TRIPLE-S MANAGEMENT CORP
Form 10-K/A
November 20, 2008

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-K/A
(Amendment No. 1)

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

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

COMMISSION FILE NUMBER 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 o NO þ

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

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

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

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

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

(Do not check if a smaller reporting company)

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant (assuming solely for the purposes of this calculation that all Directors and executive officers of the registrant are

affiliates) as of June 30, 2007 was approximately $26,709,000. Aggregate market value was determined at par because at that time there was no established public trading market for TSM s common stock.

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

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Explanatory Note

Triple-S Management Corporation is filing this Amendment No. 1 on Form 10-K/A for the purpose of amending the contractual obligations disclosure in Item 7 and Item 9A of Part II of our Annual Report on Form 10-K for the year ended December 31, 2007 filed with the U.S. Securities and Exchange Commission (the SEC) on March 13, 2008 (the Original Filing).

Except for the Items listed above, this Amendment does not amend, modify or update the Original Filing in any respect. Information included in this Amendment is stated as of December 31, 2007 and does not reflect events that have occurred subsequent to the filing of the Original Filing and, accordingly, this Amendment should be read in conjunction with our Original Filing made with the SEC.

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

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

Overview

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

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

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

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

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

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

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

Results of Operations

Revenue

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

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

Premiums are generally fixed by contract in advance of the period during which healthcare is covered. Our Commercial premiums are generally fixed for the plan year in the annual renewal process. Our Medicare Advantage

contracts entitle us to premium payments from CMS on behalf of each Medicare beneficiary enrolled in our plans, generally on a per member per month (PMPM) basis. We submit rate proposals to CMS in June for each Medicare Advantage product that will be offered beginning January 1 of the subsequent year in accordance with the new competitive bidding process under the MMA. Retroactive rate

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adjustments are made periodically with respect to our Medicare Advantage plans based on the aggregate health status and risk scores of our plan participants.

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

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

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

Investment Income and Other Income. Investment income consists of interest income and other income consists of net realized gains on investment securities. See note 2(e) to our audited consolidated financial statements.

Expenses

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

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

Operating Expenses. Operating expenses include commissions to external brokers, general and administrative expenses, cost containment expenses such as case and disease management programs, and depreciation and amortization. The operating expense ratio is calculated by dividing operating expenses by

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premiums earned, net and administrative service fees. A significant portion of our operating expenses are fixed costs. Accordingly, it is important that we maintain or increase our volume of business in order to distribute our fixed costs over a larger membership base. Significant changes in our volume of business will affect our operating expense ratio and results of operations. We also have variable costs, which vary in proportion to changes in volume of business.

Membership

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

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

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

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

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

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

government employees.

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

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

Significant Transactions

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

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that year. Comparable basis information, unlike the pro forma financial information included in note 17 of the audited financial consolidated financial statements for the years ended December 31, 2007, 2006 and 2005, does not reflect adjustments, such as interest expense associated with indebtedness incurred in connection with the acquisition.

Consolidated

	Year ended December 31, 2005		
(Dollar amounts in millions, except per share data)	**TSM**	**GA Life**	**Comparable Basis**
Revenues:			
Premiums earned, net	$1,380.2	61.6	1,441.8
Administrative service fees	14.4		14.4
Net investment income	29.1	10.6	39.7
Total operating revenues	1,423.7	72.2	1,495.9
Net realized investment gains	7.2	4.4	11.6
Net unrealized investment loss in trading securities	(4.7)		(4.7)
Other income, net	3.7		3.7
Total revenues	1,429.9	76.6	1,506.5
Benefits and expenses:			
Claims incurred	1,208.3	29.0	1,237.3
Operating expenses	181.7	31.5	213.2
Total operating costs	1,390.0	60.5	1,450.5
Interest expense	7.6	1.4	9.0
Total benefits and expenses	1,397.6	61.9	1,459.5
Income before taxes	32.3	14.7	47.0
Income tax expense (benefit):			
Current	4.0	0.6	4.6
Deferred	(0.1)	(1.4)	(1.5)
Total income taxes	3.9	(0.8)	3.1
Net income	$ 28.4	15.5	43.9

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Life and Disability Insurance Segment

