TRIPLE-S MANAGEMENT CORP
Form 10-K
March 17, 2014

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

FORM 10-K

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

For the fiscal year ended December 31, 2013

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

For the transition period from ______ to ______

COMMISSION FILE NUMBER 001-33865

TRIPLE-S MANAGEMENT CORPORATION

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

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

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

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

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

Indicate by check mark if the registrant is well-known seasoned issuer, as defined in Rule 405 of the Securities Act.
¨ Yes þ No

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).

þ Yes ¨ No

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

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

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2013 was approximately $538,762,684 for the Class B common stock (the only stock of the registrant that trades in a public market) and $2,380,686 for the Class A common stock (valued at its par value of $1.00 since it is not publicly traded).

As of March 3, 2014, the registrant had 2,377,689 of its Class A common stock outstanding and 24,907,477 of its Class B common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the definitive Proxy Statement to be delivered to shareholders in connection with the Annual Meeting of Shareholders to be held on April 30, 2014 are incorporated by reference into Parts II and III of this Annual Report on Form 10-K.

TRIPLE-S MANAGEMENT CORPORATION

FORM 10-K

For The Fiscal Year Ended December 31, 2013

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Part I

Item 1. Business
General Description of Business and Recent Developments

Triple-S Management Corporation ("Triple-S", "TSM", the "Company", the "Corporation", "we", "us" or "our") is one of the significant players in the managed care industry in Puerto Rico, serving approximately 2,188,000 members across all regions, with a 26% market share in terms of premiums written in Puerto Rico for the nine-month period ended September 30, 2013. We have the exclusive right to use the Blue Cross and Blue Shield ("BCBS") name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica and the British Virgin Islands and Anguilla and over 50 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the commercial and Medicare markets. We market our managed care products through an extensive network of independent agents and brokers located throughout Puerto Rico as well as an internal salaried sales force. Until September 30, 2010 we provided fully-insured managed care services to the Puerto Rico Health Insurance Plan (similar to Medicaid) ("HIP" or "Medicaid") and beginning on November 1, 2011 we resumed our participation in this sector as an Administrative Service Only ("ASO") provider. HIP is a government of Puerto Rico-funded managed care program for the medically indigent that is similar to the Medicaid program in the U.S.

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

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

On February 11, 2014, the Company filed a Current Report on Form 8-K including the earnings press release announcing the Company's consolidated financial results for its fiscal fourth quarter and year ended December 31, 2013. The consolidated financial statements included in this Annual Report on Form 10-K differ from those included in our earnings press release, primarily reflecting the effect of the refinement of the Managed Care segment's risk scores estimate based upon evidence obtained subsequent to the filing of our earnings press release, as well as other adjustments increasing the segment's incurred claims and operating expenses. As a result, the Company's consolidated net income for the year ended December 31, 2013 included in this Annual Report on Form 10-K increased $1.6 million to $55.9 million, or $2.01 per diluted share, as compared to net income of $54.3 million or $1.95 per diluted share, as reported on February 11, 2014. The consolidated and Managed Care premiums, claims incurred and operating expenses are $5.4 million, $1.9 million and $0.8 million, respectively, higher than as reported in our earnings press release.

On November 7, 2013, our subsidiary Triple-S Vida, Inc. ("TSV") completed the acquisition of 100% of the outstanding capital stock of Atlantic Southern Insurance Company ("ASICO"), a life insurance company authorized to do business in Puerto Rico, Costa Rica, Anguilla and British Virgin Islands. The cost of this acquisition was approximately $9.4 million and was funded with unrestricted cash. Our consolidated results of operating and financial condition included in this Annual Report on Form 10-K reflect ASICO's acquisition in periods subsequent to the effective date of the transaction and were included within the Life Insurance segment.

On July 29, 2013, we announced the immediate commencement of an $11.5 million share repurchase program, as authorized by our Board of Directors. This program is being conducted in accordance with Rules 10b5-1 and 10b-18 under the Securities Exchange Act of 1934.

On May 17, 2013, the Company converted $6.7 million of the $9.0 million outstanding Class A shares into Class B shares and concurrently conducted a marketed secondary public offering for a substantial majority of the converted shares. As part of this transaction the Company repurchased and retired 1,000,000 shares at a price of $18.25.

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

On February 7, 2011, our managed care subsidiary Triple-S Salud, Inc. ("TSS") completed the acquisition of 100% of the outstanding capital stock of Socios Mayores en Salud Holdings, Inc. (effective January 7, 2014 this entity changed its name to Triple-S Advantage Solutions, Inc.), the indirect parent company of American Health, Inc. (from now on referred to as "American Health" or "AH"), a provider of Medicare Advantage services. The cost of this acquisition was approximately $84.8 million, and was funded with unrestricted cash. The consolidated results of operations and financial condition of the Corporation included in this Annual Report on Form 10-K reflect the results of operations of AH in periods subsequent to the effective date of the transaction and were included within our Managed Care segment.

In this Annual Report on Form 10-K, references to "shares" or "common stock" refer collectively to our Class A and Class B common stock, unless the context indicates otherwise.

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Industry Overview

Managed Care

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

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

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

We are licensed by the Blue Cross and Blue Shield Association (“BCBSA”) to use the Blue Cross Blue Shield (“BCBS”) name and mark in Puerto Rico, the U.S. Virgin Islands, Costa Rica and the British Virgin Islands and Anguilla. The BCBSA had 37 independent licensees as of December 31, 2013. BCBS membership stood at approximately 100 million members at December 31 2013, which represents approximately 32% of the U.S. population. The BCBS plans work cooperatively in a number of ways that create significant market advantages, especially when competing for very large, multi-state employer groups. For example, all BCBS plans participate in the BlueCard program, which effectively creates a national “Blue” network. Each plan is able to take advantage of other BCBS plans’ broad provider networks and negotiated provider reimbursement rates where a member covered by a policy in one state or territory lives or travels outside such state or territory. The BlueCard program is a source of revenue from services provided in Puerto Rico to individuals who are customers of other BCBS plans and also provides us a significant network in the U.S, creating a significant competitive advantage for us because Puerto Ricans frequently travel to the continental United States.

Life Insurance

Total annual premiums in Puerto Rico for the year ended December 31, 2012 for the life insurance market approximated $1.3 billion. The main products in this market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are independent agents. In recent years banks have established general agencies to cross sell many life insurance products, such as term life and credit life.

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Property and Casualty Insurance

The total property and casualty market in Puerto Rico in terms of gross premiums written as of September 30, 2013 was approximately $1.4 billion. Property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi-peril, fire and allied lines and other general liabilities. Approximately 66% of the market is written by the top six companies in terms of market share, and approximately 88% of the market is written by companies incorporated under the laws of and which operate principally in Puerto Rico.

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

Puerto Rico's Economy

History and Description

Puerto Rico's economy experienced a considerable transformation during the past sixty-five years, passing from an agriculture economy to an industrial one. Every sector in the economy participated in this expansion. Factors contributing to this expansion include government-sponsored economic developments programs, increases in the level of federal transfer payments, and the relatively low cost of borrowing. In some years, these factors were aided by a significant rise in construction investment driven by infrastructure projects, private investment, primarily in housing, and relatively low oil prices. Nevertheless, the significant oil price increases in past years, the continuous contraction of the manufacturing sector, and budgetary pressures on government finances have triggered a general contraction in the economy.

Puerto Rico's economy is currently in a recession that began in the fourth quarter of fiscal year 2006, during which the real gross national product grew by only 0.5%. For fiscal years 2007, 2008, 2009, 2010 and 2011 the real gross national product contracted by 1.2%, 2.9%, 3.8%, 3.6%, and 1.6% respectively. For fiscal year 2012 Puerto Rico's gross national product grew by 0.1%. In October 2013, the Puerto Rico Planning Board (the "Planning Board") released its revised gross national product forecast for fiscal years 2013 and 2014. The gross national product forecast for fiscal year 2013 was revised downward from a projected growth of 0.4% increase to contraction of 0.3%. The Planning Board's forecast for fiscal year 2014 was also revised downward from projected growth of 0.2% to a contraction of 0.8%.

Personal income, both aggregate and per capita, has shown a positive average growth rate from 1947 to 2010. In fiscal year 2012, aggregate personal income was $62.3 billion and personal income per capita was $16,611. According to the Puerto Rico Department of Labor and Human Resources Household Employment Survey, known as the "Household Survey", the number of persons employed in Puerto Rico during the fiscal year 2013 averaged 1,029,019, a decrease of 0.6% compared to the previous fiscal year. During the first five month of fiscal years 2014 total employment averaged 1,016,000, a 2.0% reduction with respect to the same period of the prior year. The unemployment rate for fiscal year 2013 and for the first six months of fiscal year 2014 was 14.0% and 14.5%, respectively.

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

The economy of Puerto Rico is closely linked to that of the United States, as most of the external factors that affect the Puerto Rico economy (other than the price of oil) are determined by the policies and results of the U.S. These external factors include exports, direct investment, the amount of federal transfer payments, the level of interest rates, the rate of inflation, and tourist expenditures. In the past, the economy of Puerto Rico has generally followed economic trends in the overall United States economy. However, in recent years economic growth in Puerto Rico has not been consistent with the performance of the United States economy. Since 2000, the government has faced a number of fiscal challenges, including an imbalance between its general fund revenues and expenditures, reaching its highest level in fiscal year 2009 with a deficit of $3.3 billion. In the past, the Government of Puerto Rico generally bridged deficits through the use of non-recurring measures, such as borrowings, postponing payments to suppliers, and other one-time measures such as the use of derivatives and borrowings collateralized with government-owned real estate. Recurrent budget deficits have substantially increased the amount of public sector debt. The total outstanding public sector debt amounted to $70.0 billion as of June 30, 2013.

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Recent Measures

In recent years, the Government of Puerto Rico has been focused on implementing measures to achieve fiscal balance, restore economic growth, find solutions for its underfunded pension system and thereby safeguarding the investment-grade ratings of its bonds. Measures taken include (1) a reduction in the amount of government employees, (2) tax reform, (3) privatization of the Luis Muñoz Marín airport in San Juan and certain highways through public-private partnerships, and, more recently, (4) pension reform reducing benefits and increasing the retirement age.

On June 30, 2013 the Governor of Puerto Rico signed into law significant changes to the Puerto Rico Internal Revenue Code of 2011, as amended ("the 2011 Code"). Relevant amendments to the 2011 Code impacting income taxes include the expansion of the corporate alternative minimum tax and individual alternative basic tax in lieu of the proposed "National Gross Receipts Tax", a moratorium on tax credits, modified excise taxes, sales and use taxes, and taxes on insurance premiums. These changes, as applicable, have been considered and recorded in the Corporation's financial statements as of and for year ended December 31, 2013. In addition to the changes in the 2011 Code, the Government of Puerto Rico may take other revenue raising measures, which could have a material adverse effect on our business, financial condition and results of operations.

In October 2013, a bill to expand the role of the Sales Tax Financing Corporation, also known as Cofina, that allows this entity issue additional bonds, was signed into law. The amendments increase the Sales and Use Tax percentage allocated to Cofina from 2.75% to 3.50%, and allows the use of these funds for financings related to the budgets of fiscal years 2012, 2013 and 2014. In December 2013 a bill to reform the Teachers' Retirement System was signed into law.

Rating Agencies and Markets

Moody's downgraded Cofina senior bonds to Baa1 on February 7, 2014 and maintained a negative outlook. The downgrade reflects Puerto Rico's weak economy and constrained growth in sales tax revenues. Moody's notes that measures have been taken to stabilize Puerto Rico's fiscal situation, but economic recovery prospects remain weak. The current four notch rating differential between General Obligation bonds (Ba2) and Cofina Senior bonds (Baa1) reflects Moody's view of a strong legal separation between the two credits.

Since the end of May 2013, Puerto Rico bonds have experienced steep price declines due to various factors, including investor worries about the economic and financial situation of Puerto Rico caused underperformance of Puerto Rico bonds. Additionally, interest rates for longer dated maturities have risen on the back of a decrease ("tapering") in asset purchases by the Federal Reserve. Besides this, the overall municipal market has underperformed compared to other fixed income sectors on the back of mutual fund outflows.

On February 4, 2014 Standard & Poor's (S&P) lowered its rating of General Obligation bonds from BBB- to BB+. Related credits were also downgraded and all ratings remained on negative watch. S&P recognizes the progress of the Government in reducing operating deficits, but notes liquidity constraints as the main reason for the downgrade. The negative watch reflects uncertainties relating to market access and potential additional liquidity needs.

On February 7, 2014 Moody's downgraded General Obligation bonds from Baa3 to Ba2 and maintained a negative outlook. Other credits, which are capped by or linked to the GO rating, were also downgraded. Moody's notes a high debt load and fixed costs, narrow liquidity and constrained market access. Efforts of the Government to address these issues are recognized, but the negative outlook signals the remaining challenges facing the Commonwealth.

Cofina senior lien sales tax bonds, in which we hold most of our positions, were downgraded from A2 to Baa2 by Moody's on February 7, 2014 and maintained a negative outlook. S&P continues to rate Cofina senior as AA-, combined with a negative outlook since September 30, 2013. Moody's has previously indicated that the rating differential between Cofina and General Obligation bonds is due to a strong legal separation between the two credits.

On March 12, 2014 the Commonwealth successfully issued 3.5 billion General Obligation bonds. This issuance improves the liquidity of the Commonwealth and addresses some of the concerns expressed by the rating agencies.

See "Item 1A. Risk Factors—Risks Related to Our Business¾The geographic concentration of our business in Puerto Rico may subject us to economic downturns in the region.''

Products and Services

Managed Care

Through our subsidiaries TSS and AH, we offer a broad range of managed care products, including HMO plans, PPO plans, Medicare Supplement, Medicare Advantage, Medicare Part D and Medicaid plans. Managed care products represented approximately 89% of our consolidated premiums earned, net for each of the years ended December 31, 2013, 2012 and 2011. We design our products to meet the needs and objectives of a wide range of customers, including employers, professional and trade associations, individuals and government entities. Our customers either contract with us to assume underwriting risk or they self-fund underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members' access to providers is subject to referral or preauthorization requirements.

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

We currently offer the following managed care plans:

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

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

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

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

Prescription Drug Benefit Plans. Every Medicare beneficiary must be given the opportunity to select a prescription drug plan through Medicare Part D, largely funded by the federal government. We are required to offer a Medicare Part D prescription drug plan to our enrollees in every area in which we operate. We offer prescription drug benefits under Medicare Part D in our Medicare Advantage plans as well as on a stand-alone basis. We also offer a Drug Discount Card for local government employees and individuals. The Drug Discount Card program is not insurance, but rather provides access to discounts from contracted pharmacies. As of December 31, 2013, we had enrolled approximately 15,506 members in the Drug Discount Card program. We plan to continue extending the program to members in group plans without drug coverage during 2014.

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

Life Insurance

We offer a wide variety of life, accident, disability and health and annuity products in Puerto Rico through our subsidiary TSV. Life insurance premiums represented approximately 6% of our consolidated premiums earned, net for each of the years ended December 31, 2013, 2012 and 2011. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases ("Cancer" line of business), and pre-need life products are marketed through independent agents. TSV is the leading distributor of life products in Puerto Rico. We are the only home service company in Puerto Rico and offer guaranteed issue, funeral and cancer policies to the lower and middle income market segments directly to people in their homes. We also market our group life and disability coverage through our independent producers.

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Property and Casualty Insurance

We offer a wide range of property and casualty insurance products through our subsidiary Triple-S Propiedad, Inc. (“TSP”). Property and casualty insurance premiums represented approximately 4% of our consolidated premiums earned, net for each of the years ended December 31, 2013, 2012 and 2011. Our predominant lines of business are commercial multi-peril, commercial property mono-line, auto physical damage, auto liability and dwelling policies. This segment’s commercial lines target small to medium size accounts.

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

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Our policy is to enter into reinsurance agreements with reinsurers considered to be financially sound. Practically all our reinsurers have an A.M. Best rating of ‘‘A-’’ or better, or an equivalent rating from other rating agencies. During the year ended December 31, 2013, 37.9% of the premiums written in the property and casualty insurance segment were ceded to reinsurers. Although these reinsurance arrangements do not relieve us of our direct obligations to our insured, we believe that the risk of our reinsurers not paying balances due to us is low.

Marketing and Distribution

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

Branding and Marketing

Our branding and marketing efforts include “brand advertising”, which focuses on the Triple-S name and the BCBS mark, “acquisition marketing”, which focuses on attracting new customers, and “institutional advertising”, which focuses on our overall corporate image. We believe that the strongest element of our brand identity is the “Triple-S” name. We seek to leverage what we believe to be the high name recognition and comfort level that many existing and potential customers associate with this brand. Acquisition marketing consists of business-to-business marketing efforts which are used to generate leads for brokers and our sales force as well as direct-to-consumer marketing efforts which are used to add new customers to our direct pay businesses. Institutional advertising is used to promote key corporate interests and overall company image. We believe these efforts support and further our competitive brand advantage. We will continue to utilize the Triple-S name and the BCBS mark for all managed care products and services in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla, except for Medicare Advantage products and services offered through our other Managed Care subsidiary AH. AH, which began selling BCBS branded products effective January 1, 2013, will continue using its own name.

Sales and Marketing

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

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Distribution

Managed Care Segment. We rely principally on our internal sales force and a network of independent brokers and agents to market our products. Individual policies are sold entirely through independent agents who exclusively sell our individual products, and Medicare Advantage and group products are sold through our 291 person internal sales force as well as our approximately 250 independent brokers and agents. We believe that each of these marketing methods is optimally suited to address the specific needs of the customer base to which it is assigned.

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

Life Insurance Segment. In our life insurance segment, we offer our insurance products through our own network of both company-employed and independent agents. The majority of our premiums (58% in 2013 and 57% in 2012) were placed through our home service distribution channel selling directly to customers in their homes. TSV employs approximately 660 full-time active agents and managers and utilizes approximately 1,073 independent agents and brokers. For individual policies, we advance first year commissions upon issuance and for group policies, we pay commissions on a monthly basis based on premiums received.

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is exclusively subscribed through approximately 14 general agencies, including our insurance agency, Triple-S Insurance Agency, Inc. ("TSIA"), where business is placed by independent insurance agents and brokers. During the years ended December 31, 2013, 2012 and 2011 TSIA placed approximately 66%, 58% and 52% of TSP's total premium volume, respectively. The general agencies contracted by TSP remit premiums net of their respective commission.

Customers

Managed Care

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

Market Sector	Enrollment at December 31, 2013	Percentage of Total Enrollment	
Commercial	654,729	29.9	%
Medicare	112,839	5.2	%
Medicaid	1,420,371	64.9	%
Total	2,187,939	100.0	%

Commercial Sector

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

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

Federal Government Employees. For over 40 years, we have maintained our leadership in providing managed care services to federal government employees in Puerto Rico. We provide our services to these employees under the Federal Employees Health Benefits Program pursuant to a direct contract with the OPM and through the Federal Employee Program of the BCBSA. We are one of two companies in Puerto Rico that has such a contract with OPM. Every year, OPM allows other insurance companies to compete for this business, provided such companies comply with the applicable requirements for service providers. This contract is subject to termination in the event of noncompliance not corrected to the satisfaction of OPM.

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Individual Accounts. We provide managed care services to individuals and their dependent family members who contract these services directly with us though our network of independent brokers. We provide individual and family contracts.

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

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

Medicare Advantage Sector

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

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

Medicare also provides a prescription drug program ("Medicare Part D"). Medicare beneficiaries are given the opportunity to select a Medicare Part D prescription drug plan provided by MCOs or other Part D sponsors. Our Medicare Advantage policies offer Medicare Part D coverage to our members throughout our service area. TSS also offers a stand-alone Medicare Part D prescription drug benefits product.

Medicaid

In 1994, the government of Puerto Rico privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into eight geographical areas. Each of the eight geographical areas is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. As of December 31, 2013, this program provided healthcare coverage to over 1.4 million people. Mental health and drug abuse benefits are currently offered to Medicaid beneficiaries by behavioral healthcare companies and are therefore not part of the benefits covered by us.

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

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We currently serve all eight geographical regions on an ASO basis pursuant to an agreement that will expire on June 30, 2014. On February 5, 2014 the government of Puerto Rico issued a request for proposal (“RFP”) for the Medicaid business and announced its intention to convert the current program to a managed care organization model, under which the selected contractors will be at risk for the provision of the physical and behavioral health components of the program. We are currently evaluating the requirements of this RFP and have not concluded whether or not we will participate in the competitive bid process to retain the Medicaid business. See “Item 1. Business¾Customers – Medicaid Sector”. Our agreement with the government of Puerto Rico is subject to termination in the event of our non-compliance that is not corrected or cured to the satisfaction of the government entity overseeing Medicaid, or in the event that the government determines that there is an insufficiency of funds to finance the program.

Life Insurance

Our life insurance customers consist primarily of individuals, who hold approximately 525,000 policies. We also insure approximately 1,700 groups.

Property and Casualty Insurance

Our property and casualty insurance segment targets small to medium size accounts with low to average exposures to catastrophic losses. Our dwelling insurance line of business aims for rate stability and seeks accounts with a very low exposure to catastrophic losses. Our auto physical damage and auto liability customer bases consist primarily of commercial accounts.

Underwriting and Pricing

Managed Care

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

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

We have been able to maintain relatively high retention rates, which is the percentage of existing business retained in the renewal process, in the corporate accounts sector of our managed care business. For 2013 our corporate accounts retention factor was 95%.

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

Life Insurance

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

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Property and Casualty Insurance

The property and casualty insurance sector is experiencing a soft market in Puerto Rico, principally as a result of economic conditions and reinsurance capacity. Notwithstanding these conditions, our property and casualty segment has maintained its leadership position in the property insurance sector by following prudent underwriting and pricing practices.

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

Quality Initiatives and Medical Management

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

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

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

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Information Systems

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

In addition, we selected Quality Care Solutions, Inc. ("QCSI") to implement a new core business application for our managed care segment. QCSI was subsequently acquired by The Trizetto Company. In the second quarter of 2010, our Managed Care segment began transitioning to the new electronic data processing system. This transition continued into the third quarter of 2012, when we completed the full migration of TSS's commercial membership. Total external costs for the entire project amounted to approximately $56.0 million.

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

Federal regulations require that we begin using a new set of standardized diagnostic codes, known as ICD-10, by October 2014, which will require a significant information technology investment. In order to become ICD-10 compliant, in September 2013 TSS upgraded the versions of its core business applications that were previously implemented in the third quarter of 2012. The cost of the core business application upgrade and ICD-10 compliance efforts was approximately $6.5 million. Additional software and efforts have and are being invested in defining the mapping of current ICD-9 codes to ICD-10 in order to load that mapping in the recently-upgraded systems. The company believes that these additional efforts to comply with ICD-10 requirements will represent an additional investment of approximately $1.0 million.

Since our goal is to manage all Medicare enrollments in one core business application, we completed effective January 1, 2014, the migration of TSS's Medicare products to the core business application currently in use in AH. We continue to manage the Medicaid enrollment in TSS's legacy core system and we expect to complete its migration to TSS's new core business application in several phases during the course of 2014.

Provider Arrangements

Approximately 98% of member services are provided through one of our contracted provider networks and the remainder is provided by out-of-network providers. Our relationships with managed care providers, physicians, hospitals, other facilities and ancillary managed care providers are guided by standards established by applicable regulatory authorities for network development, reimbursement and contract methodologies. As of December 31, 2013, we had provider contracts with approximately 4,711 primary care physicians, 3,382 specialists and 68 hospitals.

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

We promote the use of electronic claims billing by our providers. Approximately 91% of claims are submitted electronically through our fully automated claims processing system, and our "first-pass rate", or rate at which a claim is approved for payment when first processed by our system without human intervention, for provider claims has averaged 85% and 78% in 2013 and 2012, respectively.

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

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

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

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

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

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

Competition

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

Managed Care

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

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

Competitors in the managed care segment include national and local managed care plans. At December 31, 2013 we had approximately 2,188,000 members enrolled in our managed care segment. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 26% for the nine-month period ended September 30,

2013. We offer a variety of managed care products, and are the leader by market share in almost every sector, as measured by the share of premiums written. Our main competitors are Medical Card Systems Inc., InnovaCare, Inc. (or MMM Healthcare & Preferred Medicare Choice), Humana, Inc. and First Medical Health Plan, Inc.

Life Insurance

We are one of the leading providers of life insurance products in Puerto Rico. In 2012, we were the second largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 13.9%. We are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines. In the life insurance sector, excluding annuities, we were the largest company with a market share of approximately 19.2%, and our main competitors are Cooperativa de Seguros de Vida de Puerto Rico, AXA Equitable Life and Mass Mutual Financial Group. In the cancer sector, we were the largest company with a market share of approximately 18.4%, and our main competitors are AFLAC and Trans Oceanic Life Insurance Company.

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Property & Casualty Insurance

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

In the nine-month period ended September 30, 2013, we were the fifth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 8.5%. Our nearest competitor in the property and casualty insurance market in Puerto Rico was American International Insurance Company of Puerto Rico. The market leaders in the property and casualty insurance market in Puerto Rico were Universal Insurance, MAPFRE Corporation Group, and Cooperativa de Seguros Múltiples de Puerto Rico.

Blue Cross and Blue Shield License

TSM has license agreements with BCBSA that permit TSM the exclusive use of the BCBS name and marks for the sale, marketing and administration of managed care plans and related services in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. Also, TSS has a license with BCBSA to use the BCBS name and marks in Puerto Rico and the U.S. Virgin Islands. As of January 1, 2013, AH has a license with BCBSA to use the name and marks of the BCBS on its Medicare Advantage products. We believe that the BCBS name and marks are valuable brands of our products and services in the marketplace. The license agreements, which have a perpetual term (but which are subject to termination under circumstances described below), contain certain requirements and restrictions regarding our operations and our use of the BCBS name and marks.

Upon the occurrence of any event causing the termination of our license agreements, we would cease to have the right to use the BCBS name and marks in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. We also would no longer have access to the networks of providers of the different plans that are members of the Association nor the BlueCard Program. We would expect to lose a significant portion of our membership if we lose these licenses. Loss of these licenses could significantly harm our ability to compete in our markets and could require payment of a significant fee to the BCBSA. Furthermore, if our licenses were terminated, the BCBSA would be free to issue a new license to use the BCBS name and marks in Puerto Rico, U.S. Virgin Islands, Costa Rica and British Virgin Islands and Anguilla to another entity, which could have a material adverse effect on our business, financial condition and results of operations. See “Item 1A Risk Factors¾Risks Related to Our Business – The termination or modification of our license agreements to use the BCBS name and marks could have a material adverse effect on our business, financial condition and results of operations.”

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

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

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

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

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

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

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

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

Pursuant to the rules and license standards of the BCBSA, TSM guarantees TSS contractual and financial obligations to their respective customers. Also, TSS guarantees AH’s contractual and financial obligations to their respective customers. In addition, pursuant to the rules and license standards of the BCBSA, we have agreed to indemnify the BCBSA against any claims asserted against it resulting from our contractual and financial obligations.

Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the BCBS name and marks. The annual BCBSA fee for the year 2014 is $2,200,495. During the years ended December 31, 2013 and 2012, we paid fees to the BCBSA in the amount of $2,126,165 and $1,224,344, respectively. The BCBSA is a national trade association of 37 independent Primary Licensees (Plans), including TSM, the primary function of which is to promote and preserve the integrity of the BCBS name and marks, as well as to provide certain coordination among the Member Plans. Each Member Plan is an independent legal organization and is not responsible for obligations of other BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the BCBS name and marks outside our BCBS licensed territory.

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

Claim Liabilities

We are required to estimate the ultimate amount of claims which have not been reported, or which have been received but not yet adjudicated, during any accounting period. These estimates, referred to as claim liabilities, are recorded as liabilities on our balance sheet. We estimate claim reserves in accordance with Actuarial Standards of Practice promulgated by the Actuarial Standards Board, the committee of the American Academy of Actuaries that establishes the professional guidelines and standards for actuaries to follow. A significant degree of judgment is involved in estimating reserves. We make assumptions regarding the propriety of using existing claims data as the basis for projecting future payments. For additional information regarding the calculation of claim liabilities, see "Item 7   Management's Discussion and Analysis of Financial Condition and Results of Operations – Critical Accounting Estimates¾Claim Liabilities."

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Investments

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

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

The investment portfolio is internally managed by an internal investment group, which is comprised of a vice president and treasurer, an investment analyst, and a treasury operations analyst. The internal investment group uses an external investment consultant and external investment managers through the use of mutual funds.

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

Trademarks

We consider our trademarks of ''Triple-S'' and ''SSS'' to be very important and material to all segments in which we are engaged. In addition to these, other trademarks used by our subsidiaries, including American Health Medicare which we acquired in 2011, that are considered important have been duly registered with the Department of State of Puerto Rico and the United States Patent and Trademark Office. It is our policy to register all our important and material trademarks in order to protect our rights under applicable corporate and intellectual property laws. In addition, we have the exclusive right to use the BCBS name and marks in Puerto Rico and the U.S. Virgin Islands. See ''—Blue Cross and Blue Shield License''.

Regulation

Our business operations are subject to comprehensive and detailed regulation in Puerto Rico, as well as U.S. federal regulation. Supervisory agencies include the Commissioner of Insurance, the Division of Banking and Insurance of the Office of the Lieutenant Governor of the U.S. Virgin Islands, the Health Department of the Commonwealth of Puerto Rico and the Administration for Health Insurance of the government of Puerto Rico ("ASES", for its Spanish acronym), which administers Medicaid, including the Medicare dual-eligible beneficiaries program. Federal regulatory agencies that oversee our operations include HHS—directly and through its Office of the Inspector General ("OIG"), its Office of Civil Rights ("OCR") and CMS, the U.S. Department of Justice ("DOJ"), the U.S. Department of Labor ("DOL"), and OPM. These government agencies have the right to:

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

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

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

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

- payments to health plans that are tied to achievement of certain quality performance measures;

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

- local government regulatory changes;

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

- the implementation of regulations in July 2011 by the Office of the Commissioner to review and approve rates in the individual and small business markets; and

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

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

- licensure;
- policy forms, including plan design and disclosures;
- premium rates and rating methodologies;
- underwriting rules and procedures;
- benefit mandates;
- eligibility requirements;
- security of electronically transmitted individually identifiable health information;
- geographic service areas;
- market conduct;
- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- special rules in contracts to administer government programs;
- transactions with affiliated entities;
- limitations on the ability to pay dividends;
- rates of payment to providers of care;
- rate review and approval;
- transactions resulting in a change of control;
- member rights and responsibilities;
- fraud and abuse;
- sales and marketing activities;
- quality assurance procedures;
- privacy of medical and other information and permitted disclosures;
- surcharges on payments to providers;
- provider contract forms;
- delegation of financial risk and other financial arrangements in rates paid to providers of care;
- agent licensing;
- financial condition (including reserves);
- reinsurance;
- issuance of new shares of capital stock;
- corporate governance;
- permissible investments; and
- guaranteed issue and renewability.

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

Puerto Rico Insurance Laws

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

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

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

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

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

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

Privacy of Financial and Health Information

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

Managed Care Provider Services

Participating managed care providers of the dual-eligible sector of the population, administered by ASES, are required to provide specific services to their subscribers. Such services include access to a provider network that guarantees emergency and specialty services. In addition, the Office of the Solicitor for the Beneficiaries of Medicaid is authorized to review and supervise the operations of entities contracted by the government of Puerto Rico to provide services to the dual-eligible sector of the population. The Solicitor may investigate and adjudicate claims filed by Medicaid beneficiaries against the various service providers contracted by the government of Puerto Rico. See "Business – Customers-Medicare Supplement and Medicare Advantage Sector" sections included in this Item for more information.

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Capital and Reserve Requirements

Since 2009, local insurers and health organizations are required by the Insurance Code to submit to the Puerto Rico Commissioner of Insurance Risk Based Capital ("RBC") reports following the NAIC RBC Model Act, and accordingly are subject to certain regulatory actions if their capital levels do not meet minimum specific risk based capital requirements. In February 2010, Insurance Regulation No. 92 ("Rule 92") issued by the Commissioner of Insurance, which establishes the guidelines to implement RBC requirements, went into effect. Rule 92 provides for gradual compliance over a period of five years.

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

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company's risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the company's total adjusted capital (defined as the total of its statutory capital, surplus, asset valuation reserve and dividend liability) to its risk-based capital. The ''company action level'' is triggered if a company's total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital. At the company action level, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. When a company's adjusted capital is between 200% and 300% and it has a combined ratio greater than 105%, a "company action level" is triggered and once the Puerto Rico Commissioner of Insurance implements the health trend test, it will also be triggered. As of December 31, 2013, the Commissioner of Insurance has not enacted the health trend test in its regulations. The ''regulatory action level'' is triggered if a company's total adjusted capital is less than 150% but greater than or equal to 100% of its risk-based capital. At the regulatory action level, the regulatory authority will perform a special examination of the company and issue an order specifying corrective actions that must be followed. The ''authorized control level'' is triggered if a company's total adjusted capital is less than 100% but greater than or equal to 70% of its risk-based capital, at which level the regulatory authority may take any action it deems necessary, including placing the company under regulatory control. The ''mandatory control level'' is triggered if a company's total adjusted capital is less than 70% of its risk-based capital, at which level the regulatory authority must place the company under its control.

