | 6.30% Senior Unsecured Notes Due September 2019 Note Purchase Agreement, dated September 30, 2004, between Triple-S Management Corporation, Triple-S, Inc. and various institutional accredited investors (incorporated herein by reference to Exhibit 10.15 to TSM's Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)). |
| 10.13 | 6.60% Senior Unsecured Notes Due December 2020 Note Purchase Agreement, dated December 15, 2005, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.16 to TSM's Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)). |
| 10.14 | 6.70% Senior Unsecured Notes Due December 2021 Note Purchase Agreement, dated January 23, 2006, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.1 to TSM's Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2006 (File No. 001-33865)). |
| 10.15 | TSM 2007 Incentive Plan, dated October 16, 2007 (incorporated herein by reference to Exhibit C to TSM's 2007 Proxy Statement (File No. 001-33865)). |
| 10.16 | Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS dated August 16, 2007 (incorporated herein by reference to Exhibit 10.15 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)). |
| 10.17 | Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(a) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)). |
| 10.18 | Addendum Number Two to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(b) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)). |
| 10.19 | Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(c) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)). |
| 10.20 | Work Order Agreement between Quality Care Solutions, Inc. and TSS (incorporated herein by reference to Exhibit 10.16 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)). |
| 10.21 | Employment Contract between Ramón M. Ruiz Comas and TSM (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on November 5, 2012 (File No. 001-33865)). |

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| Exhibits | Description |
|---|---|
| 10.22 | Settlement and Release Agreement between Triple-S Management Corporation, Triple-S Salud, Inc., and the Health Insurance Administration of Puerto Rico (incorporated herein by reference to Exhibit 10.22 to TSM's Annual Report on Form 10-K for the year ended December 31, 2015 (File No. 001-33865)). |
| 10.23 | Resolution Agreement between Triple-S Management Corporation, Triple-S Salud, Inc., and the Department of Health and Human Services (incorporated herein by reference to Exhibit 10.23 to TSM's Annual Report on Form 10-K for the year ended December 31, 2015 (File No. 001-33865)). |
| 10.24 | Employment Contract between Roberto García-Rodríguez and TSM (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K/A filed on January 6, 2016 (File No. 001-33865)). |
| 10.25 | Credit Agreement dated December 28, 2016 by and between Triple-S Management Corporation and FirstBank Puerto Rico (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on December 30, 2016 (File No. 001-33865)). |
| 11.1 | Statement re computation of per share earnings; an exhibit describing the computation of the earnings per share has been omitted as the detail necessary to determine the computation of earnings per share can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K. |
| 21 | List of Subsidiaries of TSM (incorporated herein by reference to Exhibit 21 to TSM's Annual Report on Form 10-K for the year ended December 31, 2014 (File No. 001-33865)). |
| 23.1* | Consent of Independent Registered Public Accounting Firm (Deloitte & Touche LLP). |
| 23.2* | Consent of Independent Registered Public Accounting Firm (PricewaterhouseCoopers LLP). |
| 31.1* | Certification of the President and Chief Executive Officer required by Rule 13a-14(a)/15d-14(a). |
| 31.2* | Certification of the 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. |
| 99.1 | Incentive Compensation Recoupment Policy (incorporated herein by reference to Exhibit 99.1 to TSM's Annual Report on Form 10-K for the year ended December 31, 2010 (File No. 001-33865)). |

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/ Roberto García-Rodríguez Date: March 9, 2017
Roberto García-Rodríguez
President and Chief Executive Officer

By: /s/ Juan J. Román-Jiménez Date: March 9, 2017
Juan J. Román-Jiménez
Executive Vice President 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/ Luis A. Clavell-Rodríguez Date: March 9, 2017
Luis A. Clavell-Rodríguez
Director and Chairman of the Board

By: /s/ Cari M. Domínguez Date: March 9, 2017
Cari M. Domínguez
Director and Vice-Chairman of the Board

By: /s/ David H. Chafey, Jr Date: March 9, 2017
David H. Chafey, Jr.
Director

By: /s/ Jorge L. Fuentes-Benejam Date: March 9, 2017
Jorge L. Fuentes-Benejam
Director