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

Consolidated Operating Results

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

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

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

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

Operating Revenues

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

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

Net Realized Investment Gains

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

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

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

Claims Incurred

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

Operating Expenses

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

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Income tax expense

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

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

Operating Revenues

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

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

Net Realized Investment Gains

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

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

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

Claims Incurred

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

Operating Expenses

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

Interest Expense

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

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Income Tax Expense

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

Managed Care Operating Results

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

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

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

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

Medical Operating Revenues

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

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

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

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

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

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

Medical Claims Incurred

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

Medical Operating Expenses

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

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

Medical Operating Revenues

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

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

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

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

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

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

Medical Claims Incurred

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

Medical Operating Expenses

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

Life Insurance Operating Results

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

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

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

Operating Revenues

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

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

Policy Benefits and Claims Incurred

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

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

Underwriting and Other Expenses

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

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

Operating Revenues

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

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

Policy Benefits and Claims Incurred

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

Underwriting and Other Expenses

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

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Property and Casualty Insurance Operating Results

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

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

Operating Revenues

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

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

Claims Incurred

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

Underwriting and Other Operating Expenses

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

segment s investment in a new IT system.

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

Operating Revenues

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

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

Claims Incurred

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

Underwriting and Other Operating Expenses

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

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Liquidity and Capital Resources

Cash Flows

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

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

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

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

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

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

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

Capital expenditures decreased by $2.5 million as the result of the completion of the renovation of a building adjacent to our corporate headquarters which was completed during the last quarter of 2006. In addition, our property and casualty insurance segment acquired new hardware and software as part of its new insurance application during 2006.

In March 2007, we declared and paid dividends to our stockholders amounting to $2.4 million.

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

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

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

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

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

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

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

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

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

Financing and Financing Capacity

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

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

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

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

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

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

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

In addition, as of December 31, 2007 we are a party to a secured term loan with a commercial bank, FirstBank Puerto Rico. This secured loan bears interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus 100 basis points and requires monthly principal repayment of $0.1 million. As of December 31, 2007, this secured loan had an outstanding balance of $25.9 million and an average annual interest rate of 6.4%.

This secured loan is guaranteed by a first lien on our land, buildings and substantially all leasehold improvements, as collateral for the term of the agreements under a continuing general security agreement. This secured loan contains certain covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2007, we are in compliance with these covenants. Failure to meet these covenants may trigger the accelerated payment of the secured loan s outstanding balances. Principal repayments on this loan are expected to be paid out from our operating and investing cash flows.

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

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

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

Planned Capital Expenditures

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

Contractual Obligations

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

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

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

Policyholder deposits The cash outflows related to these instruments are not included because they do not have defined maturities, such that the timing of payments and withdrawals is uncertain. There are currently no significant policyholder deposits in paying status. As of December 31, 2007, our policyholder deposits had a carrying amount of $45.9 million.

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

		Contractual obligations by year					
(Dollar amounts in millions)	**Total**	**2008**	**2009**	**2010**	**2011**	**2012**	**Thereafter**
Long-term borrowings (1)	$ 302.9	12.6	12.6	12.5	12.4	12.2	240.6
Operating leases	13.3	5.3	3.7	2.2	1.2	0.5	0.4
Purchase obligations (2)	235.5	235.2	0.1	0.1	0.1		
Claim liabilities (3)	353.8	228.7	69.5	16.9	11.0	8.6	19.1
Estimated obligation for future policy benefits (4)	945.4	66.2	57.9	54.7	52.2	49.8	664.6
	$1,850.9	548.0	143.8	86.4	76.9	71.1	924.7

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

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

See the Financing and Financing Capacity section for additional information regarding our long-term borrowings.

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

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

(3) Claim liabilities represent the amount of our claims processed and incomplete as well as an estimate of the amount of incurred but not reported claims and loss-adjustment expenses. This amount does not include an estimate of claims to be incurred subsequent to December 31, 2007. The expected claims payments are an estimate and may 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 $54.8 million of reserves had been ceded at December 31, 2007.

(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

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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, 2007, and are gross of any reinsurance recoverable. The $945.4 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $194.1 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual

experience and the assumptions used in the estimation of these payments.

Off-Balance Sheet Arrangements

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

Restriction on Certain Payments by the Corporation s Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico. These regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by the insurance subsidiaries to TSM. Our managed care subsidiary is required to have minimum capital of $1.0 million, our life insurance subsidiary is required to have minimum capital of $2.5 million and our property and casualty insurance subsidiary is required to have minimum capital of $3.0 million. As of December 31, 2007, our insurance subsidiaries were in compliance with such minimum capital requirements.

These regulations are not directly applicable to us, as a holding company, since we are not an insurance company. Our secured term loan restricts the amount of dividends that we and our subsidiaries can declare or pay to shareholders. Under the secured term loan, dividend payments cannot be made in excess of the accumulated retained earnings of the paying entity.