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

In addition to its catastrophic reinsurance coverage, TSP is required by local regulatory authorities to establish and maintain a reserve supported by a trust fund (the "Trust") to protect policyholders against their dual exposure to hurricanes and earthquakes. The funds in the Trust are solely to be used to pay catastrophic losses whenever qualifying catastrophic losses exceed 5% of catastrophe premiums or when authorized by the Commissioner of Insurance. Contributions to the Trust, and accordingly additions to the reserve, are determined by a rate, imposed by the Commissioner of Insurance on the catastrophe premiums written in that year. As of December 31, 2013 and 2012, we had $40.1 million and $39.0 million, respectively, invested in securities deposited in the Trust. The income generated by investment securities deposited in the Trust becomes part of the Trust fund balance and are therefore considered an addition to the reserve. For additional details see note 18 of the audited consolidated financial statements.

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Dividend Restrictions

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

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

Guaranty Fund Assessments

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

Federal Regulation

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

Medicare Generally

Medicare is the federal health insurance program created in 1965 for all people aged 65 and older (regardless of income or medical history), qualifying disabled persons, and persons suffering from end-stage renal disease. Medicare is funded by the federal government and administered by CMS, with the day-to-day operations of the program (e.g., provider enrollment, claims payment) handled by private contractors under contract with CMS. There are approximately 52 million Medicare beneficiaries.

Medicare is divided into 4 distinct parts:

- Part A covers, among other things, inpatient hospital stays, skilled nursing facility stays, home health visits (also covered under Part B), and hospice care. While there is no monthly premium for Medicare Part A, beneficiaries may be subject to significant deductibles and co-payments ($1,184 and $1,216 deductible for a hospital stay of up to 60 days in 2013 and 2014, respectively).

- Part B covers physician visits, outpatient services, laboratory services, durable medical equipment, certain preventive services, and home health visits. Enrollment in Part B is voluntary and subject to an annual deductible ($147 in 2013 and 2014). Beneficiaries who enroll in Medicare Part B pay a monthly premium ($104.90 for 2014 and 2013) commonly deducted automatically from beneficiaries' monthly Social Security checks. Medicare Part B generally pays 80% of the cost of services and beneficiaries pay the remaining 20% after the beneficiary has satisfied the annual $147 deductible. Beneficiaries who report 2013 income above $85,000 a year ($170,000 filing jointly) are legally responsible for covering a larger portion of the cost of their coverage. These premium adjustments range from $42.00

to $230.80 a month for Medicare Part B.

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

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

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

Initially, Medicare was offered only on a fee-for-service basis. Under the Medicare fee-for-service payment system, a Medicare beneficiary can choose any licensed healthcare provider and use the services of any hospital, healthcare provider, or facility that has signed a participation agreement and meets applicable certification requirements with Medicare. CMS reimburses facilities and providers if the service is medically reasonable and necessary and meets other applicable national Medicare and/or local contractor coverage criteria. Generally, Medicare does not cover eyeglasses (exception for after cataract surgery), hearing aids, dentures and most dental services.

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

On April 12, 2012, CMS issued a final rule (the “2012 Final Rule”), effective June 1, 2012, to implement certain changes to the Medicare Advantage and Part D programs mandated by ACA, including strengthening CMS’ ability to remove poor performers from the Medicare Advantage and Part D programs beginning in 2015. Under the 2012 Final Rule, beginning with Medicare contract year 2015, CMS will have the authority to terminate its contract with any Medicare Advantage or Part D plan for substantial contract non-compliance, or refuse to renew such plan, if the plan fails to achieve an overall Star Rating of three stars (out of five) for any consecutive three (3) year period. Although CMS has issued annual Star Ratings for Part D plans since 2007 and for Medicare Advantage plans since 2008, CMS will use Star Ratings issued for Medicare contract years 2013 and beyond in implementing the 2012 Final Rule. Thus, contract year 2015 will be the first year in which CMS will have the authority under the 2012 Final Rule to terminate a Medicare Advantage or Part D plan from participation in the federal program based on a plan’s ratings for contract years 2013, 2014 and 2015. CMS issues Star Ratings on a prospective basis, typically in the fall preceding the contract year. The 2012 Final Rule provides CMS the authority to use the lower Star Ratings as a means to invoke its existing authority under Section 1857(c)(2) of the Social Security Act to terminate a contract when CMS determines that the Medicare Advantage or Part D plan has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage or Part D program.

Payments to Medicare Advantage Participating Plans

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

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

Beginning in 2006, Medicare has used a bidding system by which plans submit bids based on costs per enrollee for Part A and Part B covered services. Bids are based on estimated costs per enrollee for the Medicare-covered services.

The bids are then analyzed against a benchmark established by federal statute, and which vary by county/region. Essentially, the benchmarks are the maximum amount Medicare will pay a plan in a given county/area. When a bid is higher than the benchmark, enrollees pay the difference (through an additional premium) between the benchmark and the bid, in addition to any other Medicare premiums. If the bid is lower than the benchmark, the plan and Medicare share the difference, and the plan must use its share (known as a “rebate”) to provide additional benefits to enrollees.

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ACA (as defined below) changed the payment methodology for plans and reduced the benchmarks. For 2011, benchmarks were frozen at 2010 levels. Starting in 2012, decreases in benchmarks are to be phased-in over 2 to 6 years. The benchmarks range from 95% to 115% of Medicare fee-for-service costs. Per ACA and the results of a CMS demonstration project, bonus payments will be made to plans with higher quality ratings. Rebates will be reduced for all plans, but plans with higher quality ratings will keep a larger proportion of the rebate.

Budget Control Act

On August 2, 2011, the Budget Control Act of 2011 was enacted to reduce the deficit and avoid default on the national debt. When a joint committee of Congress established to develop debt reduction legislation failed to cut at least $1.5 trillion over the coming 10 years, an automatic process of across-the-board cuts (“sequestration”) split equally between defense and non-defense programs was triggered. Under the sequestration, automatic spending cuts became effective beginning March 1, 2013. This resulted in cuts of 2% ($11.1 billion) to Medicare. Medicaid programs are not subject to automatic spending cuts.

Medicaid Generally

Medicaid is a public insurance program intended for low-income individuals and families. Medicaid provides coverage to almost 60 million Americans, including children, pregnant women, and individuals with disabilities. To participate in Medicaid, states must cover certain groups but have the flexibility to cover other population groups. States may apply to CMS for waivers to provide coverage to populations beyond what is normally covered under the program. States are able to establish eligibility criteria within federal minimum standards. States are allowed to set Medicaid provider payment rates, and may reimburse providers through fee-for-service or managed care. They also have the flexibility to determine the type, amount, duration, and scope of services of their respective Medicaid programs, so long as within federal guidelines, although states are required to cover certain mandatory benefits. In Puerto Rico, the Medicaid program, currently referred to as the Medicaid program and formerly known as Reform, is administered locally by ASES.

Medicaid is jointly funded by the federal government and the states with the federal government paying states for a specified percentage of program expenditures known as the Federal Medical Assistance Percentage (“FMAP”). The FMAP varies by state based on factors such as per capita income. The average state FMAP is about 57%, while the FMAP for Puerto Rico is 55%. FMAPs are adjusted based on a 3 year cycle. Generally, during economic recessions such as the one that began in 2008, state revenues fall while Medicaid enrollment and spending rise. To help alleviate the shortfall, the federal government temporarily increased its share of Medicaid costs through the American Recovery and Reinvestment Act of 2009. However, that temporary fix ended starting in 2012, and while many states have enacted cost containment initiatives to help control costs, states continue to wrestle with falling revenue while Medicaid enrollment and spending increase.

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

Dual-Eligible Beneficiaries

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

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Additionally, ACA created the Federal Coordinated Health Care Office to better integrate Medicare and Medicaid benefits and improve coordination between federal and state governments. In July 2011, CMS announced three initiatives related to improving quality and lowering the cost of care for dual-eligibles: (i) a demonstration program to test two new financial models designed to help states improve quality and share in lower costs resulting from better coordinated care for dual eligible beneficiaries; (ii) a demonstration program to help states improve the quality of care for people in nursing homes by focusing on reducing preventable inpatient hospitalizations; and (iii) a technical resource center available to all states to help them improve care for high-need, high-cost beneficiaries. The two new financial models provide for: (i) a state, CMS, and health plan that enter into a three-way contract where the managed care plan receives a prospective blended payment to provide comprehensive, coordinated care; and (ii) a state and CMS that enter into an agreement where the state would be eligible to benefit from savings resulting from managed fee-for-service initiatives designed to improve quality and reduce costs for both Medicare and Medicaid)

Under ACA, 15 states (not including Puerto Rico) have been awarded contracts to support the design of demonstration projects that aim to improve the coordination of care for people with Medicare and Medicaid coverage. Each of the selected states will receive up to $1.0 million to develop patient-centered demonstration projects that focus on coordinating primary, acute, behavioral, and long-term care services for dual-eligibles.

Special Needs Plans

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

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

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

Fraud and Abuse Laws. Insurance providers in Puerto Rico are subject to local and federal laws that prohibit fraud and abuse, and are required to have anti-fraud units in place. In addition, entities, such as TSS and AH, that receive federal funds from government health care programs, such as Medicare and Medicaid, are subject to a wide variety of federal fraud and abuse laws and enforcement activities. Such laws include the federal anti-kickback laws and the False Claims Act.

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

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Federal False Claims Act. Federal regulations also strictly prohibit the presentation of false claims or the submission of false information to the federal government. Under the federal False Claims Act, any person or entity that has knowingly presented or caused to be presented a false or fraudulent request for payment from the federal government or who has made a false statement or used a false record in the submission of a claim may be subject to treble damages and penalties of up to $11,000 per claim. The federal government has taken the position that claims presented in relationships that violate the federal anti-kickback statute may also be considered to be violations of the federal False Claims Act. Furthermore, the federal False Claims Act permits private citizen “whistleblowers” to bring actions on behalf of the federal government for violations of the Act and to share in the settlement or judgment that may result from the lawsuit. In fiscal year ended September 30, 2013, recoveries from civil health care matters brought under the False Claims Act were approximately $3.8 billion nationally.

HIPAA, HITECH, and Gramm-Leach-Bliley Act

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

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

Puerto Rican and federal regulators are conducting investigations in connection with two events related to our handling of protected health information. See “Item 3. Legal Proceedings” for more information.

The American Recovery and Reinvestment Act of 2009 (H.R. 1, S. 1) (“the Stimulus”), enacted on February 17, 2009, contains several provisions that expand the scope and enforcement of HIPAA. Many of those Stimulus provisions that affect and expand HIPAA became effective on February 17, 2010. Additionally, on January 17, 2013, the Secretary of HHS promulgated a final rule (the “Omnibus Rule”), clarifying certain aspects of the Stimulus pertaining to HIPAA and bolstering both the Privacy Rule and the Security Rule. We have updated our internal policies and operations to comply with the Stimulus pertaining to HIPAA, and we will modify our policies and operations as necessary to comply with the Omnibus Rule in advance of the compliance deadlines contained therein. In the fall of 2010, CMS notified all Medicare Advantage plans, including our Managed Care subsidiaries that it intends to devote greater attention to HIPAA enforcement under its legal mandate to protect Medicare beneficiaries and ensure that CMS contractors comply with the law. See “Item 1. Business — Regulation – Legislative and Regulatory Initiatives” for additional information.

HHS has released rules mandating the use of standard formats in electronic health care transactions (for example, health care claims submission and payment, plan eligibility, precertification, claims status, plan enrollment and disenrollment, payment and remittance advice, plan premium payments and coordination of benefits). HHS also has published rules mandating the use of standardized code sets and unique identifiers for employers and providers. Our managed care subsidiary believes that it is in material compliance with these requirements. In addition, the federal government will require that healthcare organizations, including health insurers, upgrade to updated and expanded standardized code sets used for describing health conditions by converting from the ICD-9 diagnosis and procedure code set to the ICD-10 diagnosis and procedure code set. Our Managed Care subsidiaries have initiated projects to comply with the ICD-10 capabilities by the original October 1, 2012 compliance deadline, which has required a substantial investment. On April 9, 2012, HHS announced the postponement of the original October 2012 compliance deadline to October 2014.

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

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Employee Retirement Income Security Act of 1974

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

Dodd-Frank Act

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

Legislative and Regulatory Initiatives

Puerto Rico Initiatives

In December 2010, the Commissioner of Insurance adopted Rule No. 83, titled ''Rules and Procedures to Regulate the Systems of the Holding Companies of Insurers and Organizations of Health Services and Criteria for Evaluating Change of Control''. Rule No. 83 requires insurance companies and health services organizations domiciled in the Commonwealth of Puerto Rico and that are within an insurance holding company system to register with the Commissioner of Insurance and to file with the Commissioner of Insurance certain reports describing capital structure, ownership, financial condition, certain intercompany transactions, and general business operations. In addition, Rule No. 83 requires prior notice, reporting and regulatory approval of mergers and acquisitions of an insurer or health services organization, distributions of extraordinary dividends and other distributions to stockholders.

Federal Initiatives

On March 23, 2010, the federal health reform legislation, known as the Patient Protection and Affordable Care Act was enacted. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, on March 30, 2010 (collectively, Pub. L. No. 111-148, and referred to herein as "ACA"), includes certain mandates that took effect in since 2010, as well as other requirements that are to be implemented over the next several years. Most of the provisions of ACA with more significant effects on the health insurance marketplace have an effective date of January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, and the assessment of new taxes and fees (including annual fees on health insurance companies). Many aspects of ACA will be further articulated and clarified through regulation and guidance. ACA affects all aspects of the health care delivery and reimbursement system in the United States, including health insurers, managed care organizations, healthcare providers, employers, and U.S. states and territories.

The implementation of ACA could have a material adverse effect on the profitability or marketability of our business, financial condition and results of operations. Various federal agencies, including, but not limited to, HHS, DOL, and the U.S. Department of the Treasury are issuing regulations in several phases implementing specific ACA provisions. CMS issued a Final Rule that implements certain ACA provisions that effect provider and supplier participation and enrollment in federal and state health payor programs. As a result of the complexity of ACA, its impacts on health care in the United States and the continuing modification and interpretation of Health Care Reform's rules, we may be adversely affected on our business, cash flows, financial condition and results of operations. Additionally, federal agencies have issued Requests for Information and Interim Final Regulations implementing certain other ACA provisions that could affect our business. Final regulations and guidance are anticipated in the near future and we will continue to assess ACA's impact on us as final regulations and guidance are issued.

Some of the more significant ACA issues that may affect our managed care business include:

- Provisions requiring greater access to coverage for certain uninsured and under-insured populations and the elimination of certain underwriting practices without adequate funding to health plans or with negative financial levies on health plans such as restrictions in the ability to charge additional premium for additional risk. These include, among others, (i) extending dependent coverage for unmarried individuals until age 26 under their parents' health coverage, (ii) limiting a health plan's ability to rescind coverage and restricting the plan's ability to establish annual and lifetime financial caps, (iii) eliminating the use of gender as a ratings factor and (iv) limiting a health plan's ability to deny or limit coverage on grounds of a person's pre-existing medical condition (guarantee issue); in the case of the territories, including Puerto Rico, the adverse selection effect associated with the guarantee issue, might be exacerbated by the non- applicability of the individual and employer mandates.
- Provisions restricting medical loss ratios and requiring premium refunds for non-compliance;
- Provisions requiring health plans to report to their members and HHS certain quality performance measures and their wellness promotion activities;
- Provisions that reduce premium payments to Medicare Advantage health plans and that tie such premium to the local Medicare fee for service costs. The adjustment began in 2012 and is being phased in over 5 to 7 years;
- Provisions that tie Medicare Advantage premiums to achievement of certain quality performance measures;
- Other efforts or specific legislative changes to the Medicare and Medicaid programs, including changes in the bidding process, authority of CMS to deny bids, or other means of materially reducing premiums such as through further adjustments to the risk adjustment methodology;
- Increased federal funding to the Medicaid program, available for years 2014 – 2019;
- Funding provided to the government of Puerto Rico to either establish a health insurance exchange or fund the Medicaid program, at the option of the government of Puerto Rico; the Government of Puerto Rico elected to fund the Medicaid program;
- Increased government funding to enforcement agencies and/or changes in interpretation or application of fraud and abuse laws;
- Expanded scope of authority and/or funding to audit Medicare Advantage health plans and recoup premiums or other funds by the government or its representatives; and
- The increase in persons eligible for coverage under the Medicaid program in Puerto Rico, which may result in some persons currently insured by us in our Commercial programs becoming eligible for, and thus moving to, the program.

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

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The ACA mandates significant changes to the rules regarding private health insurance to facilitate competition for market efficiency, promote prevention and wellness, increase pooling of risk, and prohibit discrimination for pre-existing conditions and/or health statues. On November 26, 2012, HHS released three proposed rules specifically related to health insurance market reforms, essential benefits, and standards for wellness programs by employers who sponsor group health plans. The market reform proposed rules concerns the sale, pricing, and renewability of health insurance. These rules apply to the individual and small group health insurance markets (whether or not in the health insurance exchanges). The rule does not generally apply to grandfathered health plans. The essential benefits proposed rule establishes the standards for covered benefits under private health insurance coverage. Under the rule, states have the ability to select a benchmark plan from ten popular private health plans. Popularity is based on enrollment figures for the plans. Should a state not select a plan, the default becomes the largest small group health plan. A covered benefit under the benchmark plan will be considered an essential health benefit. Under the ACA, health plans that are not grandfathered in the individual and small group market are required to cover essential health benefits. While essential benefits are not specifically defined, the ACA outlines 10 categories of benefits that are required to be covered by plans, including: a) emergency services; b) ambulatory patient services; c) hospitalization; and d) preventive and wellness services and chronic disease management. The wellness proposed rule amends an earlier regulation regarding the design and implementation of wellness programs offered by employers in group health plans. Among other things, it increases the maximum reward allowable under reasonably designed programs from 20 to 30 percent, and would further increase the maximum reward to 50 percent for wellness programs designed to prevent or reduce tobacco use. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs of mandated benefits or other increased costs caused by potential legislation, regulation or court rulings. See part I, Item 1A "Risk Factors - The health care reform law and implementation of the law could have a material effect on our business, financial condition, cash flows, or results of operations" for more information.

Financial Information About Segments

Operating revenues (with intersegment premiums/service revenues shown separately), operating income and total assets attributable to the reportable segments are set forth in note 28 to the audited consolidated financial statements for the years ended December 31, 2013, 2012 and 2011.

Employees

As of December 31, 2013, we had approximately 3,555 full-time employees and 484 temporary employees. TSS has a collective bargaining agreement with the Unión General de Trabajadores, which represents approximately 43% of our managed care subsidiary's approximately 1,380 regular employees. The collective bargaining agreement expires on July 31, 2016. The Corporation considers its relations with employees to be good.

Available Information

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

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Special Note Regarding Forward-Looking Statements

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

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

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

- trends in health care costs and utilization rates;
- ability to secure sufficient premium rate increases;
- competitor pricing below market trends of increasing costs;
- re-estimates of our policy and contract liabilities;
- changes in government regulation of managed care, life insurance or property and casualty insurance;
- significant acquisitions or divestitures by major competitors;
- introduction and use of new prescription drugs and technologies;
- a downgrade in our financial strength ratings;
- litigation or legislation targeted at managed care, life insurance or property and casualty insurance companies;
- ability to contract with providers and government agencies consistent with past practice;
- ability to successfully implement our disease management and utilization management programs;
- volatility in the securities markets and investment losses and defaults; and
- general economic downturns, major disasters and epidemics.

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

Item 1A. Risk Factors

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

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Risks Relating to our Capital Stock

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

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

Notwithstanding the fact that TSS and its predecessor, SSS, were never in a position to issue new shares to providers as contemplated by the share acquisition agreements because shareholder approval for such issuance was never obtained, and the fact that SSS on several occasions in the 1990s offered providers the opportunity to purchase shares of its treasury stock and such offers were accepted by very few providers, providers who entered into share acquisition agreements may claim that the share acquisition agreements entitled them to acquire our or TSS's shares at a subscription price equivalent to that provided for in the share acquisition agreements. SSS entered into share acquisition agreements with approximately 3,000 providers, the substantial majority of whom never came to own shares of SSS. Such share acquisition agreements provide for the purchase and sale of approximately 15,000 shares of SSS. If we or TSS were required to issue a significant number of shares in respect of these agreements, the interest of our existing shareholders would be substantially diluted. As of the date of this Annual Report on Form 10-K, only one judicial claim to enforce any of these agreements has been brought against the Company. The case was settled by the parties and, on August 2013, dismissed by the court with prejudice. Additionally, we have received inquiries with respect to fewer than 700 shares under share acquisition agreements. The share numbers set forth in this paragraph reflect the number of SSS shares provided for in the share acquisition agreements. Those agreements do not include anti-dilution protections and we do not believe that the amounts of any claims under the agreements with SSS should be multiplied to reflect the 3,000-for-one stock split effected by us on May 1, 2007. We cannot provide assurances, however, that claimants will not successfully seek to increase the size of their claims by reference to the stock split.

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

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

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

For much of our history, we and our predecessor entity have restricted the ownership or transferability of our shares, including by reserving to us or our predecessor a right of first refusal with respect to share transfers and by limiting ownership of such shares to physicians and dentists. In addition, we and our predecessor, consistent with the requirements of our and our predecessor's bylaws, have sought to repurchase shares of deceased shareholders at the amount originally paid for such shares by those shareholders. Nonetheless, former shareholders' heirs who were not eligible to own or be transferred shares because they were not physicians or dentists at the time of their purported inheritance ("non-medical heirs"), may claim an entitlement to our shares or to damages with respect to the repurchased shares notwithstanding applicable transfer and ownership restrictions. Our records indicate that there may be as many as approximately 450 former shareholders whose non-medical heirs may claim to have inherited up to 10,500,000 shares after giving effect to the 3,000-for-one stock split. As of the date of this Annual Report on Form 10-K, we are defending six judicial claims by non-medical heirs of former shareholders whose shares were repurchased upon their death seeking the return of or compensation for a total of 92 shares (prior to giving effect to the 3,000-for-one stock split). See "Item 3. Legal Proceedings – Claims by Heirs of Former Shareholders". In addition, we have received inquiries from non-medical heirs with respect to fewer than 700 shares (or 2,100,000 shares after giving effect to the 3,000-for-one stock split).

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

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

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

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

In the event that claimants acquire shares of our managed care subsidiary, TSS, at less than fair value, we will not be able to prevent dilution of the value of the Class B shareholders' ownership interest in us to the extent that the net value received by such claimants exceeds the value of our outstanding shares of Class A common stock. Finally, the anti-dilution protection afforded by the dual class structure may cease to be of further effect at any time because all remaining shares of Class A common stock may, at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted into shares of Class B common stock. On May 17, 2013, the Company converted 6,660,423 shares of Class A common stock to Class B common stock. Concurrently with the conversion, 6,210,423 of such converted shares were sold in a registered secondary public offering.

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

Sales of a substantial number of shares of our common stock in the public market, or the perception that large sales could occur, could cause the market price of our Class B common stock to decline. Either of these limits our future ability to raise capital through an offering of equity securities. As of December 31, 2013 there were 25,091,277 shares of Class B common stock and 2,377,689 shares of Class A common stock. Our Class A common stock is no longer subject to contractual lockup; thus, such shares are freely tradable without restriction or further registration under the Securities Act by persons other than our ''affiliates'' within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the NYSE and will not be fungible with our listed shares of Class B common stock. All or any portion of our shares of Class A common stock may at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock.

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

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

Risks Related to Our Business

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

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

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

In addition to the challenge of managing managed care costs, we face pressure to contain premium rates. Our customers may move to a competitor at policy renewal to obtain more favorable premiums. Also, the Office of the Commissioner of Insurance may disapprove proposed rate increases in the individual and small business markets. Future Medicare premium rate levels may be affected by continuing government efforts to contain medical expense or other budgetary constraints. Changes in the Medicare Advantage program, including with respect to funding, may lead to reductions in the amount of reimbursement, elimination of coverage for certain benefits, or reductions in the number of persons enrolled in or eligible for Medicare. A limitation on our ability to increase or maintain our premium levels could adversely affect our business, financial condition and results of operations.

The property and casualty insurance industry is under soft market conditions for commercial lines and consequently is highly competitive, and we believe that it will remain highly competitive for the foreseeable future. Competitors may offer products at prices and on terms that are not consistent with economic standards in an effort to maintain or increase their business. The property and casualty insurance industry has historically been cyclical, with periods characterized by intense price competition and less restrictive underwriting standards followed by periods of higher premium rates and more selective underwriting standards. The competitive environment in which we operate is also impacted by current general economic conditions, which could reduce the volume of business available to us, as well as to our competitors.

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

Our profitability is dependent upon our ability to contract on favorable terms with hospitals, physicians and other managed care providers. We face heavy competition from other managed care plans to enter into contracts with hospitals, physicians and other providers in our provider networks. Consolidation in our industry, both on the provider side and on the managed care side, only exacerbates this competition. In recent years some groups of providers have been pressing for legislation that would allow them to collectively negotiate certain contract terms through cooperatives. As of the date of this Annual Report on Form 10-K, no such legislation has been passed by the local Legislature. However, on January 3, 2013, the Public Corporation for the Supervision and Insurance of Cooperatives in Puerto Rico ("COSSEC", by its Spanish acronym), a governmental entity, enacted rule No. 8320 to allow providers to collectively negotiate service fees through cooperatives with insurance companies and healthcare organizations on a voluntary basis. On February 10, 2014, we were notified that the Officer of the Commissioner of Insurance of Puerto Rico ("OCS", by its Spanish acronym) requested a legal opinion from the Department of Justice on the authority of COSSEC to issue rule No. 8320, as the Commissioner believes the OCS is the governmental entity responsible for regulating the matters contemplated under rule No. 8320. While compliance with rule No. 8320 is currently voluntary, if the Department of Justice disagrees with OCS's position or if COSSEC independently decides that it has the authority to regulate in this space notwithstanding the Department of Justice's legal opinion, it may become difficult for us to not comply with the rule. If we were to comply with such rule, we expect that maintaining or securing new cost-effective managed care provider contracts would become more difficult, which could result in a loss in membership or higher medical costs and could adversely affect our business.

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

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

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

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

- Medicare: We provide services through our Medicare Advantage products pursuant to a limited number of contracts with CMS. These contracts generally have terms of one year and must be renewed each year. Each of our contracts with CMS is cancellable for cause if we breach a material provision of the contract or violate relevant laws or regulations. If we are unable to renew, or to successfully re-bid or compete for any of these contracts, or if the process for bidding materially changes or if any of these contracts are terminated, our business could be materially impaired. During each of the years ended December 31, 2013, 2012 and 2011, contracts with CMS represented 47.0%, 47.6% and 43.6% of our consolidated premiums earned, net, respectively, and 52.5%, 5.0% and 12.5% of our consolidated operating income, respectively.

- Commercial: Our managed care subsidiary is a qualified contractor to provide managed care coverage to federal government employees within Puerto Rico. Such coverage is provided pursuant to a contract with the OPM that is subject to termination in the event of noncompliance not corrected to the satisfaction of the OPM. During each of the years ended December 31, 2013, 2012and 2011 premiums generated under this contract represented 7.0%, 6.4% and 6.7% of our consolidated premiums earned, net, respectively. The operating income generated under this contract represented 2.6%, 1.6% and 1.3% of our consolidated operating income during the years ended December 31, 2013, 2012 and 2011, respectively.

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- Medicaid: We participate in the government of Puerto Rico Health Reform Program (similar to Medicaid) to provide health coverage to medically indigent citizens in Puerto Rico. Since we obtained our first contract in 1995, we were the sole provider for two to three regions each year, until September 30, 2010 when our contracts with the government of Puerto Rico expired by their own terms. On October 17, 2011, TSS entered into a new contract with the government of Puerto Rico to resume the administration of the physical health component of this program in five designated service regions in Puerto Rico, effective November 1, 2011. On July 1, 2013, TSS amended its agreement with the government of Puerto Rico and extended for a 12-month period the administration of the provision of the health component of the program in the five designated service regions. The amended contract also transferred the administration of the three remaining service regions to TSS on October 1, 2013. The amended contract expires on June 30, 2014. TSS receives a monthly per-member, per-month administrative fee for its services and does not bear the insurance risk of the program. Under the terms of the contract, TSS is a third party administrator responsible for the provision of administrative services to subscribers in all service regions. This program currently services approximately 1,420,000 members. The administrative services to be provided in the Service Regions include case, disease and utilization management, network management and credentialing, enrollment and enrollee services and claims administration, among others. TSS, however, is not financially responsible or otherwise at risk for the provision of services to subscribers in the Service Regions.

On February 5, 2014 the government of Puerto Rico issued a Request for Proposal (RFP) process for the Medicaid business and announced its intention to convert the current program to a managed care organization model. Also, selected contractors will be at risk for the provision of the physical and behavioral health components of the program. We are currently evaluating the requirements of this RFP and have not concluded whether or not we will participate in the competitive bid process to retain the Medicaid business. Should we decide to participate in the bid process, there is no guarantee that we will be selected to continue providing services under the managed care organization model. If we are selected, we may not retain the right to service a particular geographical area in which we currently operate after the expiration of our current contract. If we are selected as a provider under the managed care organization model, we will be at risk for the cost of services provided to members which can be unpredictable, thus we cannot assure that any new contract for this program will be profitable, or that any such contract will be as profitable to TSS as our current administrative services contract. Our current contract for the Medicaid business is subject to termination in the event of any non-compliance by TSS that is not corrected or cured to the satisfaction of ASES the government entity overseeing this program, or on 90 days' prior written notice in the event that ASES determines that there is an insufficiency of funds to finance the program. For the years ended December 31, 2013, 2012 and 2011, operating income generated under this contract represented 34.3%, 46.0% and 7.4% of our consolidated operating income, respectively.

If any of these contracts is terminated for any reason, including by reason of any noncompliance by us, or not renewed or replaced by a comparable contract, our consolidated premiums and profitability earned could be materially adversely affected. See "—Risks Relating to the Regulation of our Industry—As a Medicare Advantage program participant, we are subject to complex regulations. If we fail to comply with these regulations, we may be exposed to criminal sanctions and significant civil penalties, and our Medicare Advantage contracts may be terminated or our operations may be required to change in a manner that has a material impact on our business" and "—Risks Relating to the Regulation of our Industry— If we fail to comply with our corrective action plans with CMS and ASES regarding our provider credentialing and re-credentialing procedures, we may be subject to CMS compliance actions and ASES sanctions, ranging in each case from monetary penalties to contract termination" for more information on the risk of termination of our contracts. In addition, if the liquidity of the Government of Puerto Rico, its agencies, municipalities and public corporations becomes significantly affected by the recent downgrades by the rating agencies or as a result of the inability to raise funding in the market or generate enough revenues, we may face credit losses in our premium and fees receivable from these government related entities, which could be significant.

Local government administration may implement a new regional pilot program in an effort to increase access to healthcare through the addition of new beneficiaries of the Health Reform Program, and the creation of a standard basic coverage aimed to promote the use of preventive health services and organ transplant benefits.

The Government of Puerto Rico has announced its intention to request CMS approval to begin a pilot program in an effort to bring universal healthcare coverage to Puerto Rico. As of the date of this Annual Report on Form 10-K, the details of this pilot program have not been detailed. This new initiative may impact utilization of health care services and the medical loss ratio. As of the date of this Annual report on Form 10-K, there is uncertainty on how this initiative, if approved by CMS, will be implemented and its likelihood of success. This new initiative may change the conditions of the next bidding and negotiation process. Also, unfavorable changes in the number of beneficiaries under the program design of the standard basic coverage could have a material adverse effect on our business, financial condition and results of operations.

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

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than ASO products and those managed care products where employer groups retain the risk, such as self-funded financial arrangements. There has been a trend in recent years among our Commercial customers of moving from fully-insured plans to ASO, or self-funded arrangements. As of December 31, 2013 and 2012, 68% of our managed care commercial customers had fully insured arrangements and 32% had ASO arrangements. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

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

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

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

We are a party to license agreements with the BCBSA that entitle us to the exclusive use of the BCBS name and mark in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. We believe that the Blue Cross and Blue Shield name and mark are valuable identifiers of our products and services in the marketplace. The termination of these license agreements or changes in their terms and conditions could adversely affect our business, financial condition and results of operations.

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

Upon any event causing termination of the license agreements, we would no longer have the right to use the BCBS name and mark in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. Furthermore, the BCBSA would be free to issue a license to use the BCBS name and marks in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla to another entity. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Accordingly, termination of a license agreement could have a material adverse effect on our business, financial condition and results of operations.

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

Upon termination of a license agreement, the BCBSA would impose a “Re-establishment Fee” upon us, which would allow the BCBSA to “re-establish” a BCBSA presence in the vacated service area with another managed care company. The fee is currently $98.33 per licensed enrollee. If the re-establishment fee were applied to our total BCBS enrollees as of December 31, 2013, we would be assessed approximately $215.1 million by the BCBSA.

See “Item 1. Business Blue Cross and Blue Shield License” for more information.

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

Reinsurance is the practice of transferring part of an insurance company’s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. In the year ended December 31, 2013, 37.9%, or $57.6 million, of the premiums written in the property and casualty insurance segment and 6.3%, or $8.7 million, of the premiums written in the life insurance segment were ceded to reinsurers. In the year ended December 31, 2012, 39.0%, or $63.5 million, of the premiums written in the property and casualty insurance segment and 6.0%, or $8 million, of the premiums written in the life insurance segment were ceded to reinsurers. The premiums ceded and the availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

It is also possible that the losses we experience on insured risks for which we have obtained reinsurance will exceed the coverage limits of the reinsurance. See “Risks Related to Our Business¾Large scale natural disasters may have a material adverse effect on our business, financial condition and results of operations.” If the amount of our reinsurance coverage is insufficient, our insurance losses could increase substantially.