By: /s/ Antonio F. Faría-Soto Date: March 9, 2017
Antonio F. Faría-Soto
Director

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By: /s/ Manuel Figueroa-Collazo Date: March 9, 2017
Manuel Figueroa-Collazo
Director

By: /s/ Joseph A. Frick Date: March 9, 2017
Joseph A. Frick
Director

By: /s/ Roberto Santa María-Ros Date: March 9, 2017
Roberto Santa María-Ros
Director

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Triple-S Management Corporation
Consolidated Financial Statements
December 31, 2016, 2015, and 2014

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited the accompanying consolidated balance sheets of Triple-S Management Corporation and its subsidiaries (the "Company") as of December 31, 2016 and 2015 and the related consolidated statements of earnings, comprehensive income, stockholders' equity, and cash flows for the two years then ended. Our audits also included the financial statement schedules listed in the Index at Item 15. These financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on the financial statements and financial statement schedules 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 includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of Triple-S Management Corporation and its subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for the two years then ended, in conformity with accounting principles generally accepted in the United States of America. Also, 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.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2016, based on the criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 9, 2017 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

San Juan, Puerto Rico
March 9, 2017

Stamp No. E242723
affixed to original.

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**Report of Independent Registered Public Accounting Firm**

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

In our opinion, the accompanying consolidated statements of earnings, comprehensive income, of stockholders' equity and of cash flows present fairly, in all material respects, the results of operations and cash flows of Triple-S Management Corporation and its subsidiaries for the year ended December 31, 2014, in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules for the year ended December 31, 2014 listed in the index appearing under Item 15 present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. These financial statements and financial statement schedules are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and financial statement schedules based on our audit. We conducted our audit of these financial statements 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 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, and evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

/s/ PricewaterhouseCoopers LLP

San Juan, Puerto Rico
March 17, 2015

CERTIFIED PUBLIC ACCOUNTANTS
(OF PUERTO RICO)
License No. LLP-216 Expires Dec. 1, 2019
Stamp E257041 of the P.R. Society of
Certified Public Accountants has been
affixed to the file copy of this report
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Triple-S Management Corporation
Consolidated Balance Sheets
December 31, 2016 and 2015
(dollar amounts in thousands, except share data)

| Assets | 2016 | 2015 |
|---|---|---|
| Investments and cash | | |
| Securities available for sale, at fair value: | | |
| Fixed maturities (amortized cost of $1,104,303 in 2016 and $1,088,258 in 2015) | $1,151,643 | $1,133,645 |
| Equity securities (cost of $240,699 in 2016 and $169,593 in 2015) | 270,349 | 197,071 |
| Securities held to maturity, at amortized cost: | | |
| Fixed maturities (fair value of $3,012 in 2016 and $3,124 in 2015) | 2,836 | 2,929 |
| Policy loans | 8,564 | 7,901 |
| Cash and cash equivalents | 103,428 | 197,818 |
| Total investments and cash | 1,536,820 | 1,539,364 |
| Premium and other receivables, net | 286,365 | 282,646 |
| Deferred policy acquisition costs and value of business acquired | 194,787 | 190,648 |
| Property and equipment, net | 66,369 | 73,953 |
| Deferred tax asset | 57,768 | 52,361 |
| Goodwill | 25,397 | 25,397 |
| Other assets | 51,493 | 41,776 |
| Total assets | $2,218,999 | $2,206,145 |
| Liabilities and Stockholders’ Equity | | |
| Claim liabilities | 487,943 | 491,765 |
| Liability for future policy benefits | 321,232 | 289,530 |
| Unearned premiums | 79,310 | 80,260 |
| Policyholder deposits | 179,382 | 179,287 |
| Liability to Federal Employees’ Health Benefits and Federal Employees' Programs | 34,370 | 26,695 |
| Accounts payable and accrued liabilities | 169,449 | 176,910 |
| Deferred tax liability | 18,850 | 15,070 |
| Long term borrowings | 35,085 | 36,827 |
| Liability for pension benefits | 30,892 | 62,945 |
| Total liabilities | 1,356,513 | 1,359,289 |
| | | |
| Commitments and contingencies | | |
| | | |
| Stockholders’ equity | | |
| Triple-S Management Corporation stockholders' equity | | |
| Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 950,968 at December 31, 2016 and 2015 | 951 | 951 |
| Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 23,321,163 and 24,047,755 shares at December 31, 2016 and 2015, respectively | 23,321 | 24,048 |
| Additional paid-in capital | 65,592 | 83,438 |
| Retained earnings | 730,904 | 713,466 |
| Accumulated other comprehensive income, net | 42,395 | 25,623 |
| Total Triple-S Management Corporation stockholders' equity | 863,163 | 847,526 |
| Non-controlling interest in consolidated subsidiary | (677) | (670) |
| Total stockholders' equity | 862,486 | 846,856 |