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

Solvency Regulation

To monitor the solvency of the operations, the BCBSA requires us and our managed care subsidiary to comply with certain specified levels of risk-based capital (RBC). RBC is designed to identify weakly capitalized companies by comparing each company s adjusted surplus to its required surplus (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2007, both we and our managed care subsidiary s estimated RBC ratio were above the 200% of our RBC required by the BCBSA and the 375% of our RBC level required by the BCBSA to avoid monitoring.

Other Contingencies

Legal Proceedings

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

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

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Guarantee Associations

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared to be insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. During 2006 and 2005, we paid assessments in connection with insurance companies declared insolvent in the amount of $1.0 million each year. During the year ended December 31, 2007, no assessment or payment was made in connection with insurance companies declared insolvent. It is the opinion of management that any possible future guarantee association assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

Pursuant to the Puerto Rico Insurance Code, our property and casualty insurance subsidiary is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED) and of the Sindicato de Aseguradores de Responsabilidad Profesional para Médicos. Both syndicates were organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the previously mentioned syndicates cannot meet their obligations. During 2007, 2006 and 2005, no assessment or payment was made for this contingency. It is the opinion of management that any possible future syndicate assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

In addition, pursuant to Article 12 of Rule LXIX of the Insurance Code, our property and casualty insurance subsidiary is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the Association). The Association was organized in 1997 to underwrite insurance coverage of motor vehicle property damage liability risks effective January 1, 1998. As a participant, the segment shares the risk proportionally with other members based on a formula established by the Insurance Code. During the years 2007, 2006 and 2005, the Association distributed a dividend based on the good experience of the business amounting to $1.0 million, $0.8 million and $0.9 million, respectively.

Critical Accounting Estimates

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

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

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Claim Liabilities

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

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

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

(2) The liability for estimated unreported losses is the amount needed

to provide for the estimated ultimate cost of settling those claims related to insured events that have occurred but have not been reported to us.

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

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

We recognize claim liabilities as follows:

Managed Care Segment

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

Liabilities for reported but incomplete claims are recorded at the contractual rate. Liabilities for unreported losses are determined employing actuarial methods that are commonly used by managed care actuaries and meet Actuarial Standards of Practice, which require that the claim liabilities be adequate under moderately adverse circumstances. The segment determines the amount of the liability for unreported losses by following a detailed actuarial process that entails using both historical claim payment patterns as well as emerging medical cost trends to project a best estimate

of claim liabilities. Under this process, historical claims incurred dates are compared to actual dates of claims payment. This information is analyzed to create completion or development factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the financial statement date to estimate the ultimate claim expense incurred for the current period. Actuarial estimates of claim liabilities are then determined by subtracting the actual paid claims from the estimate of the total expected claims incurred. The majority of unpaid claims, both reported and unreported, for any period are those claims which are incurred in the final months of the period. Since the percentage of claims paid during the period with respect to claims incurred in those months is generally very low, the above-described completion factor methodology is less reliable for such months. In order to complement the analysis to determine the unpaid claims, historical completion factors and payment

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patterns are applied to incurred and paid claims for the most recent twelve months and compared to the prior twelve month period. Incurred claims for the most recent twelve months also take into account recent claims expense levels and health care trend levels (trend factors). Using all of the above methodologies, our actuaries determine based on the different circumstances the unpaid claims as of the end of any period.

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

Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns and claim submission patterns. A comparison of prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 77% of the claims are paid within three months after the last day of the month in which they were incurred and about 13% are within the next three months, for a total of 90% paid within six months after the last day of the month in which they were incurred.

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

As described above, completion factors and 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, 2007 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

(Dollar amounts in millions)

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

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

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

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The segments reserving practice is to consistently recognize the actuarial best estimate as the ultimate liability for claims within a level of confidence required by actuarial standards. Management believes that the methodology for determining the best estimate for claim liabilities at each reporting date has been consistently applied.
Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments, or run-out, becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred claims related to prior years result from claims being settled for amounts less than originally estimated. The reverse is true of reserve shortfalls. Medical claim liabilities are usually described as having a short tail , which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 95%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 5% related to claims incurred prior to the previous calendar year-end. In 2005, the managed care segment began offering Medicare Advantage products for the first time. There has been a rapid growth in this line of business from minimal enrollment in 2005 to approximately 49,000 members by the end of 2007. There have been some increases in both completion and trend factors because of the growth of this business. The effect should lessen with the maturity of this business. Management has not noted any significant emerging trends in claim frequency and severity, other than as described above, and the normal fluctuation in utilization trends from year to year.
The following table shows the variance between the segment s incurred claims for current period insured events and the incurred claims for such years had they been determined retrospectively (the Incurred claims related to current period insured events for the year shown plus or minus the Incurred claims related to prior period insured events for the following year as included in note 8 to the audited consolidated financial statements). This table shows that the segments estimates of this liability have approximated the actual development.