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

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

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

Ratings assigned by A.M. Best are an important factor influencing the competitive position of the property and casualty insurance companies in Puerto Rico. In 2013, A.M. Best maintained our property and casualty insurance subsidiary's rating of "A-" (the fourth highest of A.M. Best's 16 financial strength ratings) with a stable outlook. A.M. Best ratings represent independent opinions of financial strength and ability to meet obligations to policyholders and are not directed toward the protection of investors. Financial strength ratings are used by brokers and customers as a means of assessing the financial strength and quality of insurers. A.M. Best reviews its ratings periodically and we may not be able to maintain our current ratings in the future. A downgrade of our property and casualty subsidiary's rating could severely limit or prevent us from writing desirable property business or from renewing our existing business. The lines of business that property and casualty subsidiary writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings.

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

Managed Care

The managed care industry in Puerto Rico is very competitive. If we are unable to compete effectively while appropriately pricing the business subscribed, our business and financial condition could be materially affected. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed of claim payments and reputation. This competitive environment has produced and will likely continue to produce significant pressures on the profitability of our managed care company. In addition, the managed care market in Puerto Rico is mature. According to the U.S. Census Bureau, Puerto Rico's population decreased by 2.2% between 2000 and 2010, however the national population rate grew 9.7% during the same period. According to the US Census Bureau, the older population is an important and growing segment of the United States population. In fact, more people were 65 years and older in 2010 than in any previous census. Between 2000 and 2010, the population 65 years and older increased at a faster rate (15.1%) than the total U.S. population. In Puerto Rico, for the same period, the population 65 years and older increased by 27.5 %. As a result, in order to increase our profitability we must increase our membership in the Medicare Advantage program, increase market share in the commercial sector, improve our operating profit margins, make acquisitions or expand geographically. In Puerto Rico, several managed care plans and other entities were awarded contracts for Medicare Advantage or stand-alone Medicare prescription drug plans. These other plans entered that market in 2006 and 2007. We anticipate that they can aggressively market their benefits to our current and our prospective members. Although we believe that we market an attractive offering, there are no assurances that we will be able to compete successfully with these other plans for new members, or that our current members will not choose to terminate their relationship with us and enroll in these other plans. Concentration in our industry also has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. The parent companies of some of our competitors are larger and have greater financial and other resources than we do. We may have difficulty competing with larger managed care companies, which can create downward price pressures on premium rates. We may not be able to compete successfully against current and future competitors. Competitive pressures faced by us may adversely affect our business, financial condition and results of operations.

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

Complementary Products

The property and casualty insurance market in Puerto Rico is extremely competitive. Due to Puerto Rico's stagnant economy, there are few new sources of business in this segment. As a result, property and casualty insurance companies compete for the same accounts through pricing, policy terms and quality of services. We also face heavy competition in the life and disability insurance market.

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

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

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

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

In addition, we are subject to RBC requirements by the BCBSA. See "Risks Related to Our Business The termination or modification of our license agreements to use the BCBS name and mark could have a material adverse effect on our business, financial conditions and results of operations."

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

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

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

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

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

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

- successfully implement our underwriting, pricing, claims management and product strategies over a larger operating region;

- properly design and price new and existing products and programs and reinsurance facilities for markets in which we have no direct experience;

- identify, train and retain qualified employees;

- identify, recruit and integrate new independent agencies and brokers and expand the range of Triple-S products carried by our existing agents and brokers;

- develop a network of physicians, hospitals and other managed care providers that meets our requirements and those of applicable regulators; and

- augment our internal monitoring and control systems as we expand our business.

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

We are expanding our business operations outside of Puerto Rico and the United States

Current and potential business operations outside Puerto Rico and the United States may be affected by our ability to identify profitable new geographic markets to enter and our ability to operate in any such new geographic markets. We may also be subject to changes in trade protection laws, policies and measures, and other regulatory requirements affecting our business, including the Foreign Corrupt Practices Act and local laws prohibiting corrupt payments. We may be also affected by our ability to obtain licenses in new areas where we wish to market our products. Deterioration of social, political, labor or economic conditions in a specific country or region and difficulties in managing foreign operations may also adversely affect our operations or financial results. Also, fluctuations in foreign currency rates could affect our financial results.

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

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

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

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

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

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

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

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

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

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

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

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

- Reducing our ability to issue other securities.

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

During the years ended December 31, 2013 and 2011, there were $1.0 million and $0.3 million, respectively, of realized losses associated with other-than-temporary impairments. During the year ended December 31, 2012, there were no realized losses associated with other-than-temporary impairments.

The gross unrealized losses of our available-for-sale and held-to-maturity securities were $11.8 million and $0.4 million at December 31, 2013 and 2012, respectively. The gross unrealized gains of our available-for-sale and held-to-maturity securities were $89.0 million and $121.3 million at December 31, 2013 and 2012, respectively. Given current market conditions, there is a continuing risk that declines in fair value may occur and material realized losses from sales or other-than-temporary impairments may be recorded in future periods.

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

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

We have business operations in the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. However, substantially all of our business activity is with corporate customers and individuals located throughout Puerto Rico, and as such, we are subject to the risks associated with the Puerto Rico economy. The major factors affecting the economy are, among others, oil prices, the economic activity in the United States, and the continuing economic uncertainty generated by the budgetary deficiency affecting the government of Puerto Rico.

The Government of Puerto Rico continues to face a deficit between recurring government revenues and expenses. The Government of Puerto Rico has implemented and is currently implementing initiatives geared towards achieving a balanced budget. These measures could have the effect of intensifying the current recessionary cycle.

Also, the Administration of Employees Retirement System of the Government of Puerto Rico ("AERS") anticipates that, based on the current contributions and benefit structure, its future cash flow needs for disbursement of benefits to participants, administrative expenses and debt service are likely to continue to exceed the sum of the employer and employee contributions received and its investment and other recurring income. Retirement systems for other public servants are also facing adverse financial situations. Legislation has been enacted to amend the Retirement System for the Employees of the Government of the Commonwealth of Puerto Rico, the Puerto Rico Teachers' Retirement System and the Judiciary Retirement System with the objective of reducing the expenses borne by the Government of Puerto

Rico. During 2013, participants under these three retirement systems challenged the constitutionality of the amendments enacted. The Supreme Court of Puerto Rico upheld the constitutionality of the amendments to the AERS retirement systems, the prospective application of the amendments to the judiciary retirement system, and stayed the effective date of the amendments to the teacher’s retirement system pending its final determination on the matter. As of the date of this Annual report on Form 10-K, there is uncertainty if this legislation will be implemented and, if implemented, its likelihood of success.

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In February 2014, Puerto Rico’s general obligation debt was downgraded by Standard & Poor’s from BBB- to BB+, by Moody’s Investors Services from Baa3 to Ba2, and by Fitch Ratings from BBB- to BB. Each of these ratings is below investment grade. If the liquidity of the Government of Puerto Rico, its agencies, municipalities and public corporations becomes significantly affected by the recent downgrades by the rating agencies or as a result of the inability to raise funding in the market or generate enough revenues, we may face credit losses in our premium and fees receivable from these government related entities, which could be significant.

If economic conditions in Puerto Rico continue to deteriorate, we may experience a reduction in existing and new business, and we may be exposed to a higher level of credit losses from both government and commercial accounts, which could have a material adverse effect on our business, financial condition and results of operations.

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

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

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

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

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

In addition, federal regulations require that we begin using ICD-10 by October 2014, which will require significant information technology investment. If we fail to adequately implement ICD-10, we may incur losses with respect to the resources invested and have other material adverse effects on our business and results of operations. In order to become ICD-10 compliant, we changed TSS's core business application, which we implemented in the third quarter of 2012. In addition, we completed the version upgrade process of such business application in the third quarter of 2013. TSS is coordinating ICD-10 implementation efforts with BCBSA, service providers, clearing houses, local and federal government stakeholders in order to insure a timely compliance.

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

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

We face risks related to litigation.

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

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

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

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

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

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

We are a party to secured loans with two commercial banks for an aggregate amount of $29.3 million, for which we have outstanding balances of $16.1 million and $13.2 million as of December 31, 2013, respectively. Also, we have outstanding a senior unsecured note with an aggregate principal amount of $35.0 million, this note bears interest at a fixed rate of 6.60% and is due in 2020. The secured term loan and the note purchase agreements governing the notes contain financial and non-financial covenants that restrict, among other things, the granting of certain liens, limitations on acquisitions and limitations on changes in control. These non-financial covenants could restrict our operations. In addition, if we fail to make any required payment under our secured term loans or note purchase agreements governing the notes or to comply with any of the non-financial covenants included therein, we would be in default and the lenders or holders of our debt, as the case may be, could cause all of our outstanding debt obligations under our secured term loans or note purchase agreements to become immediately due and payable, together with accrued and unpaid interest and, in the case of the secured term loans, cease to make further extensions of credit. If the indebtedness under our secured term loans or note purchase agreements is accelerated, we may be unable to repay or re-finance the amounts due and our business may be materially adversely affected.

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

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

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

We may pursue acquisitions in the future.

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

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

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

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

As of December 31, 2013 we had approximately $25.4 million and $18.3 million of goodwill and intangible assets recorded on our balance sheet, primarily related to the AH acquisition, that represent 2.1% of our total consolidated assets and 5.6% of our consolidated stockholders' equity. If we make additional acquisitions it is likely that we will record additional goodwill and intangible assets on our consolidated balance sheet.

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

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

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

Risks Relating to Taxation

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

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

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

Based on our current business assets and operations, we do not expect that we will be considered a ‘‘passive foreign investment company’’ (a “PFIC”) for U.S. federal income tax purposes. However, because PFIC status depends upon the composition of our income and assets and the market value of our assets (including, among others, less than 25 percent owned equity investments) in each year, which may be uncertain and may vary substantially over time, there can be no assurance that we will not be considered a PFIC for any taxable year. Our belief that it is not a PFIC is based, in part, on the fact that the PFIC rules include provisions intended to provide an exception for bona fide insurance companies predominately engaged in an insurance business. However, the scope of this exception is not entirely clear and there are no administrative pronouncements, judicial decisions or Treasury regulations that provide guidance as to the application of the PFIC rules to insurance companies. If the Company were treated as a PFIC for any taxable year, certain adverse consequences could apply to certain U.S. persons that own our shares of Class B common stock.

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Risks Relating to the Regulation of Our Industry

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

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

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

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

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

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

The ACA provides comprehensive changes to the U.S. health care system, which are being phased in at various stages through 2018. The legislation imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes. If the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this new tax, our results of operations, financial position and liquidity may be materially adversely affected. Also, beginning in 2014, health plans serving the individual market are subject to the guaranteed issue provisions under which the plans are required to issue coverage to individuals without regard to their health status of pre-existing conditions, which could lead to adverse selection by consumers. If we are unable to adapt our premium structure to address the guaranteed issue requirement, our results of operations, financial position and liquidity may be materially adversely affected.

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

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

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

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

Under CMS regulations to implement certain ACA requirements that became effective on June 1, 2012, CMS has the authority not to renew our contracts at the beginning of 2015 based solely on our Star Ratings if our ratings do not improve to three or more stars for at least one of the three contract years starting in 2013 and ending in 2015. See the subcaption "Federal regulations" in Item 1 of this annual report on Form 10-K for detailed information of the Stars Ratings. In addition, CMS has the existing authority to terminate any of our Medicare Advantage contracts or our Part D contract if it determines that any of these plans has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage or Part D program. Any termination or non-renewal of our Medicare Advantage or Part D plans would have a material adverse effect on our business and financial results.

Beginning in 2012, Medicare Advantage plans with an overall Star Rating of three or more stars (out of five) are eligible for a quality bonus in their basic premium rates. Initially, quality bonuses were limited to the few plans that achieved 4 or more stars as their overall Star Rating, but CMS is using demonstration authority to expand the quality bonus to 3 star plans for a three year period through 2014. Also beginning in 2012, Medicare Advantage Star Ratings affect the rebate percentage available for plans to provide additional member benefits (plans with quality ratings of 3.5 stars or above will have their rebate percentage increased from a base rate of 50% to 65% or 70%). In all cases, these rebates percentages are lower than the previous percentage of 75%. Furthermore, CMS implemented a series of initiatives to encourage beneficiaries to receive care through plans that receive Star Ratings of 3 stars or higher. These initiatives include: (i) notifying beneficiaries in low rated plans of their plan's low rating and advising them of their ability to elect another plan with a Star Rating of 3 or higher in 2014; (ii) limiting a low rated plan's ability to accept enrollments online through the Medicare Plan Finder; and (iii) limiting the scope and detail of information about low rated plans set forth in the CMS Medicare & You handbook.

TSS has a contract with CMS with regards to three (3) Medicare Advantage plans and one (1) stand-alone Part D plan. AH has a single plan covering both Part C and Part D services. For 2013, the AH plan was rated at 3 stars and the four TSS plans received Star Ratings of 2.5 stars. Three of the TSS's plans had received a Star Rating lower than three stars for each of years 2011 through 2013. As a result, on October 2012, CMS issued notices to enrollees concerning these three plans alerting them of the plans' low rating, encouraging them to explore higher rated plan options, and offering them the opportunity to move into higher quality plans during a special enrollment period in 2013.

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

In October 2013, CMS issued its Star Ratings for 2014. The AH plan retained its 3 star rating for Part C and increased its Part D rating from 2.5 to 3 stars. Two of our TSS plans increased their overall ratings to 3 stars; the Part D portion of these plans, however, received 2.5 stars. The other two TSS plans remained at 2.5 stars. Accordingly, CMS issued notices to enrollees in all four TSS plans alerting them of the plans' low rating, encouraging them to explore higher rated plan options, and offering them the opportunity to move into higher quality plans using a special enrollment period during 2014. If the TSS plans do not achieve Star Ratings of 3 stars or higher for 2015, CMS will have the discretion not to renew their Medicare Advantage contracts as of December 31, 2014.

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We are devoting the resources and management attention we believe necessary to improve our Star ratings, but may not be successful in increasing the TSS plans to 3 stars or higher. Our failure to achieve Star Ratings of 3 or higher for each of our plans, or to otherwise improve our administration of these plans, would jeopardize our ability to attract and retain members in our TSS Medicare Advantage and Part D plans, as well as our ability to continue to participate in these federal programs and to successfully bid for future CMS contracts in these programs.

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

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

During 2013, CMS issued engagement letters to TSS and AH to review the validation processes for their respective Medicare Advantage products, including TSS’s Part D product. CMS review went through the corrective measures we implemented in connection with the findings issued during CMS’s audit in 2012. This review on the validation processes was completed and we are waiting the CMS’s closing letter on this matter.

If we fail to comply with our corrective action plans with CMS and ASES regarding our provider credentialing and re-credentialing procedures, we may be subject to CMS compliance actions and ASES sanctions, ranging in each case from monetary penalties to contract termination

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

Under the CAP we submitted to CMS for the credentialing and re-credentialing of our TSS Medicare Advantage provider network, we committed to complete the corresponding procedures for all of the providers by October 31, 2013. As the result of a slower than anticipated external source verification process and provider response rate, we adjusted the CAP deadline to December 20, 2013, the same deadline established in the ASES CAP described below.

Our failure to have properly credentialed and re-credentialed the TSS Medicare Advantage provider network may result in compliance action by CMS. We believe this action, if any, could range from a monetary fine, to a ban on certain marketing of the TSS Medicare Advantage plans, to a termination of TSS’s Medicare Advantage contracts with CMS. Any penalty that CMS ultimately imposes could materially adversely affect our business, financial condition, operating results and cash flows.

On April 5, 2013, ASES approved the CAP we submitted on March 4, 2013 regarding the credentialing of our provider network used Medicaid. In August 2013, ASES retained external auditors to test the credentialing and re-credentialing procedures for such network and the progress we had made under the CAP. The auditors concluded that the credentialing documentation examined did not comply with the minimum requirements under federal regulation and under the Medicaid contract. As a result, ASES supplemented the CAP and set a credentialing schedule with weekly milestones intended to bring all of our Medicaid provider files into compliance with the applicable credentialing and re-credentialing requirements by December 20, 2013.

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We failed to meet initial milestones under the CAP, for which ASES issued a warning and a notice of administrative inquiry on September 13, 2013, and October 30, 2013, respectively. As a result, and pursuant to the notice, we submitted a supplemental CAP, outlining how we planned to achieve the goal of re-credentialing all of the providers in the TSS's Medicaid network within the deadline. The supplemental CAP also included additional activities to be completed on or before April 30, 2014. We met the milestones under the supplemental CAP scheduled to be completed by the December 20, 2013 deadline.

In connection with this credentialing and re-credentialing process, TSS sent 1,556 letters of intent of contract termination to providers in the TSS Medicaid network, with an effective date of January 31, 2014. Subsequently, some of these providers completed their credentialing or re-credentialing process. On January 31, 2013, TSS canceled its contracts with 487 providers that were not properly credentialed and removed them from the Medicaid network. Some of those providers subsequently completed a re-credentialing and, as of the date of this Annual Report on Form 10-K, our contracts with 249 of these providers remain canceled.

We intend to come into full compliance with our CMS and ASES credentialing and re-credentialing requirements. Although we can give no assurances as to whether we will be able to satisfy CMS or ASES credentialing and re-credentialing requirements with respect to all current providers. If we are unable to maintain the adequacy of our network our ability to conduct our business may be adversely affected.

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

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

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

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

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

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

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

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

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

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

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

Compliance with new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain our ability to manage our business model. For example, final HHS regulations released in January 2013 implementing the ARRA amendments to HIPAA may further restrict our ability to collect, disclose and use sensitive personal information and may impose additional compliance requirements on our business. In addition, HHS has announced that it will continue its audit program to assess HIPAA compliance efforts by covered entities. Although we are not aware of HHS plans to audit any of our covered entities, an audit resulting in findings or allegations of noncompliance could have a material adverse effect on our results of operations, financial position and cash flows. We are also subject to Puerto Rico Act No. 194 of August 25, 2000, also known as the Patient's Rights and Responsibilities Act, including provisions more stringent than HIPAA. There is uncertainty regarding many aspects of such state requirements which make compliance with applicable health information laws more difficult. For these reasons, our total compliance costs may increase in the future.

On February 11, 2014, ASES notified TSS of its intention to impose a civil monetary penalty of $6.8 million dollars with respect to a breach involving the inadvertent display of protected health information of Medicare Advantage beneficiaries. See, “Item 3. Legal Proceedings–Unauthorized Disclosure of Protected Health Information” for more information.

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

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

Effective January 1, 2006, a revised rate calculation system based on a competitive bidding process was instituted for Medicare Advantage managed care plans, including our Dual and Non-Dual products. The statutory payment rate was relabeled as the benchmark amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. For 2014, if the accepted bid is less than the benchmark, Medicare pays the plan its bid plus a rebate of 50% of the amount by which the benchmark exceeds the bid, if the star rating is 3.5 or 4 stars the rebate is 65% of the amount by which the benchmark exceeds the bid and if the star rating is 4.5 or 5 stars the rebate is 70% of the amount by which the benchmark exceeds the bid. However, these rebates can only be used to enhance benefits or lower premiums and co-pays for plan members. If the bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid and the benchmark, which could affect our ability to attract enrollees. CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability. On February 21, 2014, CMS released the "Advance Notice of Methodological Changes for Calendar Year 2015 for Medicare Advantage Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter", in which CMS announced significant rate cuts that could have a material adverse effect on our revenue, financial position, results of operations or cash flow.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- permit our board of directors to issue one or more series of preferred stock;
- divide our board of directors into three classes serving staggered three-year terms;
- limit the ability of shareholders to remove directors;
- impose restrictions on shareholders’ ability to fill vacancies on our board of directors;

- impose advance notice requirements for shareholder proposals and nominations of directors to be considered at meetings of shareholders; and

- impose restrictions on shareholders’ ability to amend our articles and bylaws.

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

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

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

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

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

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

Item 3. Legal Proceedings

Our business is subject to numerous laws and regulations promulgated by Federal and Puerto Rico governmental authorities. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. The Commissioner of Insurance of Puerto Rico, as well as other Federal and Puerto Rico government authorities, regularly make inquiries and conduct audits concerning the Company's compliance with such laws and regulations. Penalties associated with violations of these laws and regulations include significant fines and penalties, and exclusion from participating in certain publicly funded programs.

We are involved in various legal actions arising in the ordinary course of business. We are also defendants in various other litigations and proceedings, some of which are described below. Where the Company believes that a loss is both probable and estimable, such amounts have been recorded. Although we believe our estimates of such losses are reasonable, these estimates could change as a result of further developments in these matters. In other cases, it is at least reasonably possible that the Company may incur a loss related to one or more of the mentioned pending lawsuits or investigations, but the Company is unable to estimate the range of possible loss which may be ultimately realized, either individually or in the aggregate, upon their resolution. The outcome of legal proceedings is inherently uncertain and pending matters for which accruals have not been established have not progressed sufficiently to enable us to estimate a range of possible loss, if any. Given the inherent unpredictability of these matters, it is possible that an adverse outcome in one or more of these matters could have a material adverse effect on the consolidated financial condition, operating results and/or cash flows of the Company.

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

Claims by Heirs of Former Shareholders

The Company and TSS are defending six individual lawsuits, all filed in state court, from persons who claim to have inherited a total of 92 shares of the Company or one of its predecessors or affiliates (before giving effect to the 3,000-for-one stock split). While each case presents unique facts and allegations, the lawsuits generally allege that the redemption of the shares by the Company pursuant to transfer and ownership restrictions contained in the Company's (or its predecessors' or affiliates') articles of incorporation and bylaws was improper.

In one of these cases, entitled Vera Sánchez, et al, v. Triple-S, the plaintiffs argued that the redemption of shares was fraudulent and was not subject to the two-year statute of limitations contained in the local securities law. The Court of First Instance determined that the plaintiffs' claims are time barred under the local securities law. The plaintiffs appealed, and in January 2012, the Puerto Rico Court of Appeals upheld the dismissal, holding that even if the plaintiffs could have survived the securities law's two-year statute of limitations, their complaint was time-barred under the Civil Code's four-year statute of limitations on claims of fraud. On March 28, 2012 the plaintiffs filed a petition for writ of certiorari before the Puerto Rico Supreme Court that was granted on May 31, 2012. We filed our respondent's brief on October 5, 2012. On October 1, 2013, the Supreme Court reversed the dismissal of the case, holding that the two-year statute of limitations contained in the local securities law did not apply based on the facts of this case and returning it to the Court of First Instance for the continuance of the case and pending further proceedings.

In the second case, entitled Olivella Zalduondo, et al, v. Seguros de Servicios de Salud, et al, the Puerto Rico Court of First Instance granted the Company's motion to dismiss on grounds that the complaint was time-barred under the two-year statute of limitations of the securities laws. On appeal, the Court of Appeals affirmed the decision of the lower court. Plaintiffs filed a petition for certiorari before the Puerto Rico Supreme Court which was granted on January 20, 2012. On January 8, 2013, the Supreme Court ruled that the applicable statute of limitations is the fifteen-year period of the Puerto Rico Civil Code for collection of monies. On January 28, 2013, the Company filed a motion for reconsideration which was subsequently denied. On March 26, 2013, Plaintiffs amended the complaint for the second time and the Company answered on April 16, 2013. Discovery is ongoing.

In the third case, entitled Heirs of Dr. Juan Acevedo, et al, v. Triple-S Management Corporation, et al, the court of First Instance denied our motion for summary judgment based on its determination that there are material issues of fact in controversy. In response to our appeal, the Puerto Rico Court of Appeals confirmed the decision of the Court of First Instance. Our request for reconsideration was denied in December 2011. Trial is set to begin on August 12, 2014.

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The fourth case, entitled Montilla López, et al, v. Seguros de Servicios de Salud, et al, was filed on November 29, 2011. The Company filed a motion to dismiss on the grounds that the claim is time barred under the local securities laws. While the motion to dismiss was pending, plaintiffs amended their complaint on October 15, 2012. The Company filed a motion to dismiss the amended complaint. On January 24, 2013, the court denied the motion to dismiss. The Company answered the complaint on March 8, 2013. Subsequently, plaintiffs amended their complaint and the Company filed its response on June 13, 2013. Discovery is ongoing.

The fifth case, entitled Cebollero Santamaría v. Triple-S Salud, Inc., et al, was filed on March 26, 2013, and the Company filed its response on May 16, 2013. On October 29, 2013, the Company filed a motion for summary judgment on the grounds that the claim is time barred under the fifteen-year period of the Puerto Rico Civil Code for collection of monies and, in the alternative, that plaintiff failed to state a claim for which relief can be granted. The court allowed plaintiff to conduct limited discovery in connection with plaintiff’s opposition to our motion for summary judgment, which is currently ongoing.

The sixth case, entitled Irizarry Antonmattei, et al, v. Seguros de Servicios de Salud, et al, was filed on April 16, 2013 and the Company filed its response on June 21, 2013. On June 28, 2013, the court of First Instance ordered the plaintiff to reply to the Company’s response specifically on the matter of the statutes of limitations applicable to the complaint. Plaintiff failed to timely respond and the Company moved to dismiss. Plaintiff subsequently moved to amend the complaint. Although the Company opposed it, the court granted leave. On November 5, 2013, the Company moved to dismiss the first amended complaint on the grounds that it is time barred under the fifteen-year period of the Puerto Rico Civil Code for collection of monies. On December 16, 2013, Plaintiffs filed an opposition thereto and the Company filed a reply on January 7, 2014. The court has not ruled on these motions.

Management believes the aforesaid claims are time barred under one or more statutes of limitations and will vigorously defend them on these grounds; however, as a result of the Supreme Court’s decision to deny the applicability of the statute of limitations contained in the local securities law, the claims will likely be litigated on their merits.

Joint Underwriting Association Litigations

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

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

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

On December 30, 2011, TSP and other insurance companies filed a joint motion to dismiss, arguing, among other things, that plaintiffs' claims are barred by the filed rate doctrine, inasmuch a suit cannot be brought, even under RICO, to amend the compulsory liability insurance rates that were approved by the Puerto Rico Legislature and the Commissioner of Insurance of Puerto Rico.

On February 17, 2012, plaintiffs filed their opposition. On April 4, 2012, TSP filed a reply in support of our motion to dismiss, which was denied by the court. On October 2, 2012, the court issued an order certifying the class. On October 12, 2012, several defendants, including TSP, filed an appeal before the U.S. Court of Appeals for the First District, requesting the court to vacate the District Court's certification order. The First Circuit denied the authorization to file the writ of appeals. Discovery is ongoing.

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Dentists Association Litigation

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

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

Two codefendant plans, whose main operations are outside Puerto Rico, removed the case to federal court in Florida, which the plaintiffs and the other codefendants, including the Company, opposed. On February 8, 2011, the federal district court in Puerto Rico decided to retain jurisdiction. The defendants filed a joint motion to dismiss the case on the merits. On August 31, 2011, the District Court dismissed all of plaintiffs' claims except for its breach of contract claim, and ordered the parties to brief the issue of whether the court still has federal jurisdiction under the Class Action Fairness Act of 2005 ("CAFA"). Plaintiffs moved the court to reconsider its August 31, 2011 decision and the defendants did the same, arguing that the breach of contract claim failed to state a claim upon which relief can be granted. On May 2, 2012, the court denied the plaintiffs' motion. On May 31, 2012, plaintiffs appealed the District Court's dismissal of their complaint and the denial of plaintiffs' motion for reconsideration. The Court of Appeals for the First Circuit dismissed the appeal for lack of jurisdiction. On September 25, 2012 the District Court denied without prejudice the defendants' motion for reconsideration. On October 10, 2012 the parties filed their briefs with respect to class certification. On March 13, 2013, the district court denied plaintiffs' request for class certification and ordered the parties to brief the court on whether jurisdiction still exists under CAFA following such denial. On April 24, 2013, all parties briefed the court on this issue. On September 6, 2013, the District Court dismissed the Dentist Association for lack of associational standing, leaving only the individual dentists as plaintiffs. The court also granted plaintiffs' leave to amend their complaint to address mediation or settlement negotiations and, to cure deficiencies pertaining to the breach-of-contract claims. On December 23, 2013, five plaintiffs filed a Second Amended Complaint seeking damages in the amount of $30 thousand in which the dentists alleged that defendants altered the coding of the claims billed by the dentist, resulting in a lower payment. Only one of the five plaintiffs presented a claim against the Company. On January 31, 2014 the Company answered the complaint. The court allowed plaintiffs to conduct limited discovery, which is currently ongoing.

In re Blue Cross Blue Shield Antitrust Litigation

TSS is a co-defendant with multiple Blue Plans and the BCBSA in a multi-district class action litigation filed on July 24, 2012 that alleges that the exclusive service area (ESA) requirements of the Primary License Agreements with Plans violate antitrust law, and the plaintiffs in these suits seek monetary awards and in some instances, injunctive relief barring ESAs. Those cases have been centralized in the United States District Court for the Northern District of Alabama. Prior to centralization, motions have been filed to dismiss some of the cases and are pending the court's decision. Discovery has not yet commenced. The Company has joined BCBSA in vigorously contesting these claims.

Claims Relating to the Provision of Health Care Services

TSS was defendant in a lawsuit filed in 2007 by Centro Médico del Turabo, Inc. ("CMT") in state court originally claiming approximately $3.7 million for collection of monies due to unpaid invoices for emergency services rendered to TSS-insured patients pursuant to the Puerto Rico Patients' Bill of Rights. In February 2012, CMT amended the complaint to increase the claimed amount to $9.8 million. Discovery began in November 2012. After careful review of invoices provided by CMT during discovery, TSS determined in April 2013 that a number of these invoices are valid, but believes the amount due to CMT is substantially below the amount claimed. On December 12, 2013, the parties settled all cases. On December 20, 2013, the court entered judgment dismissing the case with prejudice.

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Several other claims for collection of monies have been filed against TSS in connection with the provision of health care services. Among them are individual complaints filed before the Puerto Rico Health Insurance Administration by six community health centers that contain similar breach of contract allegations and claim an aggregate of $9.6 million. Discovery has not yet commenced in these complaints, and given their early stage, the Company cannot assess the probability of an adverse outcome or the reasonable financial impact that any such outcome may have on the Company. However, we believe these complaints are time-barred and intend to vigorously defend them on these and other grounds.

Intrusions into TCI's Internet IPA Database

On September 21, 2010, the Company learned from a competitor that a specific internet database containing information pertaining to individuals insured at the time by TSS under the Government of Puerto Rico Medicaid program and to independent practice associations that provided services to those individuals, had been accessed without authorization by certain of its employees.

The Company reported these events to the appropriate Puerto Rico and federal government agencies. It then received and complied with requests for information from ASES and the Office for Civil Rights ("OCR") of the U.S. Department of Health and Human Services, which entities are conducting reviews of these data breaches and TSS' and TCI's compliance with applicable security and privacy rules. ASES levied a fine of $100 thousand on TSS in connection incidents, but following the Company's request for reconsideration, ASES withdrew the fine pending the outcome of the review by the OCR. The OCR has not issued its determination on this matter. The Company at this time cannot reasonably assess the impact of these proceedings on the Company.

The Company conducted an investigation of these events with the assistance of external resources and identified the information that was accessed and downloaded into the competitor's network. As a result, on February 11, 2011, the Company filed an action before the Puerto Rico Court of First Instance against certain individuals believed to have participated in the intrusions, which was later amended to include additional defendants, including the Company's competitor. On October 17, 2013, the parties filed a joint stipulation for dismissal with prejudice filed with the court, as the Company reached a settlement agreement with the defendants to end the case. The settlement agreement did not impact our consolidated financial condition, cash flows, or results of operations for the year ending December 31, 2013.

Unauthorized Disclosure of Protected Health Information

On September 20, 2013, TSS mailed to our approximately 70,000 Medicare Advantage beneficiaries a pamphlet that inadvertently displayed the receiving beneficiary's Medicare Health Insurance Claim Number ("HICN"). The HICN is the unique number assigned by the Social Security Administration to each Medicare beneficiary and is considered protected health information under HIPAA. TSS conducted an investigation and reported the incident to the appropriate Puerto Rico and federal government agencies. It then received and complied with requests for information from ASES concerning our dual eligible Medicare beneficiaries. On February 20, 2014, TSS also received a request of information from OCR. TSS issued a breach notification through the local media and notified the situation to all affected beneficiaries by mail. TSS also provided a toll-free number for inquiries and complaints from the individuals to whom notice was provided, and is offering them 12 months of free credit monitoring and identity protection through an independent provider.

On February 11, 2014, ASES notified TSS of its intention to impose a civil monetary penalty of $6.8 million and other administrative sanctions with respect to the breach described above involving 13,336 of our dual eligible Medicare beneficiaries. The sanctions include the suspension of all new enrollments of dual eligible Medicare beneficiaries and the obligation to notify affected individuals of their right to disenroll. In its letter, ASES alleged TSS has failed to take all required steps in response to the breach. ASES subsequently informed TSS that it expected TSS to cease such enrollment immediately and TSS complied. On February 20, 2014, TSS submitted a corrective action plan and, on February 21, 2014, ASES requested TSS to provide additional information in connection with the corrective action plan. On February 26, 2014, ASES temporarily lifted the sanctions related to the enrollment of dual eligible Medicare beneficiaries subject to the approval of the corrective action plan. On March 6, 2014, ASES confirmed its determination regarding the lift of the enrollment sanction and notified its intention to provide TSS a corrective action plan. On March 11, 2014, TSS filed an answer challenging the monetary civil penalty and requesting an administrative hearing and simultaneously filed a notice of removal in the federal District Court for the District of Puerto Rico. TSS alleges that the administrative proceeding should be dismissed on several grounds, including lack of jurisdiction.

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While TSS is collaborating with ASES on these matters, it intends to vigorously contest the monetary fine and other sanctions subject of ASES' notices. At this time, the Company is unable to determine the ultimate outcome of its challenge to ASES' sanctions, the incident's ultimate financial impact on TSS or what measures, if any, will be taken by the OCR or other regulators regarding this matter.