| | | |
|---|---|---|
| Total liabilities and stockholders' equity | $2,218,999 | $2,206,145 |

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

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Triple-S Management Corporation
Consolidated Statements of Earnings
December 31, 2016, 2015, and 2014
(dollar amounts in thousands, except per share data)

| | 2016 | 2015 | 2014 |
|---|---|---|---|
| Revenues: | | | |
| Premiums earned, net | $2,890,641 | $2,783,154 | $2,128,566 |
| Administrative service fees | 17,843 | 44,705 | 119,302 |
| Net investment income | 48,913 | 45,174 | 47,540 |
| Other operating revenues | 3,461 | 3,719 | 4,232 |
| Total operating revenues | 2,960,858 | 2,876,752 | 2,299,640 |
| Net realized investment gains (losses): | | | |
| Total other-than-temporary impairment losses on securities | (1,434) | (5,212) | (1,170) |
| Net realized gains, excluding other-than-temporary impairment losses on securities | 18,813 | 24,153 | 19,401 |
| Total net realized investment gains on sale of securities | 17,379 | 18,941 | 18,231 |
| Other income, net | 6,569 | 7,043 | 2,243 |
| Total revenues | 2,984,806 | 2,902,736 | 2,320,114 |
| Benefits and expenses: | | | |
| Claims incurred | 2,472,191 | 2,318,715 | 1,747,595 |
| Operating expenses | 493,894 | 518,721 | 497,194 |
| Total operating costs | 2,966,085 | 2,837,436 | 2,244,789 |
| Interest expense | 7,635 | 8,169 | 9,274 |
| Total benefits and expenses | 2,973,720 | 2,845,605 | 2,254,063 |
| Income before taxes | 11,086 | 57,131 | 66,051 |
| Income tax (benefit) expense | (6,345) | 5,099 | 745 |
| Net income | 17,431 | 52,032 | 65,306 |
| Less: Net loss attributable to non-controlling interest | 7 | 89 | 354 |
| Net income attributable to Triple-S Management Corporation | $17,438 | $52,121 | $65,660 |
| Earnings per share attributable to Triple-S Management Corporation | | | |
| Basic net income per share | $0.71 | $2.03 | $2.42 |
| Diluted net income per share | $0.71 | $2.02 | $2.41 |

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

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Triple-S Management Corporation
Consolidated Statements of Comprehensive Income
December 31, 2016, 2015, and 2014
(dollar amounts in thousands)

| | 2016 | 2015 | 2014 |
|---|---|---|---|
| Net income | $17,431 | $52,032 | $65,306 |
| Other comprehensive income (loss), net of tax: | | | |
| Net unrealized change in fair value of available for sale securities, net of taxes | (107) | (38,989) | 35,883 |
| Defined benefit pension plan: | | | |
| Actuarial gain (loss), net | 18,232 | 16,105 | (18,967) |
| Prior service credit, net | (1,353) | (269) | (269) |
| Total other comprehensive income (loss), net of tax | 16,772 | (23,153) | 16,647 |
| Comprehensive income | 34,203 | 28,879 | 81,953 |
| Comprehensive loss attributable to non-controlling interest | 7 | 89 | 354 |
| Comprehensive income attributable to Triple-S Management Corporation | $34,210 | $28,968 | $82,307 |