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

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

Management expects that substantially all of the development of the 2007 estimate of medical claims payable will be known during 2008 and that the variance of the total incurred claims on a retrospective basis when compared to reported incurred claims will be similar to the prior years.
In the event this segment experiences an unexpected increase in health care cost or utilization trends, we have the following options to cover claim payments:

Through the management of our cash flows and investment portfolio.

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

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

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

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Life Insurance Segment

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

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

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

The key assumption with regard to claim liabilities for our life insurance segment is related to claims included prior to the end of the year, but not yet reported to our subsidiary. A liability for these claims is estimated based upon experience with regards to amounts reported subsequent to the close of business in prior years. There are uncertainties attendant to these estimates; however, in recent years our estimates have proved to be slightly conservative.

Property and Casualty Insurance Segment

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

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

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

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

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

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the indications produced by each actuarial projection method, which, in turn, rely on the expected paid and reported development patterns and the expected loss ratio for that year.

At December 31, 2007, the actuarial reserve range determined by the actuaries was from $110.9 million to $125.3 million. Management reviews the results of the reserve estimates in order to determine any appropriate adjustments in the recording of reserves. Adjustments to reserve estimates are made after management s consideration of numerous factors, including but not limited to the magnitude of the difference between the actuarial indication and the recorded reserves, improvement or deterioration of actuarial indications in the period, the maturity of the accident year, trends observed over the recent past and the level of volatility within a particular line of business. In general, changes are made more quickly to more mature accident years and less volatile lines of business. Varying the net expected loss ratio by +/-1% in all lines of business for the six most recent accident years would increase/decrease the claims incurred by approximately $5.0 million and $3.9 million, respectively.

Liability for Future Policy Benefits

Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. We compute the amounts for actuarial liabilities in conformity with GAAP. Liabilities for future policy benefits for whole life and term insurance products are computed by the net level premium method, using interest assumptions ranging from 5.0% to 5.4% and withdrawal, mortality and morbidity assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.

The liabilities for all products, except for universal life and deferred annuities, are based upon a variety of actuarial assumptions that are uncertain. The most significant of these assumptions is the level of anticipated death and health claims. Other assumptions that are less significant to the appropriate level of the liability for future policy benefits are anticipated policy persistency rates, investment yields, and operating expense levels. These are reviewed frequently by our subsidiary s external actuaries, to assure that the current level of liabilities for future policy benefits is sufficient, in combination with anticipated future cash flows, to provide for all contractual obligations. For all products except for universal life and deferred annuities, according to Statement of Financial Accounting Standards (SFAS) No. 60, *Accounting and Reporting by Insurance Enterprises*, the basis for the liability for future policy benefits is established at the time of issuance of each contract and would only change if our experience deteriorates to the point that the level of the liability is not adequate to provide for future policy benefits. We do not currently expect that level of deterioration to occur.

Deferred Policy Acquisition Costs and Value of Business Acquired

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

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

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The schedules of amortization of life insurance deferred policy acquisition costs (DPAC) and VOBA are based upon actuarial assumptions regarding future events that are uncertain. For all products, other than universal life and deferred annuities, the most significant of these assumptions is the level of contract persistency and investment yield rates. For these products according to FASB No. 60 the basis for the amortization of DPAC and VOBA is established at the issue of each contract and would only change if our segment s experience deteriorates to the point that the level of the liability is not adequate. We do not currently expect that level of deterioration to occur. For the universal life and deferred annuity products, amortization schedules are based upon the level of historic and anticipated gross profit margins, from the date of each contract s issued (or purchase, in the case of VOBA). These schedules are based upon several actuarial assumptions that are uncertain, are reviewed annually and are modified if necessary. The most significant of these assumptions are anticipated universal life claims, investment yield rates and contract persistency. Based upon the most recent actuarial reviews of all of the assumptions, we do not currently anticipate material changes to the level of these amortization schedules.

The property and casualty business acquisition costs consist of commissions incurred during the production of business and are deferred and amortized ratably over the terms of the policies.

Impairment of Investments

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

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

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

Our fixed maturity securities are sensitive to interest rate fluctuations, which impact the fair value of individual securities. Our equity securities are sensitive to equity price risks, for which potential losses

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could arise from adverse changes in the value of equity securities. For additional information on the sensitivity of our investments, see Item 7A Quantitative and Qualitative Disclosures About Market Risk in this Annual Report on Form 10-K.