In connection with this event, on February 10, 2014, one individual, on his behalf and on behalf of his spouse, filed suit against TSS in the Court of First Instance of Puerto Rico asserting emotional damages due the disclosure of his protected health information. Also, on February 24, 2014, another individual filed a class-action suit against TSS claiming approximately $20 million in damages. On February 27, 2013, we filed a motion to dismiss the class-action suit based on several grounds, including lack of standing. The Company intends to vigorously defend against these claims.

Item 4. Mine Safety Disclosures

None.

Part II

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

Market Information

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

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The following table presents high and low sales prices of our Class B common stock for each quarter of the years ended December 31, 2013 and 2012:

	High	Low
2012		
First quarter	$19.38	$17.23
Second quarter	22.87	17.18
Third quarter	22.66	18.39
Fourth quarter	20.34	17.47
2011		
First quarter	$24.99	$19.79
Second quarter	23.20	16.63
Third quarter	21.60	17.50
Fourth quarter	21.17	16.05

On March 14, 2014 the closing price of our Class B common stock on the NYSE was $16.70.

Holders

As of March 3, 2014, there were 2,377,689 and 24,907,477 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A common stock as of March 3, 2014 was 749. The number of our holders of Class B common stock as of March 3, 2014 was 4,796.

Dividends

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

Our ability to pay dividends is dependent on cash dividends from our subsidiaries. Our subsidiaries are subject to regulatory surplus requirements and additional regulatory requirements, which may restrict their ability to declare and pay dividends or distributions to us. In addition, our secured term loan restricts our ability to pay dividends if a default thereunder has occurred and is continuing. Please refer to “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations – Liquidity and Capital Resources – Restriction on Certain Payments by the Corporation’s Subsidiaries”. Also, see note 19 of the audited consolidated financial statements for the years ended December 31, 2013, 2012 and 2011.

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

Securities Authorized for Issuance Under Equity Compensation Plan

See note 21 of the audited consolidated financial statements for the years ended December 31, 2013, 2012 and 2011.

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Performance Graph

The following graph compares the cumulative total return to shareholders on our Class B common stock for the period from January 1, 2009 through December 31, 2013, with the cumulative total return over such period of (i) the Standard and Poor's 500 Stock Index (the "S&P 500 Index"), (ii) the Standard & Poor's Managed Health Care Index (the "S&P MHC Index"), our current industry index and (iii) the Morgan Stanley Healthcare Payor Index (the "MSHP Index"), which was the industry index used in previous filings and was last published in October 18, 2013. For illustrative purposes we assumed that the last published MSHP Index remained unchanged until December 31, 2013. The comparison assumes an investment of $100 on January 1, 2009 in each of our Class B common stock, the S&P 500 Index, the MSHP Index and the S&P MHC Index. The performance graph is not necessarily indicative of future performance.

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

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Recent Sales of Unregistered Securities

Not applicable.

Purchases of Equity Securities by the Issuer

Not applicable.

Item 6. Selected Financial Data

Statement of Earnings Data

	2013	2012	2011	2010	2009
(Dollar amounts in millions, except per share data)					
Years ended December 31,					
Premiums earned, net	$2,203.0	$2,253.4	$2,054.5	$1,901.1	$1,869.1
Administrative service fees	108.7	110.1	38.5	39.6	48.6
Net investment income	47.3	46.8	48.2	49.1	52.1
Other operating revenues	4.8	4.3	-	-	-
Total operating revenues	2,363.8	2,414.6	2,141.2	1,989.8	1,969.8
Net realized investments gains	2.6	5.2	18.6	2.5	0.6
Net unrealized investment gain (loss) on trading securities	-	-	(7.3)	5.4	10.5
Other income, net	15.3	2.2	0.7	0.9	1.3
Total revenues	2,381.7	2,422.0	2,153.2	1,998.6	1,982.2
Benefits and expenses:					
Claims incurred	1,836.2	1,919.8	1,716.3	1,596.8	1,605.8
Operating expenses	478.2	425.2	347.6	305.0	279.4
Total operating costs	2,314.4	2,345.0	2,063.9	1,901.8	1,885.2
Interest expense	9.5	10.6	10.8	12.6	13.3
Total benefits and expenses	2,323.9	2,355.6	2,074.7	1,914.4	1,898.5
Income before taxes	57.8	66.4	78.5	84.2	83.7
Income tax expense	2.3	12.5	20.5	17.4	14.9
Net income	55.5	53.9	58.0	66.8	68.8
Net loss attributable to non-controlling interest	(0.4)	(0.1)	-	-	-
Net income attributable to TSM	$55.9	$54.0	$58.0	$66.8	$68.8
Basic net income per share (1):	$2.02	$1.91	$2.02	$2.30	$2.33
Diluted net income per share:	$2.01	$1.90	$2.01	$2.28	$2.33

Balance Sheet Data

	2013	2012	2011	2010	2009
December 31,					
Cash and cash equivalents	$74.4	$89.6	$71.8	$45.0	$40.4
Total assets	$2,047.6	$2,059.3	$1,880.6	$1,759.4	$1,648.7
Long-term borrowings	$89.3	$101.3	$114.4	$166.0	$167.7

Total stockholders' equity	$785.2	$762.1	$677.0	$617.3	$537.8

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Additional Managed Care Data (2)

	2013	2012	2011	2010	2009
Years ended December 31,					
Medical loss ratio	86.7 %	88.8 %	87.2 %	88.1 %	89.9 %
Operating expense ratio	17.0 %	14.5 %	12.9 %	11.6 %	10.7 %
Medical membership (period end)	2,187,939	1,721,114	1,683,696	788,881	1,347,033

(1) Further details of the calculation of basic earnings per share are set forth in notes 2 and 22 of the audited consolidated financial statements for the years ended December 31, 2013, 2012 and 2011.
(2) Does not reflect inter-segment eliminations.

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

This financial discussion contains an analysis of our consolidated financial position and financial performance as of December 31, 2013 and 2012, and consolidated results of operations for 2013, 2012 and 2011. References to the terms "we", "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations ("MD&A"), refer to TSM and unless the context otherwise requires, its direct and indirect subsidiaries. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

Update to the Interim Condensed Consolidated Financial Statements Included in Earnings Press Release Dated February 11, 2014 for the Fourth Quarter and Year Ended December 31, 2013

On February 11, 2014, the Company filed a Current Report on Form 8-K including the earnings press release announcing the Company's consolidated financial results for its fiscal fourth quarter and year ended December 31, 2013. The consolidated financial statements included in this Annual Report on Form 10-K differ from those included in our earnings press release, primarily reflecting the effect of the refinement of the Managed Care segment's risk scores estimate based upon evidence obtained subsequent to the filing of our earnings press release, as well as other adjustments increasing the segment's incurred claims and operating expenses. As a result, the Company's consolidated net income for the year ended December 31, 2013 included in this Annual Report on Form 10-K increased $1.6 million to $55.9 million, or $2.01 per diluted share, as compared to net income of $54.3 million or $1.95 per diluted share, as reported on February 11, 2014. The consolidated and Managed Care premiums, claims incurred and operating expenses are $5.4 million, $1.9 million and $0.8 million, respectively, higher than as reported in our earnings press release.

The structure of our MD&A is as follows:

I. Overview

We are one of the most significant players in the managed care industry in Puerto Rico and have over 50 years of experience in this industry. We offer a broad portfolio of managed care and related products in the Commercial and the Medicare (including Medicare Advantage and the Part D stand-alone prescription drug plans ("PDP")) markets. In the Commercial market we offer products to corporate accounts, U.S. federal government employees, local government employees, individual accounts and Medicare Supplement. We also participate in the Government of Puerto Rico Health Reform (a government of Puerto Rico-funded managed care program for the medically indigent that is similar to the Medicaid program in the U.S.) ("Medicaid"), by administering the provision of the physical health component in designated service regions in Puerto Rico.

We have the exclusive right to use the BCBS name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. As of December 31, 2013 we serve approximately 2,188,000 members across all regions of Puerto Rico. For the years ended December 31, 2013 and 2012 respectively, our managed care segment represented approximately 89.5% and 90.2% of our total consolidated premiums earned, net, and approximately 73.4% and 67.6% of our operating income. We also have significant positions in the life insurance and property and casualty insurance markets. Our life insurance segment had a market share of approximately 13.9% (in terms of premiums written) for 2012. Our property and casualty segment had a market share of approximately 8.5% (in terms of direct premiums) during the nine-month period ended September 30, 2013.

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

We participate in the life insurance market through our subsidiary, TSV, and in the property and casualty insurance market through our subsidiary, TSP. TSV and TSP represented approximately 5.9% and 4.6%, respectively, of our consolidated premiums earned, net for the year ended December 31, 2013 and 32.9% and 4.5%, respectively, of our operating income for that period.

On November 7, 2013, our subsidiary TSV completed the acquisition of 100% of the outstanding capital stock of Atlantic Southern Insurance Company ("ASICO"), a life insurance company authorized to do business in Puerto Rico, Costa Rica, Anguilla and the British Virgin Islands. The cost of this acquisition was approximately $9.4 million and was funded with unrestricted cash. Our consolidated results of operations and financial condition included in this Annual Report on Form 10-K reflect ASICO's acquisition in periods subsequent to the effective date of the transaction and were included within the Life Insurance segment.

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

The Commissioner of Insurance of the Commonwealth of Puerto Rico ("Commissioner of Insurance of Puerto Rico") recognizes only statutory accounting practices for determining and reporting the financial condition and results of operations of an insurance company, for determining its solvency under the Puerto Rico insurance laws and for determining whether its financial condition warrants the payment of a dividend to its stockholders. No consideration is given by the Commissioner of Insurance of Puerto Rico to financial statements prepared in accordance with U.S. generally accepted accounting principles ("GAAP") in making such determinations. See note 25 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:

	Years ended December 31,		
(Dollar amounts in millions)	2013	2012	2011
Premiums earned, net:			
Managed care	$1,974.7	$2,033.5	$1,846.4
Life insurance	130.6	124.7	113.0
Property and casualty insurance	100.3	97.7	97.6
Intersegment premiums earned	(2.6)	(2.5)	(2.5)
Consolidated premiums earned, net	$2,203.0	$2,253.4	$2,054.5
Administrative service fees:			
Managed care	$112.8	$114.8	$43.0
Intersegment administrative service fees	(4.1)	(4.7)	(4.5)
Consolidated administrative service fees	$108.7	$110.1	$38.5
Operating income:			
Managed care	$36.1	$47.0	$53.0
Life insurance	16.2	16.7	17.7
Property and casualty insurance	2.2	6.8	4.5
Intersegment and other	(5.1)	(0.9)	2.1
Consolidated operating income	$49.4	$69.6	$77.3

Revenue

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

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

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

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

Administrative Service Fees. Administrative service fees include amounts paid to us for administrative services provided to self-insured contracts. We provide a range of customer services pursuant to our administrative services only (“ASO”) contracts, including claims administration, billing, access to our provider networks and membership services. TSS has a contract with the Government of Puerto Rico, to administer the provision of the physical health component of the Medicaid program in designated service regions in Puerto Rico. On July 1, 2013, TSS extended this contract for a 12-month period. This amendment also transferred the administration of the three remaining service regions to TSS upon completion of a transition period, which ended on October 1, 2013. On February 5, 2014 the Government of Puerto Rico issued an RFP for the Medicaid business and announced its intention to convert the current program to a managed care organization model, under which the selected contractors will be at risk for the provision of the physical and behavioral health components of the program. We are currently evaluating the requirements of this RFP and have not concluded whether or not we will participate in the competitive bid process to retain the Medicaid business. Administrative service fees are recognized in the month in which services are provided.

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

Investment Income. Investment income consists of interest and dividend income from investment securities. See note 4 to our audited consolidated financial statements.

Expenses

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

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

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

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II. Membership

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

TSS has a contract with the Government of Puerto Rico to administer the provision of the physical health component of the Medicaid program (similar to Medicaid) in designated service regions in Puerto Rico. On July 1, 2013, TSS extended this contract for a 12-month period. This amendment also transferred the administration of the three remaining service regions to TSS upon completion of a transition period, which ended on October 1, 2013.

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

	As of December 31,		
	2013	2012	2011
Commercial (1)	654,729	703,072	711,508
Medicare (2)	112,839	122,741	113,431
Medicaid (3)	1,420,371	895,301	858,757
Total	2,187,939	1,721,114	1,683,696

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

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

(3) All are self-funded members.

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III. Results of Operations

Consolidated Operating Results

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

(Dollar amounts in millions)	2013	2012	2011
Years ended December 31,			
Revenues:			
Premiums earned, net	$2,203.0	$2,253.4	$2,054.5
Administrative service fees	108.7	110.1	38.5
Net investment income	47.3	46.8	48.2
Other operating revenues	4.8	4.3	-
Total operating revenues	2,363.8	2,414.6	2,141.2
Net realized investment gains	2.6	5.2	18.6
Net unrealized investment gain (loss) on trading securities	-	-	(7.3)
Other income, net	15.3	2.2	0.7
Total revenues	2,381.7	2,422.0	2,153.2
Benefits and expenses:			
Claims incurred	1,836.2	1,919.8	1,716.3
Operating expenses	478.2	425.2	347.6
Total operating costs	2,314.4	2,345.0	2,063.9
Interest expense	9.5	10.6	10.8
Total benefits and expenses	2,323.9	2,355.6	2,074.7
Income before taxes	57.8	66.4	78.5
Income tax expense	2.3	12.5	20.5
Net income	55.5	53.9	58.0
Net loss attributable to non-controlling interest	(0.4)	(0.1)	-
Net income attributable to TSM	$55.9	$54.0	$58.0

Year ended December 31, 2013 compared with the year ended December 31, 2012

Operating Revenues

Consolidated premiums earned, net decreased by $50.4 million, or 2.2%, to $2.2 billion during the year ended December 31, 2013 compared to the year ended December 31, 2012. The decrease was mostly the result of lower member month enrollment in the Medicare and Commercial businesses and the receipt of lower risk score adjustments from CMS in 2013 as compared to 2012.

The consolidated administrative service fees decreased by $1.4 million, or 1.3%, to $108.7 million for the year ended December 31, 2013 when compared with the year ended December 31, 2012. This fluctuation primarily reflects the effect of the amended Medicaid contract, which includes lower per-member per-month fees, offset in part by the increased enrollment after the addition of the three new regions effective October 1, 2013. The new rate per-member per-month fees were effective July 1, 2013.

Net Realized Investment Gains

Consolidated net realized investment gains of $2.6 million during the year ended December 31, 2013 are the result of net realized gains from the sale of debt and equity securities classified as available for sale, following our asset/liability management and tax planning strategies. The net realized gains were partially offset by a $1.0 million other-than-temporary impairments related to certain equity securities that have been at an unrealized loss for a period exceeding six months.

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Other Income, Net

Consolidated other income increased by $13.1 million during the year ended December 31, 2013 compared with to the year ended December 31, 2012 mostly due to a special distribution received from the Puerto Rico Joint Underwriting Association (“JUA”) in the Property and Casualty segment of $12.8 million, net of a special tax.

Claims Incurred

Consolidated claims incurred during the year ended December 31, 2013 decreased by $83.6 million, or 4.4%, to $1.8 billion when compared to the claims incurred during the year ended December 31, 2012. This decrease in the claims incurred primarily results from the lower Managed Care member month enrollment and lower utilization and cost trends in the Medicare and Commercial businesses year over year. This decrease was partially offset by an increase in claims of the Life and Property and Casualty segments. The consolidated loss ratio decreased by 190 basis points to 83.3%.

Operating Expenses

Consolidated operating expenses during the year ended December 31, 2013 increased by $53.0 million, or 12.5%, to $478.2 million as compared to the operating expenses during the year ended December 31, 2012. For the year ended December 31, 2013, the consolidated operating expense ratio increased by 270 basis points to 20.7%, The higher operating expenses and operating expenses ratio are mainly related to special technology initiatives, expenses related to the reorganization of the Medicare business, higher payroll and related expenses mostly as a result of recruitment of additional Medicare sales force, and additional expenses incurred to serve the additional three Medicaid regions effective October 1, 2013. Professional services also reflect an increase related to our CMS star ratings efforts. Operating expenses for the year ended December 31, 2013 also include approximately $5.0 million in premium taxes. These premium taxes became effective on July 1, 2013.

Income tax expense

Consolidated income tax expense during the year ended December 31, 2013 decreased by $10.2 million, or 81.6%, to $2.3 million as compared to the income tax expense during the year ended December 31, 2012. This decrease is primarily due to the effect of a $7.7 million adjustment to the consolidated net deferred tax assets after an increase in the enacted tax rate from 30% to 39% and the lower income before taxes during the year 2013, net of additional tax expense due to the aforementioned tax rate increase that was effective January 1, 2013. The effective tax rate decreased from 14.8% in 2012 to 4.0% in 2013 primarily reflecting the net effect of the change in the enacted tax rate.

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

Operating Revenues

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

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

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

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

Net Realized Investment Gains

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

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Other Income, Net

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

Claims Incurred

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

Operating Expenses

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

Income tax expense

Consolidated income tax expense during the year ended December 31, 2012 decreased by $8.0 million, or 39.0%, to $12.5 million as compared to the income tax expense during the year ended December 31, 2011. The effective tax rate decreased by 730 basis points, to 18.8%, during the year ended December 31, 2012. The consolidated income tax expense for the year ended December 31, 2011 includes a one-time charge of $6.4 million resulting from the reduction of the net deferred tax assets following the reduction in income tax rates after the enactment of the new Puerto Rico tax reform, which was effective January 2011, that reduced the maximum corporate tax rate from 39% to approximately 30%.

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Managed Care Operating Results

We offer our products in the managed care segment to three distinct market sectors in Puerto Rico: Commercial, Medicare (including Medicare Advantage and PDP) and Medicaid. For the year ended December 31, 2013, the Commercial sector represented 42.4% and -17.6% of our consolidated premiums earned, net and operating income, respectively. Premiums earned, net and operating income generated from our Medicare contracts (including PDP) during the year ended December 31, 2013 represented 47.2% and 58.4%, respectively, of our consolidated earned premiums, net and operating income, respectively. The operating income of the Medicaid sector represented 32.5% of the consolidated operating income for the year ended December 31, 2013.

(Dollar amounts in millions)	2013		2012		2011	
Operating revenues:						
Medical premiums earned, net:						
Commercial	$935.8		$960.0		$947.1	
Medicare	1,038.9		1,073.5		896.6	
Medicaid	-		-		2.7	
Medical premiums earned, net	1,974.7		2,033.5		1,846.4	
Administrative service fees	112.8		114.8		43.0	
Net investment income	16.3		16.4		17.5	
Total operating revenues	2,103.8		2,164.7		1,906.9	
Medical operating costs:						
Medical claims incurred	1,712.9		1,806.4		1,610.5	
Medical operating expenses	354.8		311.3		243.4	
Total medical operating costs	2,067.7		2,117.7		1,853.9	
Medical operating income	$36.1		$47.0		$53.0	
Additional data:						
Member months enrollment:						
Commercial:						
Fully-insured	5,503,281		5,817,009		5,806,053	
Self-funded	2,595,162		2,681,962		2,744,431	
Total Commercial member months	8,098,443		8,498,971		8,550,484	
Medicaid:						
Self-funded	12,280,349		10,562,571		1,718,888	
Total Medicaid member months	12,280,349		10,562,571		1,718,888	
Medicare:						
Medicare Advantange	1,274,652		1,354,301		1,132,634	
Stand-alone PDP	97,496		101,675		105,987	
Total Medicare member months	1,372,148		1,455,976		1,238,621	
Total member months	21,750,940		20,517,518		11,507,993	
Medical loss ratio	86.7	%	88.8	%	87.2	%
Operating expense ratio	17.0	%	14.5	%	12.9	%

Year ended December 31, 2013 compared with the year ended December 31, 2012

Medical Operating Revenues

Medical premiums earned for the year ended December 31, 2013 decreased by $58.8 million, or 2.9%, to $2.0 billion when compared to the medical premiums earned during the year ended December 31, 2012. This decrease is principally the result of the following:

- Medical premiums generated by the Medicare business decreased by $34.6 million, or 3.2%, to $1.0 billion. This fluctuation is the result of an overall decrease in the member month enrollment of this business by 83,828, or 5.8%, when compared with the same period in 2012. Decrease in member month enrollment was attributed to lower sales of our non-dual offerings. This fluctuation also results from the receipt of a lower risk score adjustments from CMS in 2013 as compared to 2012. The 2013 and 2012 periods include the net effect of approximately $2.9 million and $12.6 million, respectively, related to CMS final risk scores adjustments corresponding to prior periods.

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- Medical premiums generated by the Commercial business decreased by $24.2 million, or 2.5%, to $935.8 million during the year ended December 31, 2013 as compared to the year ended December 31, 2012. This fluctuation is primarily the result of a decrease in member month enrollment by 313,728, or 5.4%, which was partially offset by an increase in average premium rates of approximately 3.0%. The decrease in member month enrollment is mostly due to the non-renewal of one large commercial account and a higher level of attrition, due to the prevailing economic conditions in the island.

Administrative service fees decreased by $2.0 million, or 1.7%, to $112.8 million during the year ended December 31, 2013 when compared with the year ended December 31, 2012. This fluctuation primarily reflects the effect of the amended Medicaid contract, which includes lower per-member per-month fees, offset in part by the increased enrollment after the addition of the three new regions effective October 1, 2013. The new rate per-member per-month fees were effective July 1, 2013.

Medical Claims Incurred

Medical claims incurred during the year ended December 31, 2013 decreased by $93.5 million, or 5.2%, to $1.7 billion, when compared to the year ended December 31, 2012. The MLR of the segment was 86.7%, decreasing by 210 basis points during the year ended December 31, 2013. These fluctuations are primarily attributed to the effect of the following:

- The medical claims incurred of the Medicare business decreased by $79.9 million, or 8.4%, during the 2013 period and its MLR was 84.0%, which is 480 basis points lower than the MLR for the prior year. The lower member month enrollment in this sector contributed to the decrease in claims incurred. Excluding the effect of risk-score premium adjustments and prior period reserve developments in the 2013 and 2012 periods, the MLR decreased by 460 basis points, mostly as the result of lower utilization and cost trends. The decrease also reflects improved drug costs after the new PBM contract in AH and the impact of changes in 2013 product design.

- The medical claims incurred of the Commercial business decreased by $12.6 million, 1.5%, during the 2013 period mostly reflecting a lower fully-insured member month enrollment. The Commercial MLR was 89.5%, which is 90 basis points higher than the MLR for the prior year. Excluding the effect of prior period reserve developments in 2013 and 2012, the MLR would have increased by 170 basis points, mostly reflecting higher utilization, plus a higher loss ratio in our USVI operation, principally as a result of higher cost and utilization trends during the year.

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2013 increased by $43.5 million, or 14.0%, to $354.8 million when compared to the year ended December 31, 2012. The operating expense ratio increased by 250 basis points, from 14.5% in 2012 to 17.0% in 2013. This increase is mainly related to on-going special project initiatives related to TSS's core system upgrade to QNXT 5.0, the implementation of a new financial system, expenses related to the reorganization of the Medicare business, higher payroll and related expenses mostly as a result of recruitment of additional Medicare sales force, an increase in professional services related to our Medicare risk scoring and CMS star ratings efforts, consultants' fees for the Medicare integration process, premium taxes amounting to $3.8 million, and incremental expenses related to the administration of the three new service regions of the Medicaid program effective October 1, 2013. These premium taxes became effective on July 1, 2013.

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

Medical Operating Revenues

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

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

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

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

Medical Claims Incurred

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

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

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

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

Medical Operating Expenses

Medical operating expenses for the year ended December 31, 2012 increased by $67.9 million, or 27.9%, to $311.3 million when compared to the year ended December 31, 2011, primarily resulting from the higher member month enrollment in 2012. The operating expense ratio increased by 160 basis points, from 12.9% in 2011 to 14.5% in 2012, reflecting a higher amount of self-insured contracts after resuming our participation in the Medicaid sector in November 2011.

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Life Insurance Operating Results

(Dollar amounts in millions)	2013	2012	2011
Years ended December 31,			
Operating revenues:			
Premiums earned, net			
Premiums earned, net	$139.5	$132.7	$118.8
Premiums earned ceded	(8.9)	(8.0)	(5.8)
Premiums earned, net	130.6	124.7	113.0
Net investment income	22.2	20.8	18.5
Total operating revenues	152.8	145.5	131.5
Operating costs:			
Policy benefits and claims incurred	70.8	66.4	57.5
Underwriting and other expenses	65.8	62.4	56.3
Total operating costs	136.6	128.8	113.8
Operating income	$16.2	$16.7	$17.7
Additional data:			
Loss ratio	54.2 %	53.2 %	50.9 %
Expense ratio	50.4 %	50.0 %	49.8 %

Year ended December 31, 2013 compared with the year ended December 31, 2012

Operating Revenues

Premiums earned, net for the segment increased by $5.9 million, or 4.7%, to $130.6 million during the year ended December 31, 2013 as compared to the year ended December 31, 2012, primarily as the result of new sales in the Cancer and Individual Life businesses during the period. Of the increase experienced year over year, $1.4 million is related to premiums earned by ASICO, the insurance company acquired by TSV in November 2013.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred increased by $4.4 million, or 6.6%, to $70.8 million during the year ended December 31, 2013. This increase is the result of claims received in the 2013 period, reflecting the growth of the segment's inforce portfolio and the addition $0.8 million of claims related to the ASICO acquisition. The loss ratio for the period increased from 53.2% in 2012 to 54.2% in 2013, or 100 basis points.

Underwriting and Other Expenses

Underwriting and other expenses for the segment increased by $3.4 million, or 5.4%, to $65.8 million during the year ended December 31, 2013, mostly related to a lower amount of expenses capitalized as Deferred Policy Acquisition Costs, primarily resulting from lower commission expenses, premium taxes and approximately $0.9 million of expenses related to the ASICO acquisition. As a result, the operating expense ratio slightly increased 40 basis points, from 50.0% in 2012 to 50.4% in 2013.

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

Operating Revenues

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

Policy Benefits and Claims Incurred

Policy benefits and claims incurred increased by $8.9 million, or 15.5%, to $66.4 million during the year ended December 31, 2012. This fluctuation is primarily the result of higher claims received for the Cancer line of business, and also to an increase in the liability for future policy benefits that was driven by new business subscribed in the period and improved persistency on the Individual Life business. The loss ratio for the period increased from 50.9% in 2011 to 53.2% in 2012, or 230 basis points.

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Underwriting and Other Expenses

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

Property and Casualty Insurance Operating Results

(Dollar amounts in millions)	2013	2012	2011
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$152.3	$162.7	$152.9
Premiums ceded	(57.6)	(63.5)	(63.0)
Change in unearned premiums	5.6	(1.5)	7.7
Premiums earned, net	100.3	97.7	97.6
Net investment income	8.3	8.9	9.5
Total operating revenues	108.6	106.6	107.1
Operating costs:			
Claims incurred	55.1	49.3	48.2
Underwriting and other operating expenses	51.3	50.5	54.4
Total operating costs	106.4	99.8	102.6
Operating income	$2.2	$6.8	$4.5
Additional data:			
Loss ratio	54.9 %	50.5 %	49.4 %
Expense ratio	51.1 %	51.7 %	55.7 %

Year ended December 31, 2013 compared with the year ended December 31, 2012

Operating Revenues

Total premiums written during the year ended December 31, 2013 decreased by $10.4 million, or 6.4%, to $152.3 million, mostly resulting from lower sales of Dwelling and Commercial insurance products. The commercial business remains under soft market conditions with strong competition.

Premiums ceded to reinsurers during the year ended December 31, 2013 decreased by approximately $5.9 million, or 9.3%, to $57.6 million. The ratio of premiums ceded to premiums written decreased by 120 basis points, to 37.8% in 2013, mostly resulting from a change in the mix of business subscribed and lower volume of premiums during 2013.

The change in unearned premiums presented an increase of $7.1 million, to $5.6 million during the year ended December 31, 2013, primarily as the result of the lower volume of premiums written during this period.

Claims Incurred

Claims incurred during the year ended December 31, 2013 increased by $5.8 million, or 11.8%, to $55.1 million. The loss ratio increased by 440 basis points, to 54.9% in 2013, as a result of unfavorable loss experience in the Commercial Package, General Liability and Auto Insurance lines of business. The increase also responds to a lower proportion of Dwelling business in our portfolio.

Underwriting and Other Expenses

Underwriting and other operating expenses for the year ended December 31, 2013 increased by $0.8 million, or 1.6%, to $51.3 million. The increase is mainly related to an assessment received from the Puerto Rico Guarantee Fund and recorded as a charge to operations of $0.6 million to cover the insolvencies of insurers under liquidation. The operating expense ratio decreased by 60 basis points during the same period, to 51.1% in 2013.

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

Operating Revenues

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

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

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

Claims Incurred

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

Underwriting and Other Expenses

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

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IV. Liquidity and Capital Resources

Cash Flows

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

(dollar amounts in millions)	2013	2012	2011
Years ended December 31,			
Sources of cash:			
Net cash provided by operating activities	$112.9	$109.7	$162.5
Proceeds from annuity contracts	9.2	39.7	31.8
Proceeds from exercise stock options	-	0.3	0.2
Net proceeds from borrowings	-	30.0	-
Other	15.1	-	4.4
Total sources of cash	137.2	179.7	198.9
Uses of cash:			
Net purchases of investment securities	(66.2)	(91.1)	(13.6)
Cash settlements of stock options	-	-	(2.4)
Capital expenditures	(11.8)	(12.1)	(16.3)
Payments of long-term borrowings	(12.0)	(26.9)	(51.6)
Payments of short-term borrowings	(30.0)	-	(15.6)
Surrenders of annuity contracts	(9.4)	(7.1)	(6.6)
Repurchase and retirement of common stock	(18.2)	(2.3)	(11.3)
Acquisition of business, net of cash of $4.6, $0.8 and $29.4 in the year ended December 31, 2013, 2012 and 2011, respectively	(4.8)	(2.7)	(54.7)
Other	-	(19.8)	-
Total uses of cash	(152.4)	(162.0)	(172.1)
Net (decrease) increase in cash and cash equivalents	$(15.2)	$17.7	$26.8

Year ended December 31, 2013 compared to year ended December 31, 2012

Cash flows from operating activities increased by $3.2 million for the year ended December 31, 2013 as compared to the year ended December 31, 2012, principally due to the effect of lower claims paid by $70.6 million, offset in part by lower premiums collections by $53.6 million and higher cash paid to suppliers and employees by $9.0 million. The decrease in premiums collected is principally the result of the lower Managed Care membership enrollment. The decrease in claim payments mostly results from the lower enrollment in the Managed Care membership. This decrease also reflects improved drug costs after the new PBM contract in AH and the impact of changes in 2013 product design.

During the year ended December 31, 2013 we received $9.2 million in policyholder deposits. This represents a decrease of $30.5 million when compared to the prior year and is the result of lower sales of annuity products. The Corporation has reduced the pricing for this product due to the current interest rate scenario.

Net proceeds from short-term borrowings decreased by $30.0 million during the year ended December 31, 2013, addressing timing differences between cash receipts and disbursements.

The increase in other sources of cash for the year ended December 31, 2013 is attributed to changes in the amount of outstanding checks in excess of bank balances.

Net purchases of investment securities were $66.2 million during the year ended December 31, 2013, $24.9 million lower than last year, primarily resulting from the investment of lower excess cash flows from operations.

Payments of long-term borrowings of $12.0 million during the year ended December 31, 2013 are primarily the result of a $10.0 million prepayment of one of our senior unsecured notes. The $14.9 million decrease in payments of long-term debt is due to the prepayment of another senior unsecured note of $25.0 million during the year ended December 31, 2012.

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Repurchase and retirement of common stock increased by $15.9 million mainly due to the repurchase and retirement of 1,000,000 shares of common stock as part of the completed secondary public offering conducted during the year ended December 31, 2013.

On November 7, 2013, we completed the acquisition of 100% of the outstanding shares of capital stock of ASICO for an aggregate purchase price of approximately $4.8 million, net of $4.6 million of cash acquired. On January 18, 2012, we acquired a controlling stake in a health clinic in Puerto Rico at a cost of $2.7 million, net of $0.8 million of cash acquired. On February 7, 2011, we acquired AH at a cost of $54.0 million, net of $30.1 million of cash acquired.

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

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

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

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

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

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

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

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

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

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

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

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

Share Repurchase Program

On September 29, 2010, we announced the immediate commencement of the 2010 stock repurchase program. The program is conducted using available cash through open-market purchases and privately-negotiated transactions of Class B shares only, in accordance with Rules 10b-18 and 10b5-1 under the Securities Exchange Act of 1934, as amended. On March 23, 2013, we discontinued our 2010 stock repurchase program.

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On March 6, 2013, the Company's Board authorized the repurchase of up to $30.0 million of Class B shares concurrent with the conversion of 7 million Class A shares into Class B shares and the public offering of a substantial majority of such convertible shares. As part of the Offering, on May 17, 2013, the Company repurchased and retired 1,000,000 shares at a price of $18.25 per share.

During the year ended December 31, 2012 we repurchased and retired 136,222 shares at an average per share price of $16.86, for an aggregate cost of $2.3 million.

In July 29, 2013 the Company's Board of Directors authorized an $11.5 million repurchase program of its Class B common stock.

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, 2013, we had $110.0 million of available credit under these facilities. There are no outstanding short-term borrowings under these facilities as of December 31, 2013.

On December 21, 2005, we issued and sold $60.0 million of our 6.6% senior unsecured notes due December 2020 (the "6.6% notes"). The 6.6% notes were privately placed to various institutional accredited investors. The notes pay interest each month until the principal becomes due and payable. These notes can be redeemed after five years at par, in whole or in part, as determined by us. On October 1, 2010 we repaid $25.0 million of the principal of these senior unsecured notes. The 6.6% notes contain certain non-financial covenants. At December 31, 2013, we are in compliance with these covenants.

