TRIPLE-S MANAGEMENT CORP
Form 10-K
March 07, 2018

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

FORM 10-K

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

For the fiscal year ended December 31, 2017

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

For the transition period from _____ to _____

COMMISSION FILE NUMBER 001-33865

Triple-S Management Corporation

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

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

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

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

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

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

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

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

Yes No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files).
Yes No

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

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

Large accelerated filer	Accelerated filer
Non-accelerated filer	Smaller reporting company
Emerging growth company	

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant as of June 30, 2017 was $397,286,415 for the Class B common stock (the only stock of the registrant that trades in a public market) and $950,968 for the Class A common stock (valued at its par value of $1.00 since it is not publicly traded).

As of February 26, 2018, the registrant had 950,968 of its Class A common stock outstanding and 22,358,325 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 27, 2018 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, 2017

Table of Contents

Part I	3
Item 1. Business	3
Item 1A. Risk Factors	29
Item 1B. Unresolved Staff Comments	54
Item 2. Properties	54
Item 3. Legal Proceedings	54
Item 4. Mine Safety Disclosures	54
Part II	55
Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	55
Item 6. Selected Financial Data	57
Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations	58
Item 7A. Quantitative and Qualitative Disclosures About Market Risk	86
Item 8. Financial Statements and Supplementary Data	89
Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosures	91
Item 9A. Controls and Procedures	92
9B. Other Information	93
Part III	93
Item 10. Directors, Executive Officers and Corporate Governance	93
Item 11. Executive Compensation	93
Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	93
Item 13. Certain Relationships and Related Transactions, and Director Independence	93
Item 14. Principal Accountanting Fees and Services	94
Part IV	94
Item 15. Exhibits and Financial Statements Schedules	94
Item 16. Form 10-K Summay	94
SIGNATURES	99

Table of Contents
Part I

Item 1. Business

General Description of Business and Recent Developments

Triple-S Management Corporation ("Triple-S", "TSM", the "Company", the "Corporation", "we", "us" or "our") is one of the l significant players in the managed care industry in Puerto Rico, serving approximately 978,000 members, with a 27% market share in terms of premiums written in Puerto Rico for the nine-month period ended September 30, 2017. We have the exclusive right to use the Blue Cross and Blue Shield ("BCBS") name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla and over 55 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the Commercial, Medicaid and Medicare markets. We market our managed care products through an extensive network of independent agents and brokers located throughout Puerto Rico as well as an internal salaried sales force. We provided administration services only or self-insured ("ASO") managed care services to the Plan de Salud del Gobierno (similar to Medicaid) ("PSG" or "Medicaid") island-wide until March 31, 2015. Effective April 1, 2015, the government changed the Medicaid delivery model from an ASO to a risk-based model and we elected to participate in this sector as a fully-insured provider in only two of the eight regions of Puerto Rico. PSG is funded by the Government of Puerto Rico and the U.S. Government.

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

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

Operating revenues (with intersegment premiums/service revenues shown separately), operating income and total assets attributable to the reportable segments are set forth in note 26 of the audited consolidated financial statements for the years ended December 31, 2017, 2016 and 2015.

On October 2017, the Centers for Medicare & Medicaid Services ("CMS") published the STAR Ratings for payment year 2018. Our Health Maintenance Organization ("HMO") contract, scored 4.0 overall on a 5.0 STAR rating system, and achieved 4.5 STARS in Part D. Our Preferred Provider Organization ("PPO") contract, scored 3.5 overall, and achieved 5.0 STARS in Part D. STAR ratings are calculated annually and are subject to change each year.

Our subsidiary Triple-S Salud, Inc. ("TSS") was granted Utilization Review Accreditation Commission ("URAC") effective March 1, 2017. Reaccreditation is scheduled for 2020. This is a requirement for the Federal Employees Program representing over $175 million in premiums. The accreditation is extensive to the whole Commercial and Medicaid lines of business since they are managed in the same operational platforms as the Federal Employees Program. These achievements evidence the corporate commitment to quality in health services for our members and affiliates.

In August 2017, we announced the immediate commencement of a Class B $30.0 million share repurchase program, as authorized by our Board of Directors. In February 2018 the Board of Directors authorized a $25.0 million expansion to the existing $30.0 million Class B repurchase program. This program is conducted in accordance with Rules 10b5-1 and 10b-18 under the Securities Exchange Act of 1934.

Table of Contents

On August 29, 2017, TSS and OptumInsight, Inc. (“Optum”) entered into a Master Services Agreement (the “Agreement”). Pursuant to the terms of the Agreement, Optum will provide healthcare technology and operations services, including information technology, claims processing and application development, to TSS and its affiliates. The Agreement was effective August 31, 2017 (the “Effective Date”) and is expected to create further operating efficiencies, mostly in the Managed Care operations. The agreement has an initial term of ten (10) years but TSS has the right to extend the term of the Agreement for two (2) additional one (1) year terms. Under the terms of the Agreement, Optum will: (i) continue providing services already provided to TSS and its affiliates, (ii) provide new services requested by TSS and (iii) provide services in support of any third party administrator arrangements entered into by TSS or its affiliates, in accordance with the terms of separate statements of work to be entered into by the parties. The different services being offered by Optum will be implemented in phases beginning in 2018. The Agreement is subject to the approval of the Puerto Rico Health Insurance Administration (“ASES” by its Spanish acronym).