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2007 and 2006 is included in note 3 to the audited consolidated financial statements.

Allowance for Doubtful Receivables

We estimate the amount of uncollectible receivables in each period and establish an allowance for doubtful receivables. The allowance for doubtful receivables amounted to $15.9 million and $18.2 million as of December 31, 2007 and 2006, respectively. The amount of the allowance is based on the age of unpaid accounts, information about the customer s creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

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

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

Other Significant Accounting Policies

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

Recently Issued Accounting Standards

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

In September 2006, the FASB issued FASB Statement No. 157, *Fair Value Measurement* (Statement 157). Statement 157 defines fair value, establishes a framework for the measurement of fair value, and enhances disclosures about fair value measurements. The Statement does not require any new fair value measures. The Statement is effective for fair value measures already required or permitted by other standards for

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fiscal years beginning after November 15, 2007. The Company is required to adopt Statement 157 beginning on January 1, 2008. Statement 157 is required to be applied prospectively, except for certain financial instruments. Any transition adjustment will be recognized as an adjustment to opening retained earnings in the year of adoption. In November 2007, the FASB proposed a one-year deferral of Statement 157 s fair-value measurement requirements for nonfinancial assets and liabilities that are not required or permitted to be measured at fair value on a recurring basis. The Company is currently evaluating the impact of adopting Statement 157 on its results of operations and financial position.

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

Item 9A. Controls and Procedures.

Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including our Chief Executive Officer and our Chief Financial Officer, we conducted an evaluation of our disclosure controls and procedures; as such term is defined under Exchange Act Rule 13a-15(e). Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer concluded that our disclosure controls and procedures were effective as of the end of the period covered by 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 Exchange Act Rule 13a-15(f)) occurred during the fiscal quarter ended December 31, 2007 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Management s Report on Internal Control Over Financial Reporting

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

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

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

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

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

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

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.

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SIGNATURES

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

Triple-S Management Corporation
Registrant

By: /s/ Ramón M. Ruiz-Comas Date: November 20, 2008

Ramón M. Ruiz-Comas
President and Chief Executive Officer

By: /s/ Juan J. Román Date: November 20, 2008

Juan J. Román
Vice President of Finance and Chief Financial Officer

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

By: /s/ Luis A. Clavell-Rodríguez, MD Date: November 20, 2008

Luis A. Clavell-Rodríguez, MD
Director and Chairman of the Board

By: /s/ Vicente J. León-Irizarry, CPA Date: November 20, 2008

Vicente J. León-Irizarry, CPA
Director and Vice-Chairman of the Board

By: /s/ Jesús R. Sánchez-Colón, DMD Date: November 20, 2008

Jesús R. Sánchez-Colón, DMD
Director and Secretary of the Board

By: /s/ Valeriano Alicea-Cruz, MD Date: November 20, 2008

Valeriano Alicea-Cruz, MD
Director

By: /s/ Mr. José Arturo Álvarez-Gallardo Date: November 20, 2008

Mr. José Arturo Álvarez-Gallardo

Director

By: /s/ Ms. Carmen Ana Culpeper-Ramírez Date: November 20, 2008

Ms. Carmen Ana Culpeper-Ramírez
Director

By: /s/ Porfirio E. Díaz-Torres, MD Date: November 20, 2008

Porfirio E. Díaz-Torres, MD
Director

By: /s/ Mr. Antonio F. Faría-Soto Date: November 20, 2008

Mr. Antonio F. Faría-Soto
Director

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By: /s/ Manuel Figueroa-Collazo, PE, Ph.D. Date: November 20, 2008

Manuel Figueroa-Collazo, PE, Ph.D.
Director

By: /s/ Jorge L. Fuentes-Benejam, PE Date: November 20, 2008

Jorge L. Fuentes-Benejam, PE
Director

By: /s/ José Hawayek-Alemañy, MD Date: November 20, 2008

José Hawayek-Alemañy, MD
Director

By: /s/ Jaime Morgan-Stubbe, Esq. Date: November 20, 2008

Jaime Morgan-Stubbe, Esq.
Director

By: /s/ Roberto Muñoz-Zayas, MD Date: November 20, 2008

Roberto Muñoz-Zayas, MD
Director

By: /s/ Juan E. Rodríguez-Díaz, Esq. Date: November 20, 2008

Juan E. Rodríguez-Díaz, Esq.
Director

By: /s/ Adamina Soto-Martínez, CPA Date: November 20, 2008

Adamina Soto-Martínez, CPA
Director