On November 1, 2010, we entered into a $25.0 million arrangement to sell securities under repurchase agreements that matures on November 2015. The repurchase agreement pays interest quarterly at 1.96%. The investment securities underlying such agreements were delivered to the financial institution with whom the agreement was transacted. The dealers may have loaned, or used as collateral such securities in the normal course of business operations. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on our consolidated balance sheet. At December 31, 2013 investment securities available for sale with fair value of $27.9 million (face value of $27.8 million) were pledged as collateral under this agreement. The proceeds obtained from this agreement were used to repay $25.0 million of the 6.6% notes.

In addition, we are a party to a secured term loan with a commercial bank in Puerto Rico. This secured loan, with original principal balance of $41,000, bears interest at a rate equal to the London Interbank Offered Rate (LIBOR) plus 100 basis points and requires monthly principal repayments of $0.1 million. As of December 31, 2013, this secured loan had an outstanding balance of $16.1 million and average annual interest rate of 1.29%. This secured loan is guaranteed by a first lien on our land, buildings and substantially all leasehold improvements, as collateral for the term of the agreements under a continuing general security agreement. This secured loan contains certain non-financial covenants which are customary for this type of facility, including, but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. As of December 31, 2013, we are in compliance with these covenants. Failure to meet these non-financial covenants may trigger the accelerated payment of the secured loan's outstanding balances.

As part of the acquisition of the controlling stake in a health clinic during 2012, we assumed a secured term loan with balance of $13.2 million as of December 31, 2013. The loan requires monthly payments of $0.1 million, including principal and interest, is due on December 23, 2014, with a final payment of $12.9 million and bears interest at an annual rate of 4.75%. This loan is guaranteed by a first position held by the bank on the health clinic's premises (land and building) and all of the health clinic's assets as collateral for the term of the loan under a continuing general security agreement. This secured loan contains certain financial and non-financial covenants, which are customary for this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. During the year 2013, the health clinic was in default with the loan's debt service ratio financial covenant, which required the health clinic to open and maintain a deposit account, which was funded by the Company, with the bank until the health clinic meets the financial covenant.

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

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Planned Capital Expenditures

Federal regulations require that we begin using a new set of standardized diagnostic codes, known as ICD-10, by October 2014, which will require a significant information technology investment. In order to become ICD-10 compliant, we changed TSS's core business application, which we implemented in the third quarter of 2012. We completed the version upgrade process of such business application in the third quarter and expect to have completed the migration of our membership on time to comply with the current ICD-10 deadline. The estimated cost of the core business application upgrade and ICD-10 compliance efforts is approximately $6.5 million.

Contractual Obligations

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

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

- Unearned premiums – This amount accounts for the premiums collected prior to the end of coverage period and does not represent a future cash outflow. As of December 31, 2013, we had $87.4 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, 2013, our policyholder deposits had a carrying amount of $115.9 million.

- Other long-term liabilities – Due to the indeterminate nature of their cash outflows, $83.6 million of other long-term liabilities are not reflected in the following table, including $54.7 million of liability for pension benefits, $20.8 million in deferred tax liabilities, and $8.1 million in liabilities to the Federal Employees' Health Benefits Plan Program.

	Contractual obligations by year						
(Dollar amounts in millions)	Total	2014	2015	2016	2017	2018	Thereafter
Long-term borrowings (1)	$108.1	$18.5	$29.6	$4.1	$4.1	$4.1	$ 47.7
Operating leases	23.0	6.2	5.0	4.5	2.9	1.8	2.6
Purchase obligations (2)	204.1	183.8	17.5	1.5	0.5	0.5	0.3
Claim liabilities (3)	382.9	270.4	79.7	7.5	9.0	5.7	10.6
Estimated obligation for future policy benefits (4)	330.7	60.1	58.0	56.0	54.2	52.0	50.4
	$1,048.8	$539.0	$189.8	$73.6	$70.7	$64.1	$ 111.6

(1) As of December 31, 2013, our long-term borrowings consist of our 6.6% senior unsecured notes payable, a $25.0 million arrangement to sell securities under repurchase agreements which requires quarterly interest payments at 1.96%, and loans payable to commercial banks. Total contractual obligations for long-term borrowings include the current maturities of long term debt. For the 6.6% senior unsecured notes and the arrangement to sell securities under repurchase agreements, scheduled interest payments were included in the total contractual obligations for

long-term borrowings until the maturity dates of the notes in 2020, and 2015 respectively. We may redeem the senior unsecured note starting five years after issuance; however no redemption is considered in this schedule. The interest payments related to our loans payable were estimated using the interest rate applicable as of December 31, 2013. The actual amount of interest payments of the loan payable will differ from the amount included in this schedule due to the loan's variable interest rate structure. See the "Financing and Financing Capacity" section for additional information regarding our long-term borrowings.

(2) Purchase obligations represent payments required by us under material agreements to purchase goods or services that are enforceable and legally binding and where all significant terms are specified, including: quantities to be purchased, price provisions and the timing of the transaction. Other purchase orders made in the ordinary course of business for which we are not liable are excluded from the table above. Estimated pension plan contributions amounting to \$8.0 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, 2013. The expected claims payments are an estimate and may differ materially from the actual claims payments made by us in the future. Also, claim liabilities are presented gross, and thus do not reflect the effects of reinsurance under which \$37.6 million of reserves had been ceded at December 31, 2013.

(4) Our life insurance segment establishes, and carries as liabilities, actuarially determined amounts that are calculated to meet its policy obligations when a policy matures or surrenders, an insured dies or becomes disabled or upon the occurrence of other covered events. A significant portion of the estimated obligation for future policy benefits to be paid included in this table considers contracts under which we are currently not making payments and will not make payments until the occurrence of an insurable event not under our control, such as death, illness, or the surrender of a policy. We have estimated the timing of the cash flows related to these contracts based on historical experience as well as expectations of future payment patterns. The amounts presented in the table above represent the estimated cash payments for benefits under such contracts based on assumptions related to the receipt of future premiums and assumptions related to mortality, morbidity, policy lapses, renewals, retirements, disability incidence and other contingent events as appropriate for the respective product type. All estimated cash payments included in this table are not discounted to present value nor do they take into account estimated future premiums on policies in-force as of December 31, 2013 and are gross of any reinsurance recoverable. The \$330.7 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of \$304.4 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual experience and the assumptions used in the estimation of these payments.

Off-Balance Sheet Arrangements

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

Restriction on Certain Payments by the Corporation’s Subsidiaries

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

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

As of December 31, 2013, our insurance subsidiaries were in compliance with such minimum capital requirements.

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

Our secured term loan, with original principal balance of $41,000, restricts the amount of dividends that we and our subsidiaries can declare or pay to shareholders. Under this 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, TSS and AH to comply with certain specified levels of RBC. RBC is designed to identify weakly capitalized companies by comparing each company's adjusted surplus to its required surplus (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2013, TSM and TSS estimated RBC ratio was above the minimum BCBSA RBC requirement of 200% and the 375% of RBC level required by the BCBSA to avoid monitoring. At December 31, 2013, AH estimated RBC ratio was above the minimum BCBSA RBC requirement of 100% for smaller controlled affiliate.

Other Contingencies

Legal Proceedings

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

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

Guarantee Associations and Other Regulatory Commitments

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. In 2013, the property and casualty segment paid $0.6 million for an assessment imposed by the Puerto Rico Guaranty Association for Property and Casualty Insurers. In accordance with insurance laws and regulations assessments are recoverable through policy surcharges. In 2013, the property and casualty segment has recorded recoveries of assessments for $15 thousand. During the years ended December 31, 2012 and 2011, no assessment or payment was made in connection with insurance companies declared insolvent. It is the opinion of management that any possible future guarantee association assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

Pursuant to the Puerto Rico Insurance Code, our property and casualty insurance subsidiary is a member of Sindicato de Aseguradores para la Suscripción Conjunta de Seguros de Responsabilidad Profesional Médico-Hospitalaria (SIMED). The syndicate was organized for the purpose of underwriting medical-hospital professional liability insurance. As a member, the property and casualty insurance segment shares risks with other member companies and, accordingly, is contingently liable in the event the syndicate cannot meet their obligations. During 2013, 2012 and 2011, no assessment or payment was made for this contingency. It is the opinion of management that any possible future syndicate assessments will not have a material effect on our operating results and/or cash flows, although there is no ceiling on these payment obligations.

In addition, our property and casualty insurance subsidiary is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the “Association”). The Association was organized in 1997 to underwrite insurance coverage of motor vehicle property damage liability risks effective January 1, 1998. As a participant, the segment shares the risk proportionally with other members based on a formula established by the Insurance Code. During the years 2013, 2012 and 2011, the Association distributed the Company a distribution based on the good experience of the business amounting to $1.2 million, $1.2 million and $1.3 million, respectively. In September 2013, the Association declared a special distribution to its members for $200 million. This distribution was subject to a special and unique tax rate of 50%. The property and casualty then received $12.8 million, net of tax, from this distribution.

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The property and casualty segment is also member of the Puerto Rico Fire and Allied Lines Underwriting Association and the Puerto Rico Auto Assign Plan. These entities periodically impose assessments to cover operations and other charges. The assessments recorded from these entities were $3 thousand in 2013. No assessments were received in 2012 and 2011.

V. Critical Accounting Policies

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

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

Claim Liabilities

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

(Dollar amounts in millions)

Managed care	$283.1
Property and casualty insurance	93.6
Life insurance	43.7
Consolidated	$420.4

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:

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Managed Care Segment

At December 31, 2013, claim liabilities for the managed care segment amounted to $283.6 million and represented 67.5% of our total consolidated claim liabilities and 22.3% of our total consolidated liabilities.

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

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

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

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

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, 2013 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

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(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%	$ 13.3	0.75 %	$ 9.9
-0.4%	8.7	0.50 %	6.7
-0.2%	4.2	0.25 %	3.3
0.2 %	(9.5)	-0.25%	(3.3)
0.4 %	(13.8)	-0.50%	(6.7)
0.6 %	(17.8)	-0.75%	(9.9)

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

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

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately settled. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claims payments, or run-out becomes known. This information is compared to the originally established year-end liability. Negative amounts reported for incurred claims related to prior years result from claims being settled for amounts less than originally estimated. The reverse is true of reserve shortfalls. Medical claim liabilities are usually described as having a "short tail": which means that they are generally paid within several months of the member receiving service from the provider. Accordingly, the majority, or approximately 93%, of any redundancy or shortfall relates to claims incurred in the previous calendar year-end, with the remaining 7% related to claims incurred prior to the previous calendar year-end. Management has not noted any significant emerging trends in claim frequency and severity and the normal fluctuations in enrollment and utilization trends from year to year.

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

(Dollar amounts in millions)	2012	2011	2010	2009
Years ended December 31,				
Total incurred claims:				
As reported [(1)]	$1,811.0	$1,612.1	$1,503.3	$1,512.1

On a retrospective basis	1,789.4	1,607.5	1,495.6	1,506.5
Variance	$21.6	$4.6	$7.7	$5.6
Variance to total incurred claims as reported	1.2 %	0.3 %	0.5 %	0.4 %

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

Management expects that substantially all of the development of the 2013 estimate of medical claims payable will be known during 2014 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.

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

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

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

Life Insurance Segment

At December 31, 2013, claim liabilities for the life insurance segment amounted to $43.7 million and represented 10.4% of total consolidated claim liabilities and 3.5% of our total consolidated liabilities.

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

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

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

Property and Casualty Insurance Segment

At December 31, 2013, claim liabilities for the property and casualty insurance segment amounted to $93.6 million and represented 22.3% of the total consolidated claim liabilities and 7.4% of our total consolidated liabilities.

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

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

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

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

At December 31, 2013, the actuarial reserve range determined by the actuaries was from $84 million to $99 million. Management reviews the results of the reserve estimates in order to determine any appropriate adjustments in the recording of reserves. Adjustments to reserve estimates are made after management's consideration of numerous factors, including but not limited to the magnitude of the difference between the actuarial indication and the recorded reserves, improvement or deterioration of actuarial indications in the period, the maturity of the accident year, trends observed over the recent past and the level of volatility within a particular line of business. In general, changes are made more quickly to more mature accident years and less volatile lines of business. Varying the net expected loss ratio by +/-1% in all lines of business for the six most recent accident years would increase/decrease the claims incurred by approximately $5.8 million.

Liability for Future Policy Benefits

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

Liabilities for future policy benefits for whole life and term insurance products and active life reserves for accident and health products are computed by the net level premium method, using interest assumptions ranging from 4.90% to 5.75% and withdrawal, mortality, morbidity and maintenance expense assumptions appropriate at the time the policies were issued (or when a block of business was purchased, as applicable). Accident and health unpaid claim reserves are stated at amounts determined by estimates on individual claims and estimates of unreported claims based on past experience. Liabilities for universal life policies are stated at policyholder account values before surrender charges. Deferred annuity reserves are carried at the account value.

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

Deferred Policy Acquisition Costs and Value of Business Acquired

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

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

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

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

Impairment of Investments

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

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

- Identification and evaluation of securities that have possible indications of other-than-temporary impairment, which includes an analysis of all investments with gross unrealized investments losses that represent 20% or more of cost and all investments with an unrealized loss greater than $100 thousand.

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

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

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

- Equity securities are considered to be impaired when a position is at an unrealized loss for a period longer than 6 months.

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

During the year ended December 31, 2013, we recognized other-than-temporary impairments amounting to $1.0 million on equity securities classified as available for sale that had been in an unrealized loss position for a period longer than six months. During the year ended December 31, 2012, there were no realized losses associated with other-than-temporary impairments, as compared to the $0.3 million recognized in 2011 on fixed income, equity securities and perpetual preferred stocks classified as available for sale. As of December 31, 2013, the investment in securities of $1.3 billion is classified as either available-for-sale or held-to-maturity and consists of high-quality investments. Of this amount, $906.2 million, or 69.6%, 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 $395.9 million, or 30.4%, are corporate fixed income securities, equity securities and mutual funds. The gross unrealized gains and losses as of December 31, 2013 of the available-for-sale and held-to-maturity portfolios amounted to $90.0 million and $11.8 million, respectively.

The impairment analysis as of December 31, 2013 indicated that, other than those securities for which an other-than-temporary impairment was recognized, none of the securities whose carrying amount exceeded its estimated fair value was considered other-than-temporarily impaired as of that date; however, several factors are beyond management's control, such as the following: financial condition of the issuer, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management's judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income.

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

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, 2013 and 2012 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 $21.5 million and $24.4 million as of December 31, 2013 and 2012, 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.

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

Goodwill and Other Intangible Assets

Our consolidated goodwill and other intangible assets at December 31, 2013 were $25.4 million and $18.3 million, respectively. At December 31, 2012 the consolidated goodwill and other intangible assets were $27.8 million and $26.9 million, respectively. The goodwill and other intangible assets balance for both years were primarily related to the acquisition AH in 2011. At December 31, 2013 the AH goodwill and other intangible assets were $25.0 million and $12.9 million, respectively. At December 31, 2012 the AH goodwill and other intangible assets were $25.0 million and $18.9 million, respectively.

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

As required by FASB guidance, we completed our annual impairment tests of existing goodwill during the fourth quarter of 2013 and 2012. These tests involve the use of estimates related to the fair value of the reporting unit and require a significant degree of management judgment and the use of subjective assumptions. Certain interim impairment tests are also performed when potential impairment indicators exist or other changes in our business occur.

The result of the impairment test performed in 2013 indicated that the fair value of the AH unit exceeded its carrying value by over 60%. The impairment test performed for the health clinic resulted in a goodwill impairment charge of $2.4 million; there is no remaining goodwill carrying value for this unit as of December 31, 2013.

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

The income approach is developed using assumptions about future premiums, expected claims, MLR, operating expenses and net income derived from our internal planning process and historical trends. These estimated future cash flows are then discounted. Our assumed discount rate is based on our industry’s weighted average cost of capital. Market valuations are based on observed multiples of certain measures including membership, revenue and EBITDA (earnings before interest, taxes, depreciation and amortization) and include market comparisons to publicly traded companies in our industry. It assumes the effective implementation of measures to contain the utilization and cost trends. Events or changes in circumstances, including a decrease in membership, an increase in MLR and/or operating expenses, could result in goodwill impairment.

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

Other Significant Accounting Policies

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

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VI. Recently Issued Accounting Standards

In July 2011, the FASB issued guidance to address questions about how health insurers should recognize and classify in their income statements fees mandated by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. A health insurer's portion of the annual fee becomes payable to the U.S. Treasury once the entity provides health insurance for any U.S. health risk for each applicable calendar year. The amendments specify that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. This guidance is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. We currently estimate that for 2014 such fee will represent approximately 1.5% of the managed care premiums earned, which we expect to recover a substantial amount from our customers.

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

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

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

On February 5, 2013 the FASB issued guidance to improve the transparency of reporting reclassifications out of accumulated other comprehensive income. In particular, the guidance requires an entity to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. This guidance applies to all entities that issue financial statements that are presented in conformity with GAAP and that report items of other comprehensive income. The Company adopted this guidance in January 1, 2013; there was no significant impact on our financial position or results of operations as a result of the adoption.

On July 18, 2013, the FASB issued guidance regarding the presentation in the statement of financial position of an unrecognized tax benefit when a net operating loss carry-forward or a tax credit carry-forward exists. In particular, the guidance provides that an entity's unrecognized tax benefit, or a portion of its unrecognized tax benefit, should be presented in its financial statements as a reduction to a deferred tax asset for a net operating loss carry-forward, a similar tax loss, or a tax credit carry-forward, with one exception. That exception states that, to the extent a net operating loss carry-forward, a similar tax loss, or a tax credit carry-forward is not available at the reporting date under the tax law of the applicable jurisdiction to settle any additional income taxes that would result from the disallowance of a tax position, or the tax law of the applicable jurisdiction does not require the entity to use, and the entity does not intend to use, the deferred tax asset for such purpose, the unrecognized tax benefit should be presented in the financial statements as a liability and should not be combined with deferred tax assets. This guidance is effective for public companies for fiscal years and interim periods within such years beginning after December 15, 2013. We are currently evaluating the impact, if any, the adoption of this guidance will have on the financial position or results of operations.

Other than the accounting pronouncement disclosed above, there were no other new accounting pronouncements issued that could have a material impact on Company's our financial position, operating results or financials statement disclosures.

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Item 7A. Quantitative and Qualitative Disclosures About Market Risk

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

Market Risk Exposure

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

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

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

Our investment portfolio is predominantly comprised of obligations of U.S. government-sponsored enterprises, U.S. Treasury securities, obligations of state and political subdivisions, obligations of the Commonwealth of Puerto Rico, which represents only 3.5% of the total portfolio value as of December 31, 2013, municipal securities and obligations of U.S. states and its political subdivisions and obligations from U.S. and Puerto Rican government instrumentalities. These investments comprised approximately 69.6% of the total portfolio value as of December 31, 2013, of which 10.9% consisted of U. S. agency-backed mortgage backed securities and collateralized mortgage obligations. The remaining balance of the investment portfolio consists of mutual funds and investments in corporate bonds.

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

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

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

Interest Rate Risk

Our exposure to interest rate changes results from our significant holdings of fixed maturity securities. We are also exposed to interest rate risk from our variable interest secured term loan and from our policyholder deposits.

Equity Price Risk

Our investments in equity securities expose us to equity price risks, for which potential losses could arise from adverse changes in the value of equity securities.

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Risk Measurement

Our available-for-sale and held-to-maturity securities are a source of market risk. As of December 31, 2013 approximately 81.5% and 100.0% of our investments in available-for-sale and held-to-maturity securities, respectively, consisted of fixed income securities. The remaining balance of the available-for-sale portfolio is comprised of equity securities and alternative investments. Available-for-sale securities are recorded at fair value and changes in the fair value of these securities, net of the related tax effect, are excluded from operations and are reported as a separate component of other comprehensive income (loss) until realized. Held-to-maturity securities are recorded at amortized cost and adjusted for the amortization or accretion of premiums or discounts. The fair value of the investments in our available-for-sale and held-to-maturity portfolios is exposed to both interest rate risk and equity price risk.

Interest Rate Risk

We have evaluated the net impact to the fair value of our fixed income investments of a significant one-time change in interest rate risk using a combination of both statistical and fundamental methodologies. From these shocked values a resultant market price appreciation/depreciation can be determined after portfolio cash flows are modeled and evaluated over instantaneous 100, 200 and 300 basis point rate shifts. Techniques used in the evaluation of cash flows include Monte Carlo simulation through a series of probability distributions over 200 interest rate paths. Necessary prepayment speeds are compiled using Salomon Brothers Yield Book, which sources numerous factors in deriving speeds, including but not limited to: historical speeds, economic indicators, street consensus speeds, etc. Securities evaluated by us under these scenarios include mortgage pass-through certificates and collateralized mortgage obligations of U.S. agencies, and private label structures, provided that cash flows information is available. The following table sets forth the result of this analysis for the years ended December 31, 2013 and 2012. The analysis does not consider any action that management can take to mitigate the impact of changes in market rates.

(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2012:			
Base Scenario	$1,065.1		
+100bp	1,007.4	(57.7)	(5.4)%
+200bp	954.2	(110.9)	(10.4)%
+300bp	901.3	(163.8)	(15.4)%
December 31, 2011:			
Base Scenario	$1,004.0		
+100bp	950.4	(53.6)	(5.3)%
+200bp	897.7	(106.3)	(10.6)%
+300bp	844.5	(159.5)	(15.9)%

We believe that an interest rate shift in a 12-month period of 100 basis points represents a moderately adverse outcome, while a 200 basis point shift is significantly adverse and a 300 basis point shift is unlikely given historical precedents. Although we classify 99.4% of our fixed income securities as available-for-sale, our cash flows and the intermediate duration of our investment portfolio should allow us to hold securities until maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Equity Price Risk

Our equity securities in the available-for-sale portfolio are comprised of mutual funds whose underlying assets are comprised of domestic equity securities, international equity securities and higher risk fixed income instruments. The fixed income mutual funds invest in loan participations, high yield debt and emerging market debt. The fixed income funds invest primarily in debt securities issued or guaranteed by corporations, financial institutions and governmental entities that are either unrated or have non-investment grade ratings from either Standard & Poor's or Moody's.

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

Assuming an immediate decrease of 10% in the market value of our equity securities as of December 31, 2013 and 2012, the hypothetical loss in the fair value of these investments would have been approximately $24.0 million and $21.0 million, respectively.

Other Risk Measurement

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

Item 8. Financial Statements and Supplementary Data

Financial Statements

For our audited consolidated financial statements as of December 31, 2013 and 2012 and for each of the three years ended December 31, 2013 see Index to financial statements in "Item 15. Exhibits and Financial Statements Schedules" to this Annual Report on Form 10-K.

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Selected Quarterly Financial Data

	2013				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$549,961	$556,035	$547,874	$549,165	$2,203,035
Administrative service fees	27,110	28,543	22,450	30,577	108,680
Net investment income	11,367	12,019	11,363	12,539	47,288
Other operating revenues	1,187	1,212	1,239	1,140	4,778
Total operating revenues	589,625	597,809	582,926	593,421	2,363,781
Net realized investment gains (losses)	1,888	1,661	(144)	(818)	2,587
Other income, net	481	366	13,931	485	15,263
Total revenues	591,994	599,836	596,713	593,088	2,381,631
Benefits and expenses					
Claims incurred	452,000	460,818	456,432	466,951	1,836,201
Operating expenses	114,865	120,225	116,156	126,923	478,169
Total operating costs	566,865	581,043	572,588	593,874	2,314,370
Interest expense	2,384	2,426	2,379	2,285	9,474
Total benefits and expenses	569,249	583,469	574,967	596,159	2,323,844
Income (loss) before taxes	22,745	16,367	21,746	(3,071)	57,787
Income tax expense (benefit)					
Current	5,463	3,768	5,636	(3,163)	11,704
Deferred	99	(7,479)	(2,494)	451	(9,423)
Total income taxes	5,562	(3,711)	3,142	(2,712)	2,281
Net income (loss)	17,183	20,078	18,604	(359)	55,506
Less: Net loss attributable to	55	64	37	262	418
non-controlling interest	$17,238	$20,142	$18,641	$(97)	$55,924
Basic net income per share	$0.61	$0.72	$0.68	$-	$2.02
Diluted net income per share	$0.61	$0.72	$0.68	$-	$2.01

During the three months ended June 30, 2013, we recorded an out-of-period adjustment that affected our consolidated results of operations of the previous quarter as well as those of our Managed Care segment, related to the recording of incentives to providers. The effect of this out-of-period adjustment in previous periods was that the claims incurred would have increased by $1.9 million during the three months ended March 31, 2013.

As a result of this out-of-period adjustment the consolidated income before tax was overstated by $1.9 million during the three months ended March 31, 2013 and understated by the same amount during the three months ended June 30, 2013.

We assessed the impact of the adjustment needed to account for this error in their appropriate period and concluded that recording this adjustment in the consolidated results of operations in the three months ended June 30, 2013, rather than restating the quarters affected, was quantitatively and qualitatively not material to the results of operations, financial position, or cash flows corresponding to each of the quarters that comprise the year ended December 31, 2013. This out-of-period adjustment involves only reported quarterly results and, because they were corrected during the year, have no effect on the results of operations, financial position and cash flows for the year ended December 31, 2013.

	2012				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$547,304	$582,246	$565,607	$558,197	$2,253,354
Administrative service fees	27,524	27,768	27,181	27,637	110,110
Net investment income	11,192	11,562	11,595	12,441	46,790
Other operating revenues	1,047	1,105	1,206	998	4,356
Total operating revenues	587,067	622,681	605,589	599,273	2,414,610
Net realized investment gains	1,678	458	21	3,040	5,197
Other (loss) income, net	1,070	(154)	598	682	2,196
Total revenues	589,815	622,985	606,208	602,995	2,422,003
Benefits and expenses					
Claims incurred	475,644	496,249	485,495	462,471	1,919,859
Operating expenses	102,506	102,268	104,604	115,795	425,173
Total operating costs	578,150	598,517	590,099	578,266	2,345,032
Interest expense	2,558	2,667	2,956	2,418	10,599
Total benefits and expenses	580,708	601,184	593,055	580,684	2,355,631
Income before taxes	9,107	21,801	13,153	22,311	66,372
Income tax expense (benefit)					
Current	3,028	3,744	1,344	5,278	13,394
Deferred	(1,421)	1,041	126	(668)	(922)
Total income taxes	1,607	4,785	1,470	4,610	12,472
Net income	7,500	17,016	11,683	17,701	53,900
Less: Net loss attributable to	14	19	32	67	132
non-controlling interest	$7,514	$17,035	$11,715	$17,768	$54,032
Basic net income per share	$0.27	$0.60	$0.41	$0.63	$1.91
Diluted net income per share	$0.26	$0.60	$0.41	$0.63	$1.90

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

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

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

In connection with the preparation of this Annual Report on Form 10-K, management, under the supervision and with the participation of the chief executive officer and the chief financial officer, conducted an evaluation of the effectiveness of our "disclosure controls and procedures" as of the end of this period (as such term is defined under Exchange Act Rule 13a-15(e)) of the Corporation and its subsidiaries, except for Atlantic Southern Insurance Company, which we acquired in November 2013. Disclosure controls and procedures are designed to ensure that information required to be disclosed by the issuer in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms and that such information is accumulated and communicated to management, including the chief executive officer and chief financial officer, to allow timely decisions regarding required disclosures. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. There are inherent limitations to the effectiveness of any system of disclosure controls and procedures, including the possibility that judgments in decision-making can be faulty, and breakdowns as a result of simple errors or mistake. Accordingly, even effective disclosure controls and procedures can only provide reasonable assurance of achieving their control objectives. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions.

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Based on this evaluation, our chief executive officer and chief financial officer have concluded that as of December 31, 2013, which is the end of the period covered by this Annual Report on Form 10-K, our disclosure controls and procedures are effective to a reasonable level of assurance.

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

Management's Report on Internal Control Over Financial Reporting

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

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

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

Management, under the supervision and with the participation of the chief executive officer and chief financial officer, assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2013 based on criteria described in the "Internal Control—Integrated Framework (1992)" issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO"). Based on that assessment and those criteria, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2013 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company's consolidated financial statements for external reporting purposes in accordance with GAAP.

Management has excluded from its assessment of internal control over financial reporting as of December 31, 2013 Atlantic Southern Insurance Company because it was acquired by the Company in a purchase business combination during 2013. Atlantic Southern Insurance Company is a wholly-owned subsidiary whose total assets and total revenues represent 0.9% and 0.1%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2013.

The effectiveness of our internal control over financial reporting as of December 31, 2013 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm, as stated in their report which is included in this Annual Report on Form 10-K.

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Changes in Internal Control Over Financial Reporting

No changes in our internal control over financial reporting (as such term is defined in the Exchange Act Rule 13a-15(f)) occurred during the fiscal quarter ended December 31, 2013 that materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

9B. Other Information

None.

Part III

Item 10. Directors, Executive Officers and Corporate Governance

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2014 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 11. Executive Compensation

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2014 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2014 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2014 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

Item 14. Principal Accountant Fees and Services

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2014 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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Item 15. Exhibits and Financial Statements Schedules

Financial Statements and Schedules

Financial Statements	Description
F-1	Report of Independent Registered Public Accounting Firm
F-2	Consolidated Balance Sheets as of December 31, 2013 and 2012
F-3	Consolidated Statements of Earnings for the years ended December 31, 2013, 2012 and 2011
F-4	Consolidated Statements of Comprehensive Income for the years ended December 31, 2013, 2012 and 2011
F-5	Consolidated Statements of Stockholders' Equity for the years ended December 31, 2013, 2012 and 2011
F-6	Consolidated Statements of Cash Flows for the years ended December 31, 2013, 2012 and 2011
F-7	Notes to Consolidated Financial Statements – December 31, 2013, 2012 and 2011

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

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

Exhibits

Exhibits	Description
3(i)(a)	Amended and Restated Articles of Incorporation (incorporated herein by reference to Exhibit 3(i)(d) to TSM's Annual Report on Form 10-K for the Year Ended December 31, 2007 (File No. 001-33865).
3(i)(b)	Amendment to Article Tenth of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation, incorporated by reference to Exhibit 3(i)(b) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865).
3(i)(c)	Articles of Incorporation of Triple-S Management Corporation, as currently in effect, incorporated by reference to Exhibit 3(i)(c) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2008 (File No. 001-33865).
3(ii)	Amended and Restated Bylaws of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3.1 to TSM's Current Report on Form 8-K filed on June 11, 2010 (File No. 001-33865)).
10.1	Amended and Restated Agreement between the Puerto Rico Health Insurance Administration and TSS to administer the provision of the physical health component of the Medicaid program in designated service regions (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on August 8, 2013 (File No. 001-33865)).
10.2	

Amendment to the Medicare Platino Contract (Medicare Wraparound) between the Puerto Rico Health Insurance Administration and TSS for the provision of wraparound coverage to health insurance dual-eligible population until December 31, 2011 (incorporated herein by reference to Exhibit 10.4 to TSM's Quarterly Report on Form 10-Q for the quarter ended September 30, 2010 (File No. 001-33865)).

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Exhibits	Description
10.3	Federal Employees Health Benefits Contract (incorporated herein by reference to Exhibit 10.5 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.4	Credit Agreement with FirstBank Puerto Rico in the amount of $41,000,000 (incorporated herein by reference to Exhibit 10.6 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.5	Credit Agreement with FirstBank Puerto Rico in the amount of $20,000,000 (incorporated herein by reference to Exhibit 10.7 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.6	Non-Contributory Retirement Program (incorporated herein by reference to Exhibit 10.8 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.7	Blue Shield License Agreement by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.11 to TSM’s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.8	Blue Shield Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.12 to TSM’s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.9	Blue Cross License Agreements by and between BCBSA and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.13 to TSM’s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.10	Blue Cross Controlled Affiliate License Agreement by and among BCBSA, TSS and TSM, including revisions, if any, adopted by Member Plans through the November 19, 2009 meeting (incorporated herein by reference to Exhibit 10.14 to TSM’s Annual Report on Form 10-K for the year ended December 31, 2009 (File No. 001-33865)).
10.11	6.30% Senior Unsecured Notes Due September 2019 Note Purchase Agreement, dated September 30, 2004, between Triple-S Management Corporation, Triple-S, Inc. and various institutional accredited investors (incorporated herein by reference to Exhibit 10.15 to TSM’s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).
10.12	6.60% Senior Unsecured Notes Due December 2020 Note Purchase Agreement, dated December 15, 2005, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.16 to TSM’s Annual Report on Form 10-K for the year ended December 31, 2005 (File No. 001-33865)).
10.13	6.70% Senior Unsecured Notes Due December 2021 Note Purchase Agreement, dated January 23, 2006, between Triple-S Management Corporation and various institutional accredited investors (incorporated herein by reference to Exhibit 10.1 to TSM’s Quarterly Report on Form 10-Q for the Quarter Ended March 31, 2006 (File No. 001-33865)).
10.14	TSM 2007 Incentive Plan, dated October 16, 2007 (incorporated herein by reference to Exhibit C to TSM’s 2007 Proxy Statement (File No. 001-33865)).