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

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Triple-S Management Corporation
Consolidated Statements of Stockholders' Equity
December 31, 2016, 2015, and 2014
(dollar amounts in thousands)

| | Class A Common Stock | Class B Common Stock | Additional Paid-in Capital | Retained Earnings | Accumulated Other Comprehensive Income (Loss) | Triple-S Management Corporation Stockholders' Equity | Non-controlling Interest in Consolidated Subsidiary | Total Stockholders' Equity |
|---|---|---|---|---|---|---|---|---|
| Balance, December 31, 2013 | $ 2,378 | $ 25,091 | $ 130,098 | $ 595,685 | $ 32,129 | $ 785,381 | $ (178) | $ 785,203 |
| Share-based compensation | - | 135 | 2,236 | - | - | 2,371 | - | 2,371 |
| Stock issued upon exercise of stock options | - | 199 | 2,686 | - | - | 2,885 | - | 2,885 |
| Repurchase and retirement of common stock | - | (771) | (13,615) | - | - | (14,386) | - | (14,386) |
| Net change in comprehensive income (loss) | - | - | - | 65,660 | 16,647 | 82,307 | (354) | 81,953 |
| Balance, December 31, 2014 | $ 2,378 | $ 24,654 | $ 121,405 | $ 661,345 | $ 48,776 | $ 858,558 | $ (532) | $ 858,026 |
| Share-based compensation | - | 202 | 8,088 | - | - | 8,290 | - | 8,290 |
| Stock issued upon exercise of stock options | - | 13 | 166 | - | - | 179 | - | 179 |
| Common stock conversion | (1,427) | 1,427 | - | - | - | - | - | - |
| Repurchase and retirement of common stock | - | (2,248) | (46,221) | - | - | (48,469) | - | (48,469) |
| Non-controlling interest decrease related to retirement of consolidated subsidiary common stock | - | - | - | - | - | - | (49) | (49) |
| Net change in comprehensive income (loss) | - | - | - | 52,121 | (23,153) | 28,968 | (89) | 28,879 |
| Balance, December 31, 2015 | $ 951 | $ 24,048 | $ 83,438 | $ 713,466 | $ 25,623 | $ 847,526 | $ (670) | $ 846,856 |
| Share-based compensation | - | 223 | 2,576 | - | - | 2,799 | - | 2,799 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Stock issued upon exercise of stock options | - | 4 | 51 | - | - | 55 | - | 55 |
| Repurchase and retirement of common stock | - | (954) | (20,473) | - | - | (21,427) | - | (21,427) |
| Net change in comprehensive income (loss) | - | - | - | 17,438 | 16,772 | 34,210 | (7) | 34,203 |
| Balance, December 31, 2016 | $951 | $23,321 | $65,592 | $730,904 | $42,395 | $863,163 | $ (677) | $862,486 |

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

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Triple-S Management Corporation
Consolidated Statements of Cash Flows
December 31, 2016, 2015, and 2014
(Dollar amounts in thousands)

| | 2016 | 2015 | 2014 |
|---|---|---|---|
| Cash flows from operating activities | | | |
| Net income | $17,431 | $52,032 | $65,306 |
| Adjustments to reconcile net income to net cash provided by operating activities | | | |
| Depreciation and amortization | 14,120 | 16,379 | 24,400 |
| Net amortization of investments | 8,671 | 6,854 | 6,091 |
| Additions to the allowance for doubtful receivables | 1,601 | 16,121 | 14,819 |
| Deferred tax benefit | (8,326) | (5,070) | (21,806) |
| Net realized investment gains on sale of securities | (17,379) | (18,941) | (18,231) |
| Interest credited to policyholder deposits | 3,794 | 5,690 | 3,510 |
| Share-based compensation | 2,463 | 8,290 | 2,371 |
| (Increase) decrease in assets | | | |
| Premium and other receivables, net | (5,320) | 6,399 | (45,046) |
| Deferred policy acquisition costs and value of business acquired | (7,286) | (6,548) | (6,811) |
| Deferred taxes | (4,799) | 3,616 | 1,954 |
| Other assets | (9,009) | (2,630) | 8,630 |
| (Decrease) increase in liabilities | | | |
| Claim liabilities | (3,822) | 101,679 | (30,335) |
| Liability for future policy benefits | 31,702 | 18,146 | 23,930 |
| Unearned premiums | (950) | (2,396) | (4,706) |
| Liability to FEHBP | 7,675 | 11,029 | 7,518 |
| Accounts payable and accrued liabilities | (24,095) | 18,444 | 6,397 |
| Net cash provided by operating activities | 6,471 | | |