Exhibits	Description
10.15	Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS dated August 16, 2007 (incorporated herein by reference to Exhibit 10.15 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.16	Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(a) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.17	Addendum Number Two to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(b) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.18	Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(c) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.19	Work Order Agreement between Quality Care Solutions, Inc. and TSS (incorporated herein by reference to Exhibit 10.16 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.20	Employment Contract between Ramón M. Ruiz Comas and TSM (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on November 5, 2012 (File No. 001-33865)).
10.21	Underwriting Agreement dated May 16, 2013 with certain shareholders of the Company named therein and Credit Suisse Securities (USA) LLC, as representative of the underwriters (incorporated herein by reference to Exhibit 1.1 to TSM's Form 8-K filed on May 22, 2013 (File No. 001-33865)).
11.1	Statement re computation of per share earnings; an exhibit describing the computation of the earnings per share has been omitted as the detail necessary to determine the computation of earnings per share can be clearly determined from the material contained in Part II of this Annual Report on Form 10-K.
21*	List of Subsidiaries of TSM.
23.1*	Consent of Independent Registered Public Accounting Firm (PricewaterhouseCoopers LLP).
31.1*	Certification of the President and Chief Executive Officer required by Rule 13a-14(a)/15d-14(a).
31.2*	Certification of the Vice President of Finance and Chief Financial Officer required by Rule 13a-14(a)/15d-14(a).
32.1*	Certification of the President and Chief Executive Officer required pursuant to 18 U.S. Section 1350.
32.2*	Certification of the Vice President of Finance and Chief Financial Officer required pursuant to 18 U.S. Section 1350.
99.1	Incentive Compensation Recoupment Policy (incorporated herein by reference to Exhibit 99.1 to TSM's Annual Report on Form 10-K for the year ended December 31, 2010 (File No. 001-33865)).

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

* Filed herein.

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SIGNATURES

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

Triple-S Management Corporation
Registrant

By: /s/ Ramón M. Ruiz-Comas Date: March 14, 2014
Ramón M. Ruiz-Comas
President and Chief Executive Officer

By: /s/ Amílcar Jordán-Pérez Date: March 14, 2014
Amílcar Jordán-Pérez
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 Date: March 14, 2014
Luis A. Clavell-Rodríguez
Director and Chairman of the Board

By: /s/ Adamina Soto-Martínez Date: March 14, 2014
Adamina Soto-Martínez
Director and Vice-Chairman of the Board

By: /s/ Jesús R. Sánchez-Colón Date: March 14, 2014
Jesús R. Sánchez-Colón
Director and Assistant Secretary of the Board

By: /s/ David H. Chafey, Jr. Date: March 14, 2014
David H. Chafey, Jr.
Director

By: /s/ Jorge L. Fuentes-Benejam Date: March 14, 2014
Jorge L. Fuentes-Benejam
Director

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By: /s/ Antonio F. Faría-Soto Date: March 14, 2014
Antonio F. Faría-Soto
Director

By: /s/ Manuel Figueroa-Collazo Date: March 14, 2014
Manuel Figueroa-Collazo
Director

By: /s/ Cari M. Domínguez Date: March 14, 2014
Cari M. Domínguez
Director

By: /s/ Joseph A. Frick Date: March 14, 2014
Juan E. Rodríguez-Díaz
Director

By: /s/ Francisco J. Toñarely-Barreto Date: March 14, 2014
Francisco J. Toñarely-Barreto
Director

Report of Independent Registered Public Accounting Firm

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

In our opinion, the consolidated financial statements listed in the index appearing under Item 15 present fairly, in all material respects, the financial position of Triple-S Management Corporation and its subsidiaries (the Company) at December 31, 2013 and December 31, 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013 in conformity with accounting principles generally accepted in the United States of America. In addition, in our opinion, the financial statement schedules listed in the index appearing under Item 15 present fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements. Also in our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on criteria established in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). The Company's management is responsible for these financial statements and financial statement schedules, for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in Management's Report on Internal Control over Financial Reporting appearing under Item 9A. Our responsibility is to express opinions on these financial statements, on the financial statement schedules, and on the Company's internal control over financial reporting based on our integrated audits. We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free of material misstatement and whether effective internal control over financial reporting was maintained in all material respects. Our audits of the financial statements included examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

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

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

As described in Management's Report on Internal Control Over Financial Reporting, management has excluded Atlantic Southern Insurance Company from its assessment of internal control over financial reporting as of December 31, 2013 because it was acquired by the Company in a purchase business combination during 2013. We have also excluded Atlantic Southern Insurance Company from our audit of internal control over financial reporting. Atlantic Southern Insurance Company is a wholly-owned subsidiary whose total assets and total revenues represent 0.9% and 0.1%, respectively, of the related consolidated financial statement amounts as of and for the year ended December 31, 2013.

/s/ PricewaterhouseCoopers LLP
San Juan, Puerto Rico
March 17, 2014

CERTIFIED PUBLIC ACCOUNTANTS
(OF PUERTO RICO)

License No. LLP - 216 Expires Dec. 1, 2016
Stamp E97078 of the P.R. Society of
Certified Public Accountants has been
affixed to the file copy of this report
3

Triple-S Management Corporation
Consolidated Balance Sheets
December 31, 2013 and 2012
(dollar amounts in thousands, except per share data)

Assets	2013	2012
Investments and cash		
Securities available for sale, at fair value:		
Fixed maturities (amortized cost of $1,031,480 in 2013 and $963,463 in 2012)	$1,055,874	$1,059,761
Equity securities (cost of $187,356 in 2013 and $185,514 in 2012)	239,933	209,722
Securities held to maturity, at amortized cost:		
Fixed maturities (fair value of $6,309 in 2013 and $5,377 in 2012)	6,139	5,000
Policy loans	6,705	6,161
Cash and cash equivalents	74,356	89,564
Total investments and cash	1,383,007	1,370,208
Premium and other receivables, net	274,939	292,197
Deferred policy acquisition costs and value of business acquired	177,289	168,657
Property and equipment, net	89,086	92,423
Deferred tax asset	33,519	33,548
Goodwill	25,397	27,766
Other assets	64,387	74,545
Total assets	$2,047,624	$2,059,344
Liabilities and Stockholders’ Equity		
Claim liabilities	420,421	416,918
Liability for future policy benefits	304,363	276,570
Unearned premiums	87,362	95,860
Policyholder deposits	115,923	111,692
Liability to Federal Employees’ Health Benefits Program	8,148	21,353
Accounts payable and accrued liabilities	161,422	128,580
Deferred tax liability	20,783	32,934
Short term borrowings	-	30,000
Long term borrowings	89,302	101,271
Liability for pension benefits	54,697	82,019
Total liabilities	1,262,421	1,297,197
Commitments and contingencies		
Stockholders’ equity		
Triple-S Management Corporation stockholders' equity		
Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 2,377,689 and 9,042,809 at December 31, 2013 and 2012, respectively	2,378	9,043
Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 25,091,277 and 19,321,944shares at December 31, 2013 and 2012, respectively	25,091	19,322
Additional paid-in capital	130,098	144,677
Retained earnings	595,685	539,761
Accumulated other comprehensive income, net	32,129	49,104
Total Triple-S Management Corporation stockholders' equity	785,381	761,907
Non-controlling interest in consolidated subsididary	(178)	240
Total stockholders' equity	785,203	762,147
Total liabilities and stockholders’ equity	$2,047,624	$2,059,344

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

Triple-S Management Corporation
Consolidated Statements of Earnings
December 31, 2013, 2012 and 2011
(dollar amounts in thousands, except per share data)

	2013	2012	2011
Revenues:			
Premiums earned, net	$2,203,035	$2,253,354	$2,054,468
Administrative service fees	108,680	110,110	38,459
Net investment income	47,288	46,790	48,226
Other operating revenues	4,778	4,356	-
Total operating revenues	2,363,781	2,414,610	2,141,153
Net realized investment gains (losses):			
Total other-than-temporary impairment losses on securities	(1,042)	-	(257)
Net realized gains, excluding other-than-temporary impairment losses on securities	3,629	5,197	18,854
Total net realized investment gains	2,587	5,197	18,597
Net unrealized investment loss on trading securities	-	-	(7,267)
Other income, net	15,263	2,196	716
Total revenues	2,381,631	2,422,003	2,153,199
Benefits and expenses:			
Claims incurred	1,836,201	1,919,859	1,716,254
Operating expenses	478,169	425,173	347,590
Total operating costs	2,314,370	2,345,032	2,063,844
Interest expense	9,474	10,599	10,855
Total benefits and expenses	2,323,844	2,355,631	2,074,699
Income before taxes	57,787	66,372	78,500
Income tax expense (benefit):			
Current	11,704	13,394	6,594
Deferred	(9,423)	(922)	13,870
Total income taxes	2,281	12,472	20,464
Net income	55,506	53,900	58,036
Less: Net loss attributable to non-controlling interest	418	132	-
Net income attributable to Triple-S Management Corporation	$55,924	$54,032	$58,036
Earnings per share attributable to Triple-S Management Corporation			
Basic net income per share	$2.02	$1.91	$2.02
Diluted net income per share	$2.01	$1.90	$2.01

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

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Triple-S Management Corporation
Consolidated Statements of Comprehensive Income
December 31, 2013, 2012 and 2011
(dollar amounts in thousands, except per share data)

	2013	2012	2011
Net income	$55,506	$53,900	$58,036
Other comprehensive income (loss), net of tax:			
Net unrealized change in fair value of available for sale securities, net of taxes	(36,931)	34,378	35,394
Defined benefit pension plan:			
Actuarial gain (loss), net	20,226	(3,531)	(21,991)
Prior service credit, net	(270)	(306)	(304)
Total other comprehensive income (loss), net of tax	(16,975)	30,541	13,099
Comprehensive income	38,531	84,441	71,135
Comprehensive loss attributable to non-controlling interest	418	132	-
Comprehensive income attributable to Triple-S Management Corporation	$38,949	$84,573	$71,135

The accompanying notes are an integral part of these financial statements.
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Triple-S Management Corporation
Consolidated Statements of Stockholders' Equity
December 31, 2013, 2012 and 2011
(dollar amounts in thousands, except per share data)

	Class A Common Stock	Class B Common Stock	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Triple-S Management Corporation Stockholders' Equity	Non-controlling Interest in Consolidated Subsidiary	Total Stockholders' Equity
Balance, December 31, 2010	$ 9,043	$ 19,773	$ 155,299	$ 427,693	$ 5,464	$ 617,272	$ -	$ 617,272
Share-based compensation	-	173	1,899	-	-	2,072	-	2,072
Cash settlement of options under share-based compensation plan	-	-	(2,420)	-	-	(2,420)	-	(2,420)
Stock issued upon exercise of stock options	-	88	1,191			1,279	-	1,279
Repurchase and retirement of common stock	-	(712)	(11,667)	-	-	(12,379)	-	(12,379)
Net change in comprehensive income	-	-	-	58,036	13,099	71,135	-	71,135
Balance, December 31, 2011	9,043	19,322	144,302	485,729	18,563	676,959	-	676,959
Non-controlling interest related to acquisition of consolidated subsidiary	-	-	-	-	-	-	372	372
Share-based compensation	-	71	2,555	-	-	2,626	-	2,626
Stock issued upon exercise of stock options	-	207	2,794	-	-	3,001	-	3,001
Repurchase and retirement of common stock	-	(278)	(4,974)	-	-	(5,252)	-	(5,252)
Net change in comprehensive income (loss)	-	-	-	54,032	30,541	84,573	(132)	84,441
Balance, December 31, 2012	$ 9,043	$ 19,322	$ 144,677	$ 539,761	$ 49,104	$ 761,907	$ 240	$ 762,147
Share-based compensation	-	96	2,685	-	-	2,781	-	2,781

Stock issued upon exercise of stock options	-	22	293	-	-	315	-	315
Common stock conversion	(6,665)	6,665	-	-	-	-	-	-
Repurchase and retirement of common stock	-	(1,014)	(17,557)	-	-	(18,571)	-	(18,571)
Net change in comprehensive income (loss)	-	-	-	55,924	(16,975)	38,949	(418)	38,531
Balance, December 31, 2013	$ 2,378	$ 25,091	$ 130,098	$ 595,685	$ 32,129	$ 785,381	$ (178)	$ 785,203

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

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Triple-S Management Corporation
Consolidated Statements of Cash Flows
December 31, 2013, 2012 and 2011
(dollar amounts in thousands, except per share data)

	2013	2012	2011
Cash flows from operating activities			
Net income	$55,506	$53,900	$58,036
Adjustments to reconcile net income to net cash provided by operating activities			
Depreciation and amortization	25,589	24,242	22,229
Net amortization of investments	5,963	6,425	3,912
Provision (reversal of provision) for doubtful receivables	(2,880)	563	7,837
Deferred tax expense (benefit)	(9,423)	(922)	13,870
Net realized investment gains	(2,587)	(5,197)	(18,597)
Net unrealized losses on trading securities	-	-	7,267
Share-based compensation	2,781	2,626	2,072
Proceeds from trading securities sold Equity securities	-	-	53,066
Acquisition of securities in trading portfolio Equity securities	-	-	(2,764)
Gain (loss) on sale of property and equipment	-	17	(13)
(Increase) decrease in assets			
Premium and other receivables, net	21,053	(4,410)	54,622
Deferred policy acquisition costs and value of business acquired	(4,133)	(12,869)	(9,702)
Deferred taxes	(9,230)	(967)	71
Other assets	2,296	(1,617)	(18,245)
Increase (decrease) in liabilities			
Claim liabilities	2,455	25,659	(11,998)
Liability for future policy benefits	22,665	22,376	17,671
Unearned premiums	(8,588)	1,088	(4,288)
Policyholder deposits	3,217	2,289	1,554
Liability to FEHBP	(13,205)	2,302	4,033
Accounts payable and accrued liabilities	21,469	(5,785)	(18,106)
Net cash provided by operating activities	112,948	109,720	162,527

Triple-S Management Corporation
Consolidated Statements of Cash Flows
December 31, 2013, 2012 and 2011
(dollar amounts in thousands, except per share data)

	2013	2012	2011
Cash flows from investing activities			
Proceeds from investments sold or matured			
Securities available for sale			
Fixed maturities sold	$160,978	$116,718	$240,034
Fixed maturities matured	96,597	141,266	104,728
Equity securities sold	132,433	53,120	38,022
Securities held to maturity			
Fixed maturities matured	1,440	11,635	1,941
Acquisition of investments			
Securities available for sale			
Fixed maturities	(323,003)	(313,188)	(265,356)
Equity securities	(132,543)	(98,095)	(129,328)
Securities held to maturity			
Fixed maturities	(1,325)	(2,494)	(755)
Other investments	(512)	(206)	(2,500)
Net repayment (disbursements) for policy loans	(313)	146	(420)
Acquisition of business, net of cash acquired of $4,618, $816 and $30,070 in the year ended December 31, 2013, 2012 and 2011, respectively	(4,795)	(2,685)	(54,680)
Net capital expenditures	(11,809)	(12,078)	(16,337)
Net cash used in investing activities	(82,852)	(105,861)	(84,651)
Cash flows from financing activities			
Repurchase and retirement of common stock	(18,250)	(2,299)	(11,289)
Cash settlement of stock options	-	-	(2,420)
Proceeds from exercise of stock options	-	316	189
Change in outstanding checks in excess of bank balances	15,123	(19,841)	4,409
Repayments of long-term borrowings	(11,969)	(26,955)	(51,640)
Net change in short-term borrowings	(30,000)	30,000	(15,575)
Proceeds from annuity contracts	9,212	39,709	31,809
Surrenders of annuity contracts	(9,420)	(7,059)	(6,546)
Net cash provided by (used in) financing activities	(45,304)	13,871	(51,063)
Net (decrease) increase in cash and cash equivalents	(15,208)	17,730	26,813
Cash and cash equivalents			
Beginning of year	89,564	71,834	45,021
End of year	$74,356	$89,564	$71,834

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1. Nature of Business

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

The Company has the following wholly owned subsidiaries that are subject directly or indirectly to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance), the Division of Banking and Insurance of the Office of the Lieutenant Governor of the U.S. Virgin Islands (USVI Division of Banking and Insurance), the General Superintendence of Insurance of Costa Rica, the British Virgin Islands Financial Services Commission, and the Anguilla Financial Services Commission: (1) Triple-S Salud, Inc. (TSS) and Socios Mayores en Salud Holdings, Inc. (from now on referred to as American Health or AH), managed care organizations that provide health benefits services to subscribers through contracts with hospitals, physicians, dentists, laboratories, and other organizations; (2) Triple-S Vida, Inc. (TSV) and Atlantic Southern Insurance Company (ASICO), which are engaged in the underwriting of life and accident and health insurance policies and the administration of annuity contracts; and (3) Triple-S Propiedad, Inc. (TSP), which is engaged in the underwriting of property and casualty insurance policies. The Company, TSS and AH are members of the Blue Cross and Blue Shield Association (BCBSA).

Effective February 7, 2011, the Company through its subsidiary TSS, completed the acquisition of 100% of the outstanding capital stock of AH, a provider of Medicare Advantage services to over 40,000 dual and non-dual eligible members in Puerto Rico. The results of operations and financial condition of AH are included in the accompanying consolidated financial statements for the period following the effective date of the acquisition.

In January 2012, we acquired a controlling interest in a health clinic in Puerto Rico, as part of our strategic initiatives. The clinic became a member of the Mayo Clinic network on 2013.

On November 7, 2013, the Company, through its subsidiary TSV, completed the acquisition of 100% of the outstanding shares of capital stock of ASICO, a life insurance company authorized to do business in Puerto Rico, the Republic of Costa Rica, Anguilla, and British Virgin Islands. The results of operations and financial condition of ASICO are included in the accompanying consolidated financial statements for the period following the effective date of the acquisition.

Through our subsidiary TSS, we provide services to participants of the Commonwealth of Puerto Rico Health Insurance Plan (similar to Medicaid) (Medicaid). On October 17, 2011, TSS entered into a contract with the Commonwealth of Puerto Rico (the government of Puerto Rico), effective November 1, 2011, to administer the provision of the physical health component of this program in designated service regions in Puerto Rico. On July 1, 2013, TSS, amended its contract extending the administration of the provision of the physical health component of the Medicaid program in service regions in the Commonwealth of Puerto Rico currently administered by TSS for a 12-month period. This amendment also transferred the administration of the three remaining service regions to TSS upon completion of a transition period, which ended on October 1, 2013. In accordance with the terms of the new contract with the government of Puerto Rico, TSS receives a monthly per-member, per-month administrative fee for its services and does not bear the insurance risk of the program.

The Company also has two other wholly owned subsidiaries, Interactive Systems, Inc. (ISI) and Triple-C, Inc. (TC). ISI is mainly engaged in providing data processing services to the Company and its subsidiaries. TC was engaged as a third-party administrator for TSS in the administration of the Medicaid business and is currently inactive.

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

2. Significant Accounting Policies

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

Basis of Presentation
The accompanying consolidated financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America (GAAP).

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

Use of Estimates
The preparation of the consolidated financial statements in conformity with GAAP requires the Company to make a number of estimates and assumptions relating to the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenue and expenses during the period. Actual results could differ from those estimates. The most significant items on the consolidated balance sheets that involve a greater degree of accounting estimates and actuarial determinations subject to changes in the near future are the assessment of other-than-temporary impairments, allowance for doubtful receivables, deferred policy acquisition costs and value of business acquired, claim liabilities, the liability for future policy benefits, and liability for pension benefits. As additional information becomes available (or actual amounts are determinable), the recorded estimates are revised and reflected in operating results of the period they are determined. Although some variability is inherent in these estimates, the Company believes the amounts provided represent management's best estimate.

Cash Equivalents
The Company considers all highly liquid debt instruments with original maturities of three months or less to be cash equivalents. Cash equivalents of $32,646 and $23,311 at December 31, 2013 and 2012, respectively, consist principally of money market funds, obligations of government sponsored enterprises and certificates of deposit with an initial term of less than three months.

Investments
Investment in securities at December 31, 2013 and 2012 consists mainly of obligations of government sponsored enterprises, U.S. Treasury securities and obligations of U.S. government instrumentalities, obligations of the Commonwealth of Puerto Rico and its instrumentalities, municipal securities, corporate bonds, mortgage-backed securities, collateralized mortgage obligations, and equity securities. The Company classifies its debt and equity securities in one of three categories: trading, available for sale, or held to maturity. Trading securities are bought and held principally for the purpose of selling them in the near term. Securities classified as held to maturity are those securities in which the Company has the ability and intent to hold the security until maturity. All other securities not

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

Transfers of securities between categories are recorded at fair value at the date of transfer. Unrealized holding gains and losses are recognized in earnings for transfers into trading securities. Unrealized holding gains or losses associated with transfers of securities from held to maturity to available for sale are recorded as a separate component of other comprehensive income. The unrealized holding gains or losses included in the separate component of other comprehensive income for securities transferred from available for sale to held to maturity, are maintained and amortized into earnings over the remaining life of the security as an adjustment to yield in a manner consistent with the amortization or accretion of premium or discount on the associated security.

If a fixed maturity security is in an unrealized loss position and the Company has the intent to sell the fixed maturity security, or it is more likely than not that the Company will have to sell the fixed maturity security before recovery of its amortized cost basis, the decline in value is deemed to be other-than-temporary and is recorded to other-than-temporary impairment losses recognized in earnings in the Company’s consolidated statements of earnings. For impaired fixed maturity securities that the Company does not intend to sell or it is more likely than not that such securities will not have to be sold, but the Company expects not to fully recover the amortized cost basis, the credit component of the other-than temporary impairment is recognized in other-than-temporary impairment losses recognized in earnings in the Company’s consolidated statements of earnings and the non-credit component of the other-than-temporary impairment is recognized in other comprehensive income. Furthermore, unrealized losses entirely caused by non-credit related factors related to fixed maturity securities for which the Company expects to fully recover the amortized cost basis continue to be recognized in accumulated other comprehensive income.

The credit component of an other-than-temporary impairment is determined by comparing the net present value of projected future cash flows with the amortized cost basis of the fixed maturity security. The net present value is calculated by discounting the Company’s best estimate of projected future cash flows at the effective interest rate implicit in the fixed maturity security at the date of acquisition.

The unrealized gains or losses on the Company’s equity securities classified as available-for-sale are included in accumulated other comprehensive income as a separate component of stockholders’ equity, unless the decline in value is deemed to be other-than-temporary and the Company does not have the intent and ability to hold such equity securities until their full cost can be recovered, in which case such equity securities are written down to fair value and the loss is charged to other-than-temporary impairment losses recognized in earnings.

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

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

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

Revenue Recognition

a. Managed Care

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

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

Prescription drug coverage is offered to Medicare eligible beneficiaries as part of MA plans (MA-PD) and on a stand-alone basis (stand-alone PDP). Premiums are based on a bid contract with CMS that considers the estimated costs of providing prescription drug benefits to enrolled participants. MA-PD and stand-alone PDP premiums are subject to adjustment, positive or negative, based upon the application of risk corridors that compare the estimated prescription drug costs included in the bids to CMS to actual prescription drug costs. Variances exceeding certain thresholds may result in CMS making additional payments or in CMS requesting a refund for a portion of the premiums collected. The Company estimates and records adjustments to earned premiums related to estimated risk corridor payments based upon actual prescription drug costs for each reporting period as if the annual contract were to end at the end of each reporting period.

Administrative service fees include revenue from certain groups which have managed care contracts that provide for the group to be at risk for all or a portion of their claims experience. For these groups, the Company is not at risk and only handles the administration of managed care coverage for an administrative service fee. The Company pays claims under commercial self-funded arrangements from its own funds, and subsequently receives reimbursement from these groups. The claims related to the administration of the Medicaid business are paid from a bank account owned and funded by the government of Puerto Rico. Claims paid under self-funded arrangements are excluded from the claims incurred in the accompanying consolidated financial statements. Administrative service fees under the self-funded arrangements are recognized based on the group's membership or incurred claims for the period multiplied by an administrative fee rate plus other fees. In addition, some of these self-funded groups purchase aggregate and/or specific stop-loss coverage. In exchange for a premium, the group's aggregate liability or the group's liability on any one episode of care is capped for the year. Premiums for the stop-loss coverage are actuarially determined based on experience and other factors and are recorded as earned over the period of the contract in proportion to the coverage provided. This fully insured portion of premiums is included within the premiums earned, net in the accompanying consolidated statements of earnings. The Medicaid contract with the Government of Puerto Rico contains a savings-sharing provision whereby the Government of Puerto Rico shares with TSS a portion of the medical cost savings obtained with the administration of the region served on an administrative service basis. Any savings-sharing amount is recorded when earned as administrative service fees in the accompanying consolidated statements of earnings.

b. Life and Accident and Health Insurance

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

c. Property and Casualty Insurance

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

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

Deferred Policy Acquisition Costs and Value of Business Acquired
Certain direct costs for acquiring successful life and accident and health, and property and casualty insurance business are deferred by the Company. Substantially all acquisition costs related to the managed care business are expensed as incurred.

In the life and accident and health business deferred acquisition costs consist of commissions and certain expenses related to the production of life, annuity, accident and health, and credit business. In the event that future premiums, in combination with policyholder reserves and anticipated investment income, could not provide for all future maintenance and settlement expenses, the amount of deferred policy acquisition costs would be reduced to provide for such amount. The related amortization is provided over the anticipated premium-paying period of the related policies in proportion to the ratio of annual premium revenue to expected total premium revenue to be received over the life of the policies. Interest is considered in the amortization of deferred policy acquisition cost and value of business acquired. For these contracts interest is considered at a level rate at the time of issue of each contract, 4.90% for 2013 and 2012, and 5.4% to 5.65% for 2011, and, in the case of the value of business acquired, at the time of any acquisition. For certain other long-duration contracts, deferred amounts are amortized at historical and forecasted credited interest rates. Expected premium revenue is estimated by using the same mortality and withdrawal assumptions used in computing liabilities for future policy benefits. The method followed in computing deferred policy acquisition costs limits the amount of such deferred costs to their estimated net realizable value. In determining estimated net realizable value, the computations give effect to the premiums to be earned, related investment income, losses and loss-adjustment expenses, and certain other costs expected to be incurred as the premium is earned. Costs deferred on universal life and interest sensitive products are amortized as a level percentage of the present value of anticipated gross profits from investment yields, mortality, expenses and surrender charges. Estimates used are based on the Company's experience as adjusted to provide for possible adverse deviations. These estimates are periodically reviewed and compared with actual experience. When it is determined that future expected experience differs significantly from that assumed, the estimates are revised for current and future issues.

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

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

Property and Equipment

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

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

Software Development Costs

Costs related to software developed or obtained for internal use that is incurred in the preliminary project stage are expensed as incurred. Once capitalization criteria are met, directly attributable development costs are capitalized and amortized over the expected useful life of the software. Upgrade and maintenance costs are expensed as incurred. During the year ended December 31, 2013 and 2012 the Company capitalized approximately $3,811 and $2,184 associated with the implementation of new softwares.

Long-Lived Assets

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

Goodwill and intangible assets that have indefinite useful lives are tested annually for impairment, and are tested for impairment more frequently if events and circumstances indicate that the asset might be impaired. An impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. For goodwill, the impairment determination is made at the reporting unit level. The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step goodwill impairment test. The Company assesses qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying amount, including goodwill. If determined to be necessary, the two-step impairment test is used to identify potential goodwill impairment and measure the amount of a goodwill impairment loss to be recognized (if any). First, the Company determines the fair value of a reporting unit and compares it to its carrying amount. Second, if the carrying amount of a reporting unit exceeds its fair value, an impairment loss is recognized for any excess of the carrying amount of the reporting unit's goodwill over the implied fair value of that goodwill. The implied fair value of goodwill is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation. The residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

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The Company performed its annual goodwill impairment analysis in the fourth quarter of year 2013 and based on the results of the test, an impairment charge for the health clinic reporting unit disclosed below was recorded.

The Company concluded that fair value was below carrying value for the health clinic reporting unit acquired in January 2012. The fair value of the health clinic reporting unit was based on the income approach. The decline in the estimated fair value of the health clinic reporting unit results from lower projected revenue growth rates and profitability levels used to calculate the discounted cash flows. The lower projected operating results reflect changes in assumptions related to organic revenue growth rates, market trends, business mix, cost structure, expected deal synergies and other expectations about the anticipated short-term and long-term operating results of the health clinic business. The decline in the fair value of the health clinic reporting unit in the step two goodwill impairment test, resulted in an implied fair value that indicated the book value should be reduced to zero. As a result, the Company recorded a goodwill impairment charge of $2,369, and there is no remaining carrying value of the health clinic goodwill as of December 31, 2013. The goodwill impairment charge is included within the consolidated operating expenses.

The 2012 annual goodwill impairment test was performed and based on the results of the test no impairment was recorded.

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

The Company contracts with various independent practice associations (IPAs) for certain medical care services provided to some policies subscribers. The IPAs are compensated on a capitation basis. In the Medicaid business and certain MA policies, a portion of the capitation payments is retained to provide for incurred but not reported losses. At December 31, 2013 and 2012, total withholdings and capitation payable amounted to $42,298 and $32,900, respectively, which are recorded as part of the claim liabilities in the accompanying consolidated balance sheets.

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

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

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

Future Policy Benefits
The liability for future policy benefits has been computed using the level premium method based on estimated future investment yield, mortality, morbidity and withdrawal experience. The interest rate assumption ranges between 4.90% and 5.75% for all years in issue. Mortality has been calculated principally on select and ultimate tables in common usage in the industry. Withdrawals have been estimated principally based on industry tables, modified by Company's experience.

Policyholder Deposits
Amounts received for annuity contracts are considered deposits and recorded as a liability along with the accrued interest and reduced for charges and withdrawals. Interest incurred on such deposits, which amounted to $3,329, $2,894, and $2,003, during the years ended December 31, 2013, 2012, and 2011, respectively, is included within the interest expense in the accompanying consolidated statements of earnings.

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

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

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

Income Taxes
Income taxes are accounted for under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in the consolidated statements of earnings in the period that includes the enactment date. The Company recognizes the effect of income tax positions only if those positions are more likely than not of being sustained. Recognized income tax positions are measured at the largest amount that is greater than 50% likely of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

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

The holding company within the AH group of companies is a U.S.-based company that has not recorded a U.S. deferred tax liability for the excess of the book basis over the tax basis of its investments in Puerto Rico corporations. AH has not recorded a deferred tax liability to the extent that the basis difference results from outside basis difference created as a result of the business combination and earnings that meet the indefinite reversal criteria. The indefinite reversal criteria is met if the Puerto Rico subsidiary has invested, or will invest, the undistributed earnings indefinitely. The decision as to the amount of undistributed earnings intended to be maintained in Puerto Rico corporations takes into account several items including, but not limited to, actual results of operations, forecasts and budgets of financial needs of cash for working capital, liquidity plans, capital improvement programs, merger and acquisition plans as well as expected cash requirements in the U.S. or in other Puerto Rico subsidiaries from the U.S.-based company.

Insurance-Related Assessments
The Company records a liability for insurance-related assessments when the following three conditions are met: (1) the assessment has been imposed or the information available prior to the issuance of the financial statements indicates it is probable that an assessment will be imposed; (2) the event obligating an entity to pay (underlying cause of) an imposed or probable assessment has occurred on or before the date of the financial statements; and (3) the amount of the assessment can be reasonably estimated. A related asset is recognized when the paid or accrued assessment is recoverable through either premium taxes or policy surcharges.

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

Share Based Compensation
Share-based compensation is measured at the fair value of the award and recognized as an expense in the financial statements over the vesting period. The Company recognizes compensation expense for its stock options based on estimated grant date fair value using the Black-Scholes option pricing model.

Earnings Per Share
Basic earnings per share excludes dilution and is computed by dividing net income available to all classes of common stockholders by the weighted average number of all classes of common shares outstanding for the period, excluding non-vested restricted stocks. Diluted earnings per share is computed in the same manner as basic earnings per share except that the number of shares is increased to include the number of additional common shares that would have been outstanding if the potentially dilutive common shares had been issued. Dilutive common shares are included in the diluted earnings per share calculation using the treasury stock method.

Recently Issued Accounting Standards

In July 2011, the FASB issued guidance to address questions about how health insurers should recognize and classify in their income statements fees mandated by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act. A health insurer's portion of the annual fee becomes payable to the U.S. Treasury once the entity provides health insurance for any U.S. health risk for each applicable calendar year. The amendments specify that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. This guidance is effective for calendar years beginning after December 31, 2013, when the fee initially becomes effective. We currently estimate that for 2014 such fee will represent approximately 1.5% of the managed care premiums earned, which we expect to recover a substantial amount from our customers.

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

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

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

On February 5, 2013 the FASB issued guidance to improve the transparency of reporting reclassifications out of accumulated other comprehensive income. In particular, the guidance requires an entity to report the effect of significant reclassifications out of accumulated other comprehensive income on the respective line items in net income if the amount being reclassified is required under GAAP to be reclassified in its entirety to net income. For other amounts that are not required under GAAP to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference other disclosures required under GAAP that provide additional detail about those amounts. This guidance applies to all entities that issue financial statements that are presented in conformity with GAAP and that report items of other comprehensive income. The Company adopted this guidance in January 1, 2013; there was no significant impact on our financial position or results of operations as a result of the adoption.

On July 18, 2013, the FASB issued guidance regarding the presentation in the statement of financial position of an unrecognized tax benefit when a net operating loss carry-forward or a tax credit carry-forward exists. In particular, the guidance provides that an entity's unrecognized tax benefit, or a portion of its unrecognized tax benefit, should be presented in its financial statements as a reduction to a deferred tax asset for a net operating loss carry-forward, a similar tax loss, or a tax credit carry-forward, with one exception. That exception states that, to the extent a net operating loss carry-forward, a similar tax loss, or a tax credit carry-forward is not available at the reporting date under the tax law of the applicable jurisdiction to settle any additional income taxes that would result from the disallowance of a tax position, or the tax law of the applicable jurisdiction does not require the entity to use, and the entity does not intend to use, the deferred tax asset for such purpose, the unrecognized tax benefit should be presented in the financial statements as a liability and should not be combined with deferred tax assets. This guidance is effective for public companies for fiscal years and interim periods within such years beginning after December 15, 2013. We are currently evaluating the impact, if any, the adoption of this guidance will have on the financial position or results of operations.

Other than the accounting pronouncements disclosed above, there were no other new accounting pronouncements issued that could have a material impact in the Company’s financial position, operating results or financials statement disclosures.

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3. Investment in Securities

The amortized cost for debt securities and cost for equity securities, gross unrealized gains, gross unrealized losses, and estimated fair value for available-for-sale and held-to-maturity securities by major security type and class of security at December 31, 2013 and 2012, were as follows:

	2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities available for sale				
Fixed maturities				
Obligations of government-sponsored enterprises	$ 104,317	$ 1,854	$ (380)	$ 105,791
U.S. Treasury securities and obligations of U.S. government instrumentalities	38,131	1,068	-	39,199
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	49,557	262	(4,814)	45,005
Municipal securities	597,297	19,328	(5,182)	611,443
Corporate bonds	146,936	9,883	(879)	155,940
Residential mortgage-backed securities	7,388	324	(9)	7,703
Collateralized mortgage obligations	87,854	3,072	(133)	90,793
Total fixed maturities	1,031,480	35,791	(11,397)	1,055,874
Equity securities				
Mutual funds	187,356	53,013	(436)	239,933
Total equity securities	187,356	53,013	(436)	239,933
Total	$ 1,218,836	$ 88,804	$ (11,833)	$ 1,295,807

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	2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities available for sale				
Fixed maturities				
Obligations of government-sponsored enterprises	$56,758	$4,876	$ -	$61,634
U.S. Treasury securities and obligations of U.S. government instrumentalities	39,365	1,848	-	41,213
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	63,470	2,277	(2)	65,745
Municipal securities	529,822	59,106	(165)	588,763
Corporate bonds	106,968	22,899	-	129,867
Residential mortgage-backed securities	20,009	551	(52)	20,508
Collateralized mortgage obligations	147,071	5,129	(169)	152,031
Total fixed maturities	963,463	96,686	(388)	1,059,761
Equity securities				
Common stock	16	993	-	1,009
Mutual funds	185,498	23,256	(41)	208,713
Total equity securities	185,514	24,249	(41)	209,722
Total	$1,148,977	$120,935	$ (429)	$1,269,483

	2013			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities held to maturity				
Obligations of government-sponsored enterprises	$1,793	$ 26	$ -	$ 1,819
U.S. Treasury securities and obligations of U.S. government instrumentalties	622	117	-	739
Residential mortgage-backed securities	346	27	-	373
Certificates of deposits	3,378	-	-	3,378
	$6,139	$ 170	$ -	$ 6,309

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	2012			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities held to maturity				
Obligations of government-sponsored enterprises	$1,793	$ 115	$ -	$ 1,908
U.S. Treasury securities and obligations of U.S. government instrumentalties	623	225	-	848
Residential mortgage-backed securities	450	37	-	487
Certificates of deposits	2,134	-	-	2,134
	$5,000	$ 377	$ -	$ 5,377

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, 2013 and 2012 were as follows:

	2013								
	Less than 12 months			12 months or longer			Total		
	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities
Securites available for sale									
Fixed maturities									
Obligations of government-sponsored enterprises	$46,797	$(380)	4	$-	$ -	-	$46,797	$(380)	4
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	22,285	(4,814)	13	-	-	-	22,285	(4,814)	13
Municipal securities	234,594	(5,145)	51	4,646	(37)	1	239,240	(5,182)	52
Corporate bonds	45,203	(879)	19	-	-	-	45,203	(879)	19
Residential mortgage-backed securities	24	(9)	6	-	-	-	24	(9)	6
Collateralized mortgage obligations	1,106	(6)	3	9,469	(127)	3	10,575	(133)	6
Total fixed maturities	350,009	(11,233)	96	14,115	(164)	4	364,124	(11,397)	100
Equity securities									
Mutual funds	25,231	(436)	7	-	-	-	25,231	(436)	7
Total equity securities	25,231	(436)	7	-	-	-	25,231	(436)	7
	$375,240	$(11,669)	103	$14,115	$ (164)	4	$389,355	$(11,833)	107

Total for securities
available for sale

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	2012								
	Less than 12 months			12 months or longer			Total		
	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities	Estimated Fair Value	Gross Unrealized Loss	Number of Securities
Securites available for sale									
Fixed maturities									
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	$5,770	$(2)	1	$-	$-	-	$5,770	$(2)	1
Municipal securities	27,426	(165)	10	-	-	-	27,426	(165)	10
Residential mortgage-backed securities	5,892	(52)	2	-	-	-	5,892	(52)	2
Collateralized mortgage obligations	20,894	(169)	6	-	-	-	20,894	(169)	6
Total fixed maturities	59,982	(388)	19	-	-	-	59,982	(388)	19
Equity securities									
Mutual funds	-	-	-	2,708	(41)	1	2,708	(41)	1
Total equity securities	-	-	-	2,708	(41)	1	2,708	(41)	1
Total for securities available for sale	$59,982	$(388)	19	$2,708	$(41)	1	$62,690	$(429)	20

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

The Corporation's process for identifying and reviewing invested assets for other-than temporary impairments during any quarter includes the following:

- Identification and evaluation of securities that have possible indications of other-than-temporary impairment, which includes an analysis of all investments with gross unrealized investment losses that represent 20% or more of their cost and all investments with an unrealized loss greater than $100.

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

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

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

- Equity securities are considered to be impaired when a position is in an unrealized loss for a period longer than 6 months.

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

Obligations of Government-Sponsored Enterprises, and obligations of U.S. Government instrumentalities: The unrealized losses on the Corporation's investments in obligations of states of the United States and political subdivisions of the states were mainly caused by fluctuations in interest rates and general market conditions. The contractual terms of these investments do not permit the issuer to settle the securities at a price less than the par value of the investment. In addition, these investments have investment grade ratings. Because the decline in fair value is attributable to changes in interest rates and not credit quality; because the Corporation does not intend to sell the investments and it is not more likely than not that the Corporation will be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Corporation expects to collect all contractual cash flows, these investments are not considered other-than-temporarily impaired.

Municipal Securities: The unrealized losses on the Corporation's investments in municipal securities were mainly caused by fluctuations in interest rates and general market conditions. The contractual terms of these investments do not permit the issuer to settle the securities at a price less than the par value of the investment. In addition, these investments have investment grade ratings. Because the decline in fair value is attributable to changes in interest rates and not credit quality; because the Corporation does not intend to sell the investments and it is not more likely than not that the Corporation will be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Corporation expects to collect all contractual cash flows, these investments are not considered other-than-temporarily impaired.

Obligations of the Commonwealth of Puerto Rico and its Instrumentalities: Our holdings in Puerto Rico municipals can be divided in (1) escrowed bonds with a fair value of $22,070 and an unrealized gain of $255, (2) Cofina bonds with a fair value of $20,580 and an unrealized gain and loss of $7 and $4,476, respectively, and (3) bonds of various other Puerto Rico issuers with a fair value of $2,355 and an unrealized loss of $338. Escrowed bonds are backed by U.S. Government securities and therefore have an implicit AA+/Aaa rating. Cofina bonds, issued by the Sales Tax Financing Corporation, are senior lien and are rated AA-/Baa1. Other Puerto Rico holdings with a total fair value of

$1,552 are rated below investment grade.

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The Cofina or sales tax bonds are secured by a 7% sales tax levied on the island, of which 1.5% goes to municipalities. Of the remaining 5.5%, the larger of 3.50% or a base amount is pledged to the sales tax bonds. The percentage pledged to the sales tax bonds was increased in October 2013 from 2.75% to 3.50%. Both senior lien and subordinate sales tax bonds are outstanding; our positions are senior lien bonds. In terms of flow of funds, the 5.5% remaining revenue is first used for debt service on the senior lien bonds, then for debt service on the subordinate bonds and the excess flows into the General Fund.

Cofina senior bonds are rated AA- by Standard & Poor's. S&P revised its outlook from stable to negative on September 30, 2013, based on declining economic and population trends. S&P notes that debt service coverage remains strong in the short term, particularly after the recent legislated expansion of the sales tax base. However, growth in sales tax revenues is still needed to maintain high annual debt service coverage for first-lien bonds. This links the credit quality of the sales tax bonds to the financial and economic condition of the Commonwealth of Puerto Rico ("Commonwealth") as a whole.

Moody's downgraded Cofina senior bonds to Baa1 on February 7, 2014 and maintained a negative outlook. The downgrade reflects the weak economy of the Commonwealth and constrained growth in sales tax revenues. Moody's notes that measures have been taken to stabilize the fiscal situation, but economic recovery prospects remain weak. The current four notch rating differential between General Obligation bonds (Ba2) and Cofina Senior bonds (Baa1) reflects Moody's view of a strong legal separation between the two credits.

The bonds of various other Puerto Rico issuers, which are mentioned above, consist of Cofina subordinate lien (A+ negative outlook, Baa2 negative outlook), General Obligation bonds insured by National Public Finance Guarantee (A stable outlook, Baa1 positive outlook), Government Development Bank notes (BB negative watch, Ba2 negative outlook) and PREPA notes (BBB negative outlook, Ba2 negative outlook).

The Corporation does not consider these positions other-than-temporarily impaired because the Corporation does not have the intent to sell these investments, and it is not more likely than not that the Corporation will be required to sell the investments before recovery of its amortized cost bases (which may be maturity); because the positions have been at an unrealized loss for a short period of time (less than 6 months); because the unrealized loss is partially due to market conditions; because most positions have an investment grade rating; and because the Corporation expects to collect all contractual cash flows.

Corporate Bonds: The unrealized losses of these bonds were principally caused by fluctuations in interest rates and general market conditions. All corporate bonds with an unrealized loss have investment grade ratings and, except for one position, which has been with an unrealized loss for less than four months, have been in an unrealized loss position for less than three months. Because the decline in estimated fair value is principally attributable to changes in interest rates; the Company does not intend to sell the investments and it is not more likely than not that the Company will be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Company expects to collect all contractual cash flows, these investments are not considered other-than-temporarily impaired.

Residential mortgage-backed securities and Collateralized mortgage obligations: The unrealized losses on investments in residential mortgage-backed securities and collateralized mortgage obligations ("CMOs") were mostly caused by fluctuations in interest rates and credit spreads. The contractual cash flows of these securities, other than private CMOs, are guaranteed by a U.S. government-sponsored enterprise. Any loss in these securities is determined according to the seniority level of each tranche, with the least senior (or most junior), typically the unrated residual tranche, taking any initial loss. The investment grade credit rating of our securities reflects the seniority of the securities that the Corporation owns. The Corporation does not consider these investments other-than-temporarily impaired because the decline in fair value is attributable to changes in interest rates and not credit quality; the Corporation does not intend to sell the investments and it is more likely than not that the Corporation will not be required to sell the investments before recovery of their amortized cost basis, which may be maturity; and because the Corporation expects to collect all contractual cash flows.

(dollar amounts in thousands, except per share data)

Mutual Funds: As of December 31, 2013, investments in mutual funds with unrealized losses are not considered other-than-temporarily impaired because the funds have been in an unrealized loss position for less than six months. During the year 2013, positions with a total fair market value of $8,958 were impaired by $1,042 as these funds were in an unrealized loss position for a period longer than six months.

Maturities of investment securities classified as available for sale and held to maturity at December 31, 2013 were as follows:

	Amortized Cost	Estimated Fair Value
Securities available for sale		
Due in one year or less	$41,131	$41,427
Due after one year through five years	281,448	286,747
Due after five years through ten years	123,269	127,366
Due after ten years	490,390	501,838
Residential mortgage-backed securities	7,388	7,703
Collateralized mortgage obligations	87,854	90,793
	$1,031,480	$1,055,874
Securities held to maturity		
Due in one year or less	$3,378	$3,378
Due after five years through ten years	1,793	1,819
Due after ten years	622	739
Residential mortgage-backed securities	346	373
	$6,139	$6,309

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

Investments with an amortized cost of $5,389 and $3,857 (fair value of $4,487 and $4,053) at December 31, 2013 and 2012, respectively, were deposited with the Commissioner of Insurance to comply with the deposit requirements of the Insurance Code of the Commonwealth of Puerto Rico (the Insurance Code). Investment with an amortized cost of $511 and $500 (fair value of $511 and $500) at December 31, 2013 and 2012, respectively, was deposited with the USVI Division of Banking and Insurance.

Information regarding realized and unrealized gains and losses from investments for the years ended December 31, 2013, 2012, and 2011 is as follows:

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	2013	2012	2011
Realized gains (losses)			
Fixed maturity securities			
Securities available for sale			
Gross gains from sales	$5,408	$1,988	$11,190
Gross losses from sales	(4,553)	(460)	(258)
Total fixed maturity securities	855	1,528	10,932
Equity securities			
Trading securities:			
Gross gains from sales	-	-	11,757
Gross losses from sales	-	-	(5,286)
	-	-	6,471
Securities available for sale			
Gross gains from sales	5,084	4,905	3,730
Gross losses from sales	(2,310)	(1,236)	(2,279)
Gross losses from other-than-temporary impairments	(1,042)	-	(257)
	1,732	3,669	1,194
Total equity securities	1,732	3,669	7,665
Net realized gains on securities	$2,587	$5,197	$18,597

	2013	2012	2011
Changes in unrealized gains (losses)			
Recognized in income			
Equity securities – trading	$-	$-	$(7,267)
Recognized in accumulated other comprehensive income (loss)			
Fixed maturities – available for sale	(71,904)	20,959	45,710
Equity securities – available for sale	28,369	17,967	(2,516)
	$(43,535)	$38,926	$43,194
Not recognized in the consolidated financial statements			
Fixed maturities – held to maturity	$(207)	$(191)	$(241)

The deferred tax asset (liability) on unrealized gains change recognized in accumulated other comprehensive income during the years 2013, 2012, and 2011 was $6,604, $(4,548), and $(7,800), respectively.

As of December 31, 2013 and 2012 no individual investment in securities exceeded 10% of stockholders' equity.

(dollar amounts in thousands, except per share data)

4. Net Investment Income

Interest and/or dividend income from:

	Years ended December 31		
	2013	2012	2011
Fixed maturities	$37,302	$38,623	$43,388
Equity securities	8,640	6,831	3,238
Policy loans	472	466	450
Cash equivalents and interest-bearing deposits	84	115	399
Other	790	755	751
Total	$47,288	$46,790	$48,226

5. Premium and Other Receivables, Net

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

	2013	2012
Premium	$108,963	$113,537
Self-funded group receivables	55,598	64,359
FEHBP	11,804	11,707
Agent balances	27,655	34,261
Accrued interest	11,879	11,409
Reinsurance recoverable	46,116	52,063
Other	34,473	29,290
	296,488	316,626
Less allowance for doubtful receivables:		
Premium	14,403	14,416
Others	7,146	10,013
	21,549	24,429
Premium and other receivables, net	$274,939	$292,197

(dollar amounts in thousands, except per share data)

6. Deferred Policy Acquisition Costs and Value of Business Acquired

The movement of deferred policy acquisition costs (DPAC) and value of business acquired (VOBA) for the years ended December 31, 2013, 2012, and 2011 is summarized as follows:

	DPAC	VOBA	Total
Balance, December 31, 2010	$100,875	$45,211	$146,086
Additions	53,843	-	53,843
VOBA interest at an average rate of 5.4%	-	2,441	2,441
Amortization	(39,378)	(7,204)	(46,582)
Net change	14,465	(4,763)	9,702
Balance, December 31, 2011	115,340	40,448	155,788
Additions	55,928	-	55,928
VOBA interest at an average rate of 5.24%	-	2,184	2,184
Amortization	(38,739)	(6,504)	(45,243)
Net change	17,189	(4,320)	12,869
Balance, December 31, 2012	$132,529	$36,128	$168,657
Additions	48,137	4,499	52,636
VOBA interest at an average rate of 5.24%	-	1,951	1,951
Amortization	(39,738)	(6,217)	(45,955)
Net change	8,399	233	8,632
Balance, December 31, 2013	$140,928	$36,361	$177,289

The VOBA addition in 2013 is related to the ASICO acquisition. The amortization expense of the deferred policy acquisition costs and value of business acquired is included within the operating expenses in the accompanying consolidated statement of earnings.

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

Year ending December 31:	
2014	$4,664
2015	3,605
2016	3,152
2017	2,811
2018	2,806

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7. Property and Equipment, Net

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

	2013	2012
Land	$10,976	$10,265
Buildings and leasehold improvements	60,459	58,168
Office furniture and equipment	18,681	19,057
Computer equipment and software	112,679	106,842
Automobiles	835	505
	203,630	194,837
Less accumulated depreciation and amortization	114,544	102,414
Property and equipment, net	$89,086	$92,423

8. Intangible Asset

Intangible assets, included within other assets, at December 31, 2013 and 2012 consist of:

	2013	2012
Trade name	$5,529	$5,529
Membership base	41,188	41,188
Provider networks	2,808	2,808
Other	3,480	3,509
	53,005	53,034
Accumulated amortization	34,741	26,103
Intangible assets, net	$18,264	$26,931

Trade name and provider networks are amortized over the expected life of 3 and 5 years, respectively. Membership base is amortized over the expected life between 1 and 13 years, or using determined percentages, ranging from 25% to 30%.

Amortization expense recorded for the years ended December 31, 2013, 2012, and 2011 amounted to $8,638, $10,443, and $9,251, respectively.

Estimated amortization expense for the following five years is as follows:

Year ending December 31:	
2014	$6,820
2015	3,411
2016	2,292
2017	1,757
2018	1,538

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9. Fair Value Measurements

Assets recorded at fair value in the consolidated balance sheets are categorized based upon the level of judgment associated with the inputs used to measure their fair value. Level inputs are as follows:

Level Input Definition:

Level 1	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level 2	Inputs other than quoted prices included in Level 1 that are observable for the asset or liability through corroboration with market data at the measurement date.
Level 3	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The Company uses observable inputs when available. Fair value is based upon quoted market prices when available. The Company limits valuation adjustments to those deemed necessary to ensure that the security's fair value adequately represents the price that would be received or paid in the marketplace. Valuation adjustments may include consideration of counterparty credit quality and liquidity as well as other criteria. The estimated fair value amounts are subjective in nature and may involve uncertainties and matters of significant judgment for certain financial instruments. Changes in the underlying assumptions used in estimating fair value could affect the results. The fair value measurement levels are not indicative of risk of investment.

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

The following table summarizes fair value measurements by level at December 31, 2013 and 2012 for assets measured at fair value on a recurring basis:

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	2013			
	Level 1	Level 2	Level 3	Total
Securities available for sale				
Fixed maturity securities				
Obligations of government-sponsored enterprises	$-	$105,791	$-	$105,791
U.S. Treasury securities and obligations of U.S. government instrumentalities	39,199	-	-	39,199
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	-	45,005	-	45,005
Municipal securities	-	611,443	-	611,443
Corporate Bonds	-	155,940	-	155,940
Residential agency mortgage-backed securities	-	7,703	-	7,703
Collaterized mortgage obligations	-	90,793	-	90,793
Total fixed maturities	39,199	1,016,675	-	1,055,874
Equity securities				
Mutual funds	158,281	63,742	17,910	239,933
Total equity securities	158,281	63,742	17,910	239,933
	$197,480	$1,080,417	$17,910	$1,295,807

	2012			
	Level 1	Level 2	Level 3	Total
Securities available for sale				
Fixed maturity securities				
Obligations of government-sponsored enterprises	$-	$61,634	$-	$61,634
U.S. Treasury securities and obligations of U.S. government instrumentalities	41,213	-	-	41,213
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	-	65,745	-	65,745
Municipal securities	-	588,763	-	588,763
Corporate Bonds	-	129,867	-	129,867
Residential agency mortgage-backed securities	-	20,508	-	20,508
Collaterized mortgage obligations	-	152,031	-	152,031
Total fixed maturities	41,213	1,018,548	-	1,059,761
Equity securities				
Common stocks	1,009	-	-	1,009
Mutual funds	134,398	61,493	12,822	208,713
Total equity securities	135,407	61,493	12,822	209,722
	$176,620	$1,080,041	$12,822	$1,269,483

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The fair value of fixed maturity and equity securities included in the Level 2 category were based on market values obtained from independent pricing services, which utilize evaluated pricing models that vary by asset class and incorporate available trade, bid and other market information and for structured securities, cash flow and when available loan performance data. Because many fixed income securities do not trade on a daily basis, the models used by independent pricing service providers to prepare evaluations apply available information, such as benchmark curves, benchmarking of like securities, sector groupings, and matrix pricing. For certain equity securities, quoted market prices for the identical security are not always available and the fair value is estimated by reference to similar securities for which quoted prices are available. The independent pricing service providers monitor market indicators, industry and economic events, and for broker-quoted only securities, obtain quotes from market makers or broker-dealers that they recognize to be market participants. The fair value of the private equity funds included in the Level 3 category was based on the net asset value (NAV) which is affected by the changes in the fair market value of the investments held in the funds.

Transfers into or out of the Level 3 category occur when unobservable inputs, such as the Company's best estimate of what a market participant would use to determine a current transaction price, become more or less significant to the fair value measurement. Transfers between levels, if any, are recorded as of the actual date of the event or change in circumstance that caused the transfer. There were no transfers between Levels 1 and 2 during the years ended December 31, 2013 and 2012.

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the years ended December 31, 2013 and 2012 is as follows:

	Level 3
Ending balance December 31, 2011	$7,094
Unrealized in other accumulated comprehensive income	1,974
Purchases	4,824
Transfers in and/or out of Level 3	(1,070)
Ending balance December 31, 2012	$12,822
Realized gains	$192
Unrealized in other accumulated comprehensive income	2,756
Purchases	2,439
Sales	(299)
Ending balance December 31, 2013	$17,910

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, FASB guidance also requires the disclosure of fair values for certain other financial instruments for which it is practicable to estimate fair value, whether or not such values are recognized in the consolidated balance sheets.

Non-financial instruments such as property and equipment, other assets, deferred income taxes and intangible assets, and certain financial instruments such as claim liabilities are excluded from the fair value disclosures. Therefore, the fair value amounts cannot be aggregated to determine our underlying economic value.

The carrying amounts reported in the consolidated balance sheets for cash and cash equivalents, receivables, accounts payable and accrued liabilities, and short-term borrowings approximate fair value because of the short term nature of these items. These assets and liabilities are not listed in the table below.

The following methods, assumptions and inputs were used to estimate the fair value of each class of financial instrument:

(i) Policy Loans

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

(ii) Policyholder Deposits

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

(iii) Long-term Borrowings

The carrying amount of the loans payable to bank – variable approximates fair value due to its floating interest-rate structure. The fair value of the loans payable to bank – fixed and senior unsecured notes payable was determined using broker quotations.

(iv) Repurchase Agreement

The value of the repurchase agreement with a long term maturity is based on the discontinued value of the contractual cash flows using current estimated market discount rates for instruments with similar terms.

A summary of the carrying value and fair value by level of financial instruments not recorded at fair value on our consolidated balance sheet at December 31, 2013 and 2012 are as follows:

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	Carrying Value	Fair Value Level 1	Level 2	Level 3	Total
Assets:					
Policy loans	$6,705	$-	$6,705	$ -	$6,705
Liabilities:					
Policyholder deposits	$115,923	$-	$115,923	$ -	$115,923
Long-term borrowings:					
Loans payable to bank - variable	16,107	-	16,107	-	16,107
Loans payable to bank - fixed	13,195	-	13,195	-	13,195
6.6% senior unsecured notes payable	35,000	-	33,775	-	33,775
Repurchase agreement	25,000	-	25,638	-	25,638
Total long-term borrowings	89,302	-	88,715	-	88,715
Total liabilities	$205,225	$-	$204,638	$ -	$204,638

	2012 Carrying Value	Fair Value Level 1	Level 2	Level 3	Total
Assets:					
Policy loans	$6,161	$-	$6,161	$ -	$6,161
Liabilities:					
Policyholder deposits	$111,692	$-	$111,692	$ -	$111,692
Long-term borrowings:					
Loans payable to bank - variable	17,747	-	17,747	-	17,747
Loans payable to bank - fixed	13,524	-	13,524	-	13,524
6.6% senior unsecured notes payable	35,000	-	34,213	-	34,213
6.7% senior unsecured notes payable	10,000	-	9,950	-	9,950
Repurchase agreement	25,000	-	25,937	-	25,937
Total long-term borrowings	101,271	-	101,371	-	101,371
Total liabilities	$212,963	$-	$213,063	$ -	$213,063

(dollar amounts in thousands, except per share data)

10. Claim Liabilities

The activity in claim liabilities during 2013, 2012, and 2011 is as follows:

	2013	2012	2011
Claim liabilities at beginning of year	$416,918	$391,259	$360,210
Reinsurance recoverable on claim liabilities	(39,051)	(37,234)	(31,449)
Net claim liabilities at beginning of year	377,867	354,025	328,761
Claim liabilities acquired from business acquisitions	1,048	-	43,047
Claims incurred			
Current period insured events	1,832,414	1,900,053	1,703,194
Prior period insured events	(19,203)	(2,978)	(2,507)
Total	1,813,211	1,897,075	1,700,687
Payments of losses and loss-adjustment expenses			
Current period insured events	1,507,302	1,579,970	1,360,806
Prior period insured events	301,960	293,263	357,664
Total	1,809,262	1,873,233	1,718,470
Net claim liabilities at end of year	382,864	377,867	354,025
Reinsurance recoverable on claim liabilities	37,557	39,051	37,234
Claim liabilities at end of year	$420,421	$416,918	$391,259

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

The credits in the claims incurred and loss-adjustment expenses for prior period insured events for 2013, 2012 and 2011 are due primarily to better than expected utilization trends. Reinsurance recoverable on unpaid claims is reported as premium and other receivables, net in the accompanying consolidated financial statements.

The claims incurred disclosed in this table exclude the portion of the change in the liability for future policy benefits amounting to $22,990, $22,784, and $15,567 that is included within the consolidated claims incurred during the years ended December 31, 2013, 2012 and 2011, respectively.

11. Federal Employees' Health Benefits Program (FEHBP)

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

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

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

The contract with OPM allows for the payment to the Company of service fees as negotiated between TSS and OPM. Service fees, which are included within the other income, net in the accompanying consolidated statements of earnings, for each of the years in the three-year period ended December 31, 2013 amounted to $1,204, $1,117, and $1,038, respectively.

The Company also has funds available related to the FEHBP amounting to $31,326 and $41,723 as of December 31, 2013 and 2012, respectively and are included within the cash and cash equivalents in the accompanying consolidated balance sheets. Such funds must only be used to cover health benefits charges, administrative expenses and service charges required by the FEHBP.

A contingency reserve is maintained by the OPM at the U.S. Treasury, and is available to the Company under certain conditions as specified in government regulations. Accordingly, such reserve is not reflected in the consolidated balance sheets. The balance of such reserve as of December 31, 2013 and 2012 was $31,328 and $25,826, respectively. The Company received $634, $3,463, and $5,305, of payments made from the contingency reserve fund of OPM during 2013, 2012, and 2011, respectively.

The claim payments and operating expenses charged to the FEHBP are subject to audit by the U.S. government. Management is of the opinion that an adjustment, if any, resulting from such audits will not have a significant effect on the accompanying financial statements. The claim payments and operating expenses reimbursed in connection with the FEHBP have been audited through 2011 by OPM.

12. Short-Term Borrowings

Short-term borrowings represent securities sold under agreements to repurchase. There were no outstanding short-term borrowings at December 31, 2013. The agreements outstanding at December 31, 2012 amounting to $30,000 matured in January 2, 2013 and accrued interest at fixed rate between 0.45% and 0.60%. The average outstanding short-term borrowings for the years ended December 31, 2013, 2012 and 2011 amounted to $8,971, $12,199 and $11,634, respectively. The weighted average interest rate for short-term borrowings for the years ended

December 31, 2013, 2012 and 2011 amounted to 0.47%, 0.47% and 0.36%, respectively.

The investment securities underlying such agreements were delivered to the dealers with whom the agreements were transacted. The dealers may have sold, loaned, or otherwise disposed of such securities in the normal course of business operations, but have agreed to resell to the Company substantially the same securities on the maturity dates of the agreements. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on the accompanying consolidated balance sheets.

At December 31, 2012 investment securities available for sale with fair value of $31,424 (face value of $28,635) were pledged as collateral under these agreements.

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13. Long-Term Borrowings

A summary of the borrowings entered by the Company at December 31, 2013 and 2012 is as follows:

	2013	2012
Senior unsecured notes payable of $60,000 issued on December 2005; due December 2020. Interest is payable monthly at a fixed rate of 6.60%.	$35,000	$35,000
Senior unsecured notes payable of $35,000 issued on January 2006; due January 2021. Interest is payable monthly at a fixed rate of 6.70%.	-	10,000
Secured loan payable of $41,000, payable in monthly installments of $137 through July 1, 2024, plus interest at a rate reset periodically of 100 basis points over selected LIBOR maturity (which was 1.25% and 1.36% at December 31, 2013,and 2012, respectively).	16,107	17,747
Repurchase agreement of $25,000 entered on November 2010, due November 2015. Interest is payable quarterly at a fixed rate of 1.96%.	25,000	25,000
Secured loan payable of $14,138, payable in 35 monthly installments of $81 of principal and interest at a fixed rate of 4.75% and a last payment of $12,931 due on December 2014.	13,195	13,524
Total borrowings	$89,302	$101,271

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Aggregate maturities of the Company's borrowings as of December 31, 2013 are summarized as follows:

Year ending December 31	
2014	$14,835
2015	26,640
2016	1,640
2017	1,640
2018	1,640
Thereafter	42,907
	$89,302

All of the Company's senior notes may be prepaid at par, in total or partially, five years after issuance as determined by the Company. The Company's senior unsecured notes contain certain non-financial covenants with which the Company has complied with at December 31, 2013. During 2012, we repaid $25,000 of the principal of the 6.70% senior unsecured note. During 2013 we repaid the remaining $10,000 of the principal of the 6.70% senior unsecured note.

Debt issuance costs related to each of the Company's senior unsecured notes were deferred and are being amortized over the term of its respective senior note. Unamortized debt issuance costs related to these senior unsecured notes as of December 31, 2013 and 2012 amounted to $157 and $225, respectively and are included within other assets in the accompanying consolidated balance sheets.

The secured loan payable with original principal balance of $41,000 is guaranteed by a first position held by the bank on the Company's land, building, and substantially all leasehold improvements, as collateral for the term of the loan under a continuing general security agreement. This secured loan contains certain non-financial covenants, which are customary for this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control.

The secured loan payable with original principal balance $14,138 is guaranteed by a first mortgage held by the bank on the health clinic's premises (land and building) and all of the health clinic's assets as collateral for the term of the loan under a continuing general security agreement. This secured loan contains certain financial and non-financial covenants, which are customary for this type of facility, including but not limited to, restrictions on the granting of certain liens, limitations on acquisitions and limitations on changes in control. During 2013, the Corporation entered into an agreement with the banking institution whereby it pledged a deposit of $974 to guarantee the monthly payments and subordinated the intercompany advances made to the clinic. This deposit account is included within other assets in the accompanying consolidated balance sheets.

The repurchase agreement has pledged as collateral investment securities available for sale with fair value of $27,915 (face value of $27,835) and $28,051 (face value of $27,835) as of December 31, 2013 and 2012, respectively. The investment securities underlying such agreements were delivered to the financial institution with whom the agreement was transacted. The dealers may have loaned, or used as collateral securities in the normal course of business operations. We maintain effective control over the investment securities pledged as collateral and accordingly, such securities continue to be carried on the accompanying consolidated balance sheets.

Interest expense on the above borrowings amounted to $4,106, $5,554, and $7,078, for the years ended December 31, 2013, 2012, and 2011, respectively.

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14. Agency Contract and Expense Reimbursement

On March 1, 2009, the Centers for Medicare and Medicaid Services (CMS) awarded to First Coast Service Options (FCSO), a non-affiliated third party organization based in Jacksonville, Florida, the Medicare Administrative Contract (MAC) for Jurisdiction 9 (Florida, Puerto Rico and the U.S. Virgin Islands). FCSO proposed TSS as a subcontractor in MAC Jurisdiction 9 to perform certain provider customer service functions, subject to terms and conditions negotiated between FSCO and TSS. Pursuant to this, TSS billed reimbursements of expenses of $2,663, $2,982 and $3,008 for performing the customer service functions during the years ended December 31, 2013, 2012 and 2011, respectively.

The operating expense reimbursements in connection with processing Medicare claims have been audited through 2009 by federal government representatives. Management is of the opinion that no significant adjustments will be made affecting cost reimbursements through December 31, 2013.

15. Reinsurance Activity

The effect of reinsurance on premiums earned and claims incurred is as follows:

	Premiums Earned			Claims Incurred[1]		
	2013	2012	2011	2013	2012	2011
Gross	$2,281,697	$2,335,942	$2,135,417	$1,841,695	$1,928,191	$1,729,192
Ceded	(78,662)	(82,588)	(80,949)	(28,484)	(31,116)	(28,505)
Net	$2,203,035	$2,253,354	$2,054,468	$1,813,211	$1,897,075	$1,700,687

(1) The claims incurred disclosed in this table exclude the portion of the change in the liability for future policy benefits amounting to $22,990, $22,784, and $15,567 that is included within the consolidated claims incurred during the years ended December 31, 2013, 2012 and 2011, respectively.

TSS, TSP and TSV, in accordance with general industry practices, annually purchase reinsurance to protect them from the impact of large unforeseen losses and prevent sudden and unpredictable changes in net income and stockholders' equity of the Company. Reinsurance contracts do not relieve any of the subsidiaries from their obligations to policyholders. In the event that all or any of the reinsuring companies might be unable to meet their obligations under existing reinsurance agreements, the subsidiaries would be liable for such defaulted amounts. During 2013, 2012 and 2011 TSP placed 12.54%, 11.47%, and 11.02% of its reinsurance business with one reinsurance company.

TSS has two excess of loss reinsurance treaties whereby it cedes a portion of its premiums to third parties. Reinsurance contracts are primarily for periods of one year, and are subject to modifications and negotiations in each renewal date. Premiums ceded under these contracts amounted to $10,930, $11,119, and $12,103 in 2013, 2012 and 2011, respectively. Claims ceded amounted to $9,745, $8,303, and $9,004 in 2013, 2012 and 2011, respectively. Principal reinsurance agreements are as follows:

- Organ transplant excess of loss treaty covering 100% of the claims up to a maximum of $1,000 per person, per life.
- Routine medical care excess of loss treaty covering 75% of claims from the amount of $100 and up to a maximum of $900 per covered person, per contract year.

TSP has a number of pro rata and excess of loss reinsurance treaties whereby the subsidiary retains for its own account all loss payments for each occurrence that does not exceed the stated amount in the agreements and a catastrophe cover, whereby it protects itself from a loss or disaster of a catastrophic nature. Under these treaties, TSP ceded premiums of $57,643, $63,515, and $63,013, in 2013, 2012, and 2011, respectively.

Reinsurance cessions are made on excess of loss and on a proportional basis. Principal reinsurance agreements are as follows:

- Property quota share treaty covering for a maximum of $20,000 for any one risk. Under this treaty 37% of the risk is ceded to reinsurers. The remaining exposure is covered by a property per risk excess of loss treaty that provides reinsurance in excess of $500 up to a maximum of $12,600, or the remaining 63% for any one risk. In addition, TSP has an additional property catastrophe excess of loss contract that provides protection for losses in excess of $8,000 resulting from any catastrophe, subject to a maximum loss of $15,000.
- Personal property catastrophe excess of loss. This treaty provides protection for losses in excess of $5,000 resulting from any catastrophe, subject to a maximum loss of $60,000.
- Commercial property catastrophe excess of loss. This treaty provides protection for losses in excess of $10,000 resulting from any catastrophe, subject to a maximum loss of $135,000.
- Property catastrophe excess of loss. This treaty provides protection in excess of $60,000 and $135,000 with respect to personal and commercial lines, respectively, resulting from any catastrophe, subject to a maximum loss of $185,000 in respect of the ceded portion of the Commercial Lines Quota Share.
- Personal lines quota share. This treaty provides protection of 1.0% on all ground up losses, subject to a limit of $1,000 for any one risk.
- Reinstatement premium protection. This treaty provides a maximum limit of approximately $3,300 for personal lines and $11,000 in commercial lines to cover the necessity of reinstating the catastrophe program in the event it is activated.
- Casualty excess of loss treaty. This treaty provides reinsurance for losses in excess of $225 up to a maximum of $12,000.
- Medical malpractice excess of loss. This treaty provides reinsurance in excess of $150 up to a maximum of $1,500 per incident.
- Builders' risk quota share and first surplus covering contractors' risk. This treaty provides protection on a 20/80 quota share basis for the initial $2,500 and a first surplus of $12,500 for a maximum of $14,500 for any one risk.

- Surety quota share treaty covering contract and miscellaneous surety bond business. This treaty provides reinsurance of up to $5,000 for contract surety bonds, subject to an aggregate of $10,000 per contractor and $3,000 per miscellaneous surety bond.

Facultative reinsurance is obtained when coverage per risk is required. All principal reinsurance contracts are for a period of one year, on a calendar basis, and are subject to modifications and negotiations in each renewal.

The ceded unearned reinsurance premiums on TSP arising from these reinsurance transactions amounted to $14,009 and $15,224 at December 31, 2013 and 2012, respectively, and are reported as other assets in the accompanying consolidated balance sheets.

TSV also cedes insurance with various reinsurance companies under a number of pro rata, excess of loss and catastrophe treaties. Under these treaties, TSV ceded premiums of $8,874, $7,954, and $5,833, in 2013, 2012, and 2011, respectively. Principal reinsurance agreements are as follows:

- Group life insurance facultative agreement, reinsuring risk in excess of $25 of certain group life policies and a combined pro rata and excess of loss agreement effective July 1, 2008, reinsuring 50% of the risk up to $200 and ceding the excess.

- Facultative pro rata agreements for the long term disability insurance, reinsuring 65% of the risk.

- Accidental death catastrophic reinsurance covering each and every accident arising out of one event or occurrence resulting in the death or dismemberment of five or more persons. The retention for each event is $250 with a maximum of $1,000 for each event and $2,000 per year.

- Several reinsurance agreements, mostly on an excess of loss basis up to a maximum retention of $50. For certain new life products that have been issued after 1999, the retention limit is $175.

16. Income Taxes

Under Puerto Rico income tax law, the Company is not allowed to file consolidated tax returns with its subsidiaries. The Company and its subsidiaries are subject to Puerto Rico income taxes. The Company’s insurance subsidiaries are also subject to U.S. federal income taxes for foreign source dividend income. As of December 31, 2013, tax years 2009 through 2013 of the Company and its subsidiaries are subject to examination by Puerto Rico taxing authorities.

Managed Care and Property and Casualty corporations are taxed essentially the same as other corporations, with taxable income primarily determined on the basis of the statutory annual statements filed with the insurance regulatory authorities. Also, operations are subject to an alternative minimum income tax, which is calculated based on the formula established by existing tax laws. Any alternative minimum income tax paid may be used as a credit against the excess, if any, of regular income tax over the alternative minimum income tax in future years.

The Company, through one of its Managed Care corporations, has a branch in the United States Virgin Islands that is subject to a 5% premium tax on policies underwritten therein. As a qualified foreign insurance company, the Company is subject to income taxes in the U.S. Virgin Islands, which has implemented a mirror tax law based on the U.S. Tax Code. The operations of the U.S. Virgin Islands had certain net operating losses for U.S. Virgin Islands tax purposes for which a valuation allowance has been recorded.

The Life Insurance corporation operates as a qualified domestic life insurance company and is subject to the alternative minimum tax and taxes on its capital gains.

Federal income taxes recognized by the Company's insurance subsidiaries amounted to approximately $790, $820, and $120, in 2013, 2012, and 2011, respectively.

All other corporations within the group are subject to Puerto Rico income taxes as a regular corporation, as defined in the P.R. Internal Revenue Code, as amended. The holding company within the AH group of companies is a U.S.-based corporation and is subject to U.S. federal income taxes. This U.S-based corporation within our group has not provided U.S. deferred taxes on an outside basis difference created as a result of the business combination of AH and cumulative earnings of its Puerto Rico-based subsidiaries that are considered to be indefinitely reinvested. The total outside basis difference at December 31, 2013 and 2012 is estimated at $56,000 and $48,000, respectively. We do not intend to repatriate earnings to fund U.S. and Puerto Rico operations nor do any transaction that would cause a reversal of that outside basis difference. Because of the availability of U.S. foreign tax credits, it is not practicable to determine the U.S. federal income tax liability if such outside basis difference was reversed.

In 2010, the government of Puerto Rico adopted a comprehensive tax reform in two phases. The first phase of the tax reform was enacted in the last quarter of 2010 and was mostly related to reducing the income tax burden to individuals. In 2010 only, corporations received an income tax credit amounting to 7% of the tax determined, defined as the tax liability less certain credits. The second phase of the reform, which was approved on January 31, 2011, provided for the reduction of the maximum corporate income tax rate from 40.95% to approximately 30%, and added several tax credits and deductions, among other tax reliefs and changes. One of the companies acquired in the AH transaction elected to continue filing its tax returns at the 39% statutory tax rate, following the previous Puerto Rico tax code. This selection was made according the provisions of the newly enacted Puerto Rico tax code in order to maximize the use of net operating losses carryforward.

On June 30, 2013 the Governor of Puerto Rico signed into law Puerto Rico's Act No.40, known as the "Tax Burden Adjustment and Redistribution Act'' and other Acts, which among other things, increased the maximum corporate income tax rate from 30% to 39%. This tax rate applies to fiscal years starting after December 31, 2012. These new laws also include some amendments to the computations of the corporate alternative minimum tax, including the consideration of an additional tax on gross receipts. In addition, the law established a premium tax of 1% on premiums earned after June 30, 2013, except for annuity deposits, and premiums derived from Medicare Advantage or Medicaid programs.

On October 14, 2013, the Governor of Puerto Rico signed into law Act No.117 providing additional changes and transitional provisions in connection with Act 40 and clarifies that gross income does not include dividends received from a 100% controlled domestic subsidiary and income attributable to a trade of business outside of Puerto Rico.

Additionally, pursuant to provisions of the Puerto Rico Insurance Code and Regulations, TSP is a member of the Compulsory Vehicle Liability Insurance Joint Underwriting Association (the Association). As a participant, TSP shares the risk, proportionately with other members, based on a formula established by the Puerto Rico Insurance Code, of the results and financial condition of the Association, and accordingly, may be subject to assessments to cover obligations of the Association or may receive distributions of good experience refunds. On July 15, 2013, the Governor of Puerto Rico signed into law Act No. 60, which authorized the Association to declare during the year 2013 an extraordinary dividend to its members up to $200,000 subject to the payment of a special tax rate of 50%. During the year ended December 31, 2013, TSP received from the Association a special distribution of $12,811, net of $12,811 of tax, which is included as other income in the accompanying consolidated statements of earnings.

(dollar amounts in thousands, except per share data)

The income tax expense differs from the amount computed by applying the Puerto Rico statutory income tax rate to the income before income taxes as a result of the following:

	2013	2012	2011
Income before taxes	$57,787	$66,372	$78,500
Statutory tax rate	39.00 %	30.00 %	30.00 %
Income tax expense at statutory rate	22,537	19,912	23,550
Increase (decrease) in taxes resulting from Exempt interest income	(5,850)	(6,079)	(7,468)
Effect of taxing life insurance operations as a qualified domestic life insurance company instead of as a regular corporation	(3,819)	(3,155)	(4,592)
Effect of using earnings under statutory accounting principles instead of GAAP for TSS and TSP	123	417	(37)
Effect of taxing capital gains at a preferential rate	(708)	(224)	(483)
Effect of using the 1994 tax code instead of the 2011 tax code	-	380	1,409
Dividends received deduction	202	(3)	(68)
Adjustment to deferred tax assets and liabilities for changes in effective tax rates	(8,285)	-	6,450
Other adjustments to deferred tax assets and liabilities	279	286	(264)
Effect of extraordinary dividend distribution from the Association - reported net of taxes in other income	(4,996)	-	-
Tax credit benefit	72	(1,445)	(865)
Other permanent disallowances, net:			
Disallowance of expenses related to exempt interest income	40	228	474
Disallowed dividend received deduction	2,502	1,028	1,298
Disallowed interest expense	21	118	193
Other	794	658	(66)
Total other permanent differences	3,357	2,032	1,899
Other adjustments	(631)	351	933
Total Income Tax Expense	$2,281	$12,472	$20,464

(dollar amounts in thousands, except per share data)

Deferred income taxes reflect the tax effects of temporary differences between carrying amounts of assets and liabilities for financial reporting purposes and income tax purposes. The net deferred tax asset at December 31, 2013 and 2012 of the Company and its subsidiaries is composed of the following:

	2013	2012
Deferred tax assets		
Allowance for doubtful receivables	$7,419	$6,669
Liability for pension benefits	19,242	24,616
Employee benefits plan	3,290	816
Postretirement benefits	54	962
Deferred compensation	2,062	1,288
Accumulated depreciation	376	594
Impairment loss on investments	563	363
Contingency reserves	-	156
Share-based compensation	2,461	1,055
Alternative minimum income tax credit	1,990	1,725
Purchased tax credits	10,193	883
Net operating loss	7,007	5,306
Unrealized loss on securities available for sale	129	-
Gross deferred tax assets	54,786	44,433
Less: Valuation allowance	(2,984)	-
Deferred tax assets	51,802	44,433
Deferred tax liabilities		
Deferred policy acquisition costs	(3,691)	(5,315)
Catastrophe loss reserve trust fund	(6,949)	(6,782)
Unrealized gain upon acquisition	(118)	(174)
Unrealized gain on securities available for sale	(10,531)	(17,006)
Unamortized bond issue costs	(61)	(54)
Intangible asset	(6,179)	(6,667)
Accumulated depreciation	(10,687)	(7,568)
Other	(850)	(253)
Gross deferred tax liabilities	(39,066)	(43,819)
Net deferred tax asset	$12,736	$614

The net deferred tax asset shown in the table above at December 31, 2013 and 2012 is reflected in the consolidated balance sheets as $33,519 and $33,548, respectively, in deferred tax assets and $20,783 and $32,934, in deferred tax liabilities, respectively, reflecting the aggregate deferred tax assets or liabilities of individual tax-paying subsidiaries of the Company.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income during the periods in which those temporary differences become deductible. Management believes that it is more likely than not that the Company will realize the benefits of these deductible differences.

The Company's U.S. Virgin Islands operations are in cumulative loss position for two year period ended December 31, 2013. For purposes of assessing the realization of the deferred tax assets, this taxable loss position is considered significant negative evidence and has caused management to conclude that it is more likely than not that the Company will not able to realize the associated deferred tax asset in the future. At December 31, 2013 the Company recorded a valuation allowance of $2,984 on the deferred tax assets of its U.S. Virgin Islands operations.

At December 31, 2013, the Company has operating loss carry-forwards for income tax purposes of approximately $10,873, which were mostly acquired with AH and that are available to offset future taxable income for up to December 2023.

17. Pension Plans

Noncontributory Defined Benefit Pension Plan

The Company sponsors a noncontributory defined-benefit pension plan for its employees and for the employees for certain of its subsidiaries. Pension benefits begin to vest after five years of vesting service, as defined, and are based on years of service and final average salary, as defined. The funding policy is to contribute to the plan as necessary to meet the minimum funding requirements set forth in the Employee Retirement Income Security Act of 1974, as amended, plus such additional amounts as the Company may determine to be appropriate from time to time. The measurement date used to determine pension benefit measures for the pension plan is December 31.

The following table sets forth the plan's benefit obligations, fair value of plan assets, and funded status as of December 31, 2013 and 2012, accordingly:

Triple-S Management Corporation
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(dollar amounts in thousands, except per share data)

	2013	2012
Change in benefit obligation		
Benefit obligation at beginning of year	$177,334	$152,561
Service cost	4,254	5,525
Interest cost	7,915	7,543
Benefit payments	(4,393)	(6,525)
Actuarial (gain) loss	(21,623)	18,230
Benefit obligation at end of year	$163,487	$177,334
Accumulated benefit obligation at end of year	$132,076	$139,675
Change in fair value of plan assets		
Fair value of plan assets at beginning of year	$101,754	$81,505
Actual return on assets	11,866	12,539
Employer contributions	7,500	14,235
Benefit payments	(4,393)	(6,525)
Fair value of plan assets at end of year	$116,727	$101,754
Funded status at end of year	$(46,760)	$(75,580)
Amounts in accumulated other comprehensive income not yet recognized as a component of net periodic pension cost		
Development of prior service credit		
Balance at beginning of year	$(3,573)	$(4,023)
Amortization	450	450
Net prior service credit	(3,123)	(3,573)
Development of actuarial loss		
Balance at beginning of year	84,285	78,433
Amortization	(7,308)	(6,135)
(Gain)/Loss arising during the year	(26,730)	11,987
Actuarial net loss	50,247	84,285
Sum of deferrals	$47,124	$80,712
Net amount recognized	$364	$5,132

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The following assumptions were used on a weighted average basis to determine benefits obligations of the plan as of December 31, 2013 and 2012.

	2013	2012
Discount rate	5.25%	4.50%
Rate of compensation increase	Graded; 3.50% to 8.00%	Graded; 3.50% to 8.00%

The assumed discount rate of 5.25% at December 31, 2013 reflects the hypothetical rate at which the projected benefit obligations could be effectively settled or paid out to participants on that date. The Company determined the discount rate based on a range of factors, including a yield curve comprised of the rates of return on high-quality, fixed-income corporate bonds available at the measurement date and the related expected duration for the obligations.

The amounts recognized in the balance sheets as of December 31, 2013 and 2012 consist of the following:

	2013	2012
Pension liability	$46,760	$75,580
Accumulated other comprehensive loss, net of a deferred tax of $15,016 and $24,214 in 2013 and 2012, respectively	32,107	56,498

The components of net periodic benefit cost for 2013, 2012, and 2011 were as follows:

	2013	2012	2011
Components of net periodic benefit cost			
Service cost	$4,254	$5,525	$5,781
Interest cost	7,915	7,543	6,681
Expected return on plan assets	(6,758)	(6,298)	(5,221)
Prior service benefit	(450)	(450)	(450)
Actuarial loss	7,308	6,135	3,326
Net periodic benefit cost	$12,269	$12,455	$10,117

Net periodic benefit cost may include settlement charges as a result of retirees selecting lump-sum distributions. Settlement charges may increase in the future if the number of eligible participants deciding to receive distributions and the amount of their benefits increases. There were no settlement charges during the years ended December 31, 2013, 2012 and 2011.

The estimated net loss and prior service benefit that will be amortized from accumulated other comprehensive loss into net periodic pension benefits cost during the next twelve months is as follows:

Prior service cost	$(450)
Actuarial loss	4,296

(dollar amounts in thousands, except per share data)

The following assumptions were used on a weighted average basis in computing the periodic benefit cost for the years ended December 31, 2013, 2012, and 2011:

	2013	2012	2011
Discount rate	4.50 %	5.00 %	6.00 %
Expected return on plan assets	7.00 %	7.25 %	7.75 %
Rate of compensation increase	Graded; 3.50% to 8.00%	Graded; 3.50% to 8.00%	Graded; 3.50% to 8.00%

The basis of the overall expected long-term rate of return on assets assumption is a forward-looking approach based on the current long-term capital market outlook assumptions of the assets categories in which the trust invests and the trust's target asset allocation. At December 31, 2013, the assumed target asset allocation for the program is: 44% to 56% in equity securities, 34% to 46% in debt securities, and 6% to 14% in other securities. Using a mean-variance model to project returns over a 30-year horizon under the target asset allocation, the 35% to 65% percentile range of annual rates of return is 6.2% to 7.8%. The Company selected a rate from within this range of 7.00% and 7.25% for 2013 and 2012, respectively, which reflects the Company's best estimate for this assumption based on the data described above, information on the historical returns on assets invested in the pension trust, and expected future conditions. This rate is net of both investment related expenses and a 0.10% reduction for other administrative expenses charged to the trust.

Plan Assets

Plan assets recorded at fair value are categorized based upon the level of judgment associated with the inputs used to measure their fair value. For level inputs and input definition, see note 9.

The following table summarizes fair value measurements by level at December 31, 2013 and 2012 for assets measured at fair value on a recurring basis:

	2013			
	Level 1	Level 2	Level 3	Total
Government obligations	$2,151	$5,329	$67	$7,547
Corporate obligations	-	5,289	2	5,291
Partnership/Joint venture	-	-	1,631	1,631
Limited Liability Corporations	-	6,400	-	6,400
Real estate	-	-	4,523	4,523
Registered investments	9,415	22,559	-	31,974
Common/Collective trusts	-	42,591	-	42,591
Hedge funds	-	7,765	-	7,765
Common stocks	8,492	-	-	8,492
Preferred stocks	202	-	-	202
Forward foreign currency contracts	4	-	-	4

Interest-bearing cash	541	-	-	541
Derivatives	(1)	8	-	7
	$20,804	$89,941	$6,223	$116,968

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	2012			
	Level 1	Level 2	Level 3	Total
Government obligations	$1,791	$2,724	$69	$4,584
Corporate obligations	-	4,394	-	4,394
Partnership/Joint venture	-	947	1,430	2,377
Limited Liability Corporations	-	2,622	-	2,622
Real estate	-	-	3,954	3,954
Registered investments	14,205	18,647	-	32,852
Common/Collective trusts	-	39,732	-	39,732
Hedge funds	-	1,926	1,874	3,800
Common stocks	6,620	-	-	6,620
Preferred stocks	207	39	-	246
Interest-bearing cash	414	-	-	414
Derivatives	-	(2)	-	(2)
	$23,237	$71,029	$7,327	$101,593

A reconciliation of the beginning and ending balances of assets measured at fair value on a recurring basis using significant unobservable inputs (Level 3) for the year ended December 31, 2013 and 2012 is as follows:

	Government Obligations	Corporate Obligations	Partnership/ Joint Venture	Real Estate	Hedge Funds	Total
Beginning balance at December 31, 2011	$ 297	$ 204	$ 1,134	$2,961	$1,455	$6,051
Actual return on program assets:						
Relating to assets still held at the reporting date	24	5	73	377	293	772
Relating to assets sold during the period	19	(7)	-	(1)	-	11
Purchases, issuances, and settlements	(141)	(101)	224	616	126	724
Transfer in and/or out	(130)	(101)	-	-	-	(231)
Ending balance at December 31, 2012	69	-	1,431	3,953	1,874	7,327
Actual return on program assets:						
Relating to assets still held at the reporting date	(6)	(18)	87	552	206	821
Relating to assets sold during the period	-	-	-	42	359	401
Purchases, issuances, and settlements	4	20	113	(24)	(954)	(841)
Transfer in and/or out	-	-	-	-	(1,485)	(1,485)
Ending balance at December 31, 2013	$ 67	$ 2	$ 1,631	$4,523	$-	$6,223

The Company’s plan assets are invested in the National Retirement Trust. The National Retirement Trust was formed to provide financial and legal resources to help members of the BCBSA offer retirement benefits to their employees.

The investment program for the National Retirement Trust is based on the precepts of capital market theory that are generally accepted and followed by institutional investors, who by definition are long term oriented investors. This philosophy holds that:

- Increasing risk is rewarded with compensating returns over time, and therefore, prudent risk taking is justifiable for long-term investors.

- Risk can be controlled through diversification of asset classes and investment approaches, as well as diversification of individual securities.

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(dollar amounts in thousands, except per share data)

- Risk is reduced by time, and over time the relative performance of different asset classes is reasonably consistent. Over the long-term, equity investments have provided and should continue to provide superior returns over other security types. Fixed-income securities can dampen volatility and provide liquidity in periods of depressed economic activity. Lengthening duration of fixed income securities may reduce surplus volatility.

- The strategic or long-term allocation of assets among various asset classes is an important driver of long term returns.

- Relative performance of various asset classes is unpredictable in the short term and attempts to shift tactically between asset classes are unlikely to be rewarded.

Investments will be made for the sole interest of the participants and beneficiaries of the programs participating in the National Retirement Trust. Accordingly, the assets of the National Retirement Trust shall be invested in accordance with these objectives:

- To ensure assets are available to meet current and future obligations of the participating programs when due.

- To invest assets with consideration of the liability characteristics in order to better align assets and liabilities.

- To earn the maximum return that can be realistically achieved in the markets over the long term at a specified and controlled level of risk in order to minimize future contributions.

- To invest the assets with the care, skill, and diligence that a prudent person acting in a like capacity would undertake. In the process, the Administration of the Trust has the objective of controlling the costs involved with administering and managing the investments of the National Retirement Trust.

Cash Flows

The Company expects to contribute $8,000 to its pension program in 2014.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Year ending December 31	
2014	$7,634
2015	7,857
2016	9,088
2017	9,730
2018	10,966
2019 – 2023	62,189

Noncontributory Supplemental Pension Plan

In addition, the Company sponsors a noncontributory supplemental pension plan. This plan covers employees with qualified defined benefit retirement plan benefits limited by the U.S. Internal Revenue Code maximum compensation and benefit limits. At December 31, 2013 and 2012, the Company has recorded a pension liability of $7,937 and $6,439, respectively. The charge to accumulated other comprehensive loss related to the noncontributory pension plan at December 31, 2013 and 2012 amounted to $1,348 and $939, respectively, net of a deferred tax asset of $866 and $402, respectively.

18. Catastrophe Loss Reserve and Trust Fund

In accordance with Chapter 25 of the Puerto Rico Insurance Code, as amended, TSP is required to record a catastrophe loss reserve. This catastrophe loss reserve is supported by a trust fund for the payment of catastrophe losses. The reserve increases by amounts determined by applying a contribution rate, not in excess of 5%, to catastrophe written premiums as instructed annually by the Commissioner of Insurance, unless the level of the reserve exceeds 8% of catastrophe exposure, as defined. The reserve also increases by an amount equal to the resulting return in the supporting trust fund and decreases by payments on catastrophe losses or authorized withdrawals from the trust fund. Additions to the catastrophe loss reserve are deductible for income tax purposes.

This trust may invest its funds in securities authorized by the Insurance Code, but not in investments whose value may be affected by hazards covered by the catastrophic insurance losses. The interest earned on these investments and any realized gains (loss) on investment transactions are part of the trust fund and are recorded as income (expense) of the Company. An amount equal to the investment returns is recorded as an addition to the trust fund.

The interest earning assets in this fund, which amounted to $40,127 and $39,059 as of December 31, 2013 and 2012, respectively, are to be used solely and exclusively to pay catastrophe losses covered under policies written in Puerto Rico.

TSP is required to contribute to the trust fund, if needed or necessary, on or before January 31 of the following year. Contributions are determined by a rate determined or established by the Commissioner of Insurance for the catastrophe policies written in that year. No contribution was required for 2013 and 2012 since the level of the catastrophe reserve exceeds 8% of the catastrophe exposure. Additions in 2011, amounting to $720, were determined by applying a rate of 1% to catastrophe premiums written.

The amount in the trust fund may be withdrawn or released in the case that TSP ceases to underwrite risks subject to catastrophe losses. Also, authorized withdrawals are allowed when the catastrophe loss reserve exceeds 8% of the catastrophe exposure, as defined.

Retained earnings are restricted in the accompanying consolidated balance sheets by the total catastrophe loss reserve balance, which as of December 31, 2013 and 2012 amounted to $39,463 and $38,649, respectively.

19. Stockholders' Equity

a. Common Stock

On December 8, 2008, the Company converted 7 million issued and outstanding Class A shares into Class B shares, in conjunction with the expiration of the lockup agreements signed by holders of Class A shares at the time of the Company's initial public offering.

For a period of five years after the completion of the Initial Public Offering (IPO) on December 7, 2007, subject to the extension or shortening under certain circumstances, each holder of Class B common stock will benefit from anti-dilution protections provided in the Company's amended and restated certificate of incorporation.

On May 16, 2013, the Company, in connection with a registered underwritten secondary public offering of its Class B common stock (the Offering), entered into an underwriting agreement (the Underwriting Agreement) with certain shareholders of the Corporation (the Selling Shareholders), pursuant to which the Selling Shareholders sold to the underwriters an aggregate of 6,210,423 shares (the Shares) of Class B common stock at a price of $18.25 per share. The Shares included 810,055 shares of Class B common stock purchased pursuant to the over-allotment option granted to the Underwriters pursuant to the Underwriting Agreement.

b. Stock Repurchase Program

On September 2010, the Company's Board approved a repurchase program ("2010 stock repurchase program") of its common stock amounting to $30,000. Repurchases were conducted through open-market purchases of Class B shares only, in accordance with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. On March 23, 2013, we discontinued our 2010 stock repurchase program. During 2012, the Company repurchased and retired 136,222 shares at an average per share price of $16.88, for an aggregate cost of $2,299. During 2011, the Company repurchased and retired 653,399 shares at an average per share price of $17.28, for an aggregate cost of $11,289. During 2010, the Company repurchased and retired 352,791 shares at an average per share price of $17.67, for an aggregate cost of $6,235.

On March 6, 2013, the Company's Board authorized the repurchase of up to $30,000 of Class B shares concurrent with the conversion of 7 million Class A shares into Class B shares and the public offering of a substantial majority of such convertible shares. As part of the Offering, on May 17, 2013, the Company repurchased and retired 1,000,000 shares at a price of $18.25 per share.

In July 2013 the Company's Board of Directors authorized a $12,000 repurchase program of its Class B common stock.

c. Preferred Stock

Authorized capital stock includes 100,000,000 of preferred stock with a par value of $1.00 per share. As of December 31, 2013 and 2012, there are no issued and outstanding preferred shares.

d. Liquidity Requirements

As members of the BCBSA, the Company, TSS, and AH are required by membership standards of the association to maintain liquidity as defined by BCBSA. That is, to maintain net worth exceeding the Company Action Level as defined in the National Association of Insurance Commissioners' (NAIC) Risk-Based Capital for Insurers Model Act. The companies are in compliance with this requirement.

e. Dividends

As a holding company, the Company's most significant assets are the common shares of its subsidiaries. The principal sources of funds available to the Company are rental income and dividends from its subsidiaries, which are used to fund our debt service and operating expenses.

(dollar amounts in thousands, except per share data)

The Company is subject to the provisions of the General Corporation Law of Puerto Rico, which restricts the declaration and payment of dividends by corporations organized pursuant to the laws of Puerto Rico. These provisions provide that Puerto Rico corporations may only declare dividends charged to their retained earnings or, in the absence of retained earnings, net profits of the fiscal year in which the dividend is declared and/or the preceding fiscal year.

The Company's ability to pay dividends is dependent, among other factors, on its ability to collect cash dividends from its subsidiaries, which are subject to regulatory requirements, which may restrict their ability to declare and pay dividends or distributions. In addition, an outstanding secured term loan restricts our ability to pay dividends in the event of default (see note 13).

The accumulated earnings of TSS, AH, TSV, and TSP are restricted as to the payment of dividends by statutory limitations applicable to domestic insurance companies. Under Puerto Rico insurance regulations, the regulated subsidiaries are permitted, without requesting prior regulatory approval, to pay dividends as long as the aggregated amount of all such dividends in any calendar year does not exceed the lesser of: (i) 10% of its surplus as of the end of the immediately preceding calendar year; or (ii) its statutory net gain from operations for the immediately preceding calendar year (excluding realized capital gains). Regulated subsidiaries will be permitted to pay dividends in excess of the lesser of such two amounts only if notice of its intent to declare such a dividend and the amount thereof is filed with the Commissioner of Insurance and such dividend is not disapproved within 30 days of its filing. As of December 31, 2013, the dividends permitted to be distributed in 2014 by the regulated subsidiaries without prior regulatory approval from the Commissioner of Insurance amounted to approximately $26,400. This amount excludes any dividend from AH because as stated in note 16, we do not intend to repatriate earnings from this subsidiary nor do any transaction that cause a reversal on an outside basis difference created as a result of the business combination of AH and cumulative earnings of its Puerto Rico-based subsidiaries that are considered to be indefinitely reinvested.

The Company has not declared any dividends subsequent to its IPO on December 7, 2007.

20. Comprehensive Income

The accumulated balances for each classification of other comprehensive income (loss) are as follows:

	Unrealized Gains on securities	Liability for Pension Benefits	Accumulated Other Comprehensive Income
Beginning balance at December 31, 2012	$ 102,515	$ (53,411)	$ 49,104
Net current period change	(34,806)	15,620	(19,186)
Reclassification adjustments for gains and losses reclassified in income	(2,125)	4,336	2,211
Ending balance at December 31, 2013	$ 65,584	$ (33,455)	$ 32,129

(dollar amounts in thousands, except per share data)

The related deferred tax effects allocated to each component of other comprehensive income in the accompanying consolidated statements of stockholders' equity and comprehensive income in 2013, 2012 and 2011 are as follows:

	2013		
	Before-Tax Amount	Deferred Tax (Expense) Benefit	Net-of-Tax Amount
Unrealized holding gains on securities arising during the period	$ (40,948)	$ 6,142	$ (34,806)
Less reclassification adjustment for gains and losses realized in income	(2,587)	462	(2,125)
Net change in unrealized gain	(43,535)	6,604	(36,931)
Liability for pension benefits:			
Reclassification adjustment for amortization of net losses from past experience and prior service costs	7,108	(2,772)	4,336
Net change arising from assumptions and plan changes and experience	25,608	(9,988)	15,620
Net change in liability for pension benefits	32,716	(12,760)	19,956
Net current period change	$ (10,819)	$ (6,156)	$ (16,975)

	2012		
	Before-Tax Amount	Deferred Tax (Expense) Benefit	Net-of-Tax Amount
Unrealized holding gains on securities arising during the period	$ 44,123	$ (6,619)	$ 37,504
Less reclassification adjustment for gains and losses realized in income	(5,197)	2,071	(3,126)
Net change in unrealized gain	38,926	(4,548)	34,378
Liability for pension benefits:			
Reclassification adjustment for amortization of net losses from past experience and prior service costs	6,112	(1,835)	4,277
Net change arising from assumptions and plan changes and experience	(11,592)	3,478	(8,114)
Net change in liability for pension benefits	(5,480)	1,643	(3,837)
Net current period change	$ 33,446	$ (2,905)	$ 30,541

(dollar amounts in thousands, except per share data)

	2011		
	Before-Tax Amount	Deferred Tax (Expense) Benefit	Net-of-Tax Amount
Unrealized holding gains on securities arising during the period	$ 55,320	$ (8,298)	$ 47,022
Less reclassification adjustment for gains and losses realized in income	(12,126)	498	(11,628)
Net change in unrealized gain	43,194	(7,800)	35,394
Liability for pension benefits:			
Reclassification adjustment for amortization of net losses from past experience and prior service costs	3,150	(945)	2,205
Net change arising from assumptions and plan changes and experience	(35,000)	10,500	(24,500)
Net change in liability for pension benefits	(31,850)	9,555	(22,295)
Net current period change	$ 11,344	$ 1,755	$ 13,099

21. Share-Based Compensation

In December 2007 the Company adopted the 2007 Incentive Plan (the Plan), which perm