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.

Table of Contents
Industry Overview

Managed Care

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

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

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

Life Insurance

Total annual premiums in Puerto Rico for the year ended December 31, 2016 for the life insurance market approximated $1.5 billion. The main products in this market are ordinary life, cancer and other dreaded diseases, term life, disability and annuities. The main distribution channels are independent agents. Banks have established general agencies to cross sell life insurance products, such as term life and credit life.

Property and Casualty Insurance

The total property and casualty market in Puerto Rico in terms of gross premiums written for the nine months ended September 30, 2017 was approximately $1.3 billion. Property and casualty insurance companies compete for the same accounts through aggressive pricing, more favorable policy terms and better quality of services. The main lines of business in Puerto Rico are personal and commercial auto, commercial multi-peril, fire and allied lines and other general liabilities. Approximately 67% of the market is written by the top six insurance groups or companies in terms of market share, and approximately 87% 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. In September 2017 Puerto Rico was hit by two hurricanes causing severe damages and losses to the insurance market. Moreover, the reinsurance market was impacted even more by other natural catastrophes in the second semester of 2017. As a result, reinsurance costs are expected to increase significantly in 2018 and subsequent periods; which will also have an effect in the insurance market in Puerto Rico.

Table of Contents

Puerto Rico's Economy

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

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

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

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

Products and Services

Managed Care

Through our subsidiaries TSS and Triple-S Advantage, Inc. ("TSA"), we offer a broad range of managed care products, including HMO plans, PPO plans, Medicare Supplement, Medicare Advantage, and Medicaid plans. Managed care products represented approximately 92% of our consolidated premiums earned before elimination, net for each of the years ended December 31, 2017, 2016 and 2015. We design our products to meet the needs and objectives of a wide range of customers, including employers, professional and trade associations, individuals and government entities. Our customers either contract with us to assume underwriting risk or they self-fund underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members' access to providers is subject to referral or preauthorization requirements.

Managed care generally refers to a method of integrating the financing and delivery of health care within a system that manages the cost, accessibility and quality of care. Managed care products can be further differentiated by the types

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

Table of Contents

We currently offer the following managed care plans:

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

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

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

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

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

Life Insurance

We offer a wide variety of life, accident, disability and health and annuity products in Puerto Rico through our subsidiary Triple-S Vida, Inc. ("TSV"). Life insurance premiums represented approximately 6% of our consolidated premiums earned, before elimination, for each of the years ended December 31, 2017, 2016 and 2015. TSV markets in-home service life and supplemental health products through a network of company-employed agents. Ordinary life, cancer and dreaded diseases ("Cancer" line of business), and pre-need life products are marketed through independent agents. TSV is the leading distributor of life products in Puerto Rico. We are the only home service company in Puerto Rico and offer guaranteed issue, funeral and cancer policies to the lower and middle income market segments directly to people in their homes. We also market our group life and disability coverage through our independent producers.

Property and Casualty Insurance

We offer a wide range of property and casualty insurance products through our subsidiary Triple-S Propiedad, Inc. ("TSP"). Property and casualty insurance net premiums earned represented approximately 3% of our consolidated premiums earned, net before elimination for each of the years ended December 31, 2017, 2016 and 2015. Our predominant insurance products are commercial multi-peril package, personal package, commercial auto, hospital malpractice, commercial liability, and commercial property. This segment's commercial products target small to medium size accounts.

Table of Contents

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, 2017, 43.3% 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 are focused on promoting our strong brands, quality care, customer service efforts, size and quality of provider networks, flexibility of plan designs, financial strength and breadth of product offerings. We distribute and market our products through several channels, including our salaried and commission-based internal sales force, direct mail, independent brokers and agents, telemarketing staff, traditional media (TV, Press, Billboards, Radio and Cinema) and Digital Media. We recently added e-commerce as part of our distribution channels.

Branding and Marketing

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

Sales and Marketing

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

Distribution

Managed Care Segment. We rely principally on our internal sales force and a network of independent brokers and agents to market our products. Individual policies are sold entirely through independent agents who exclusively sell our individual products, and Medicare Advantage and group products are sold through our 370 person internal sales force (promotors and sales representatives) as well through over 200 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.

Table of Contents

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

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 (61.5% in 2017 and 64.0% in 2016) were placed through our home service distribution channel selling directly to customers in their homes. TSV employs approximately 630 full-time active agents and managers and utilizes approximately 400 independent agents and brokers. For individual policies, we advance first year commissions upon issuance and for group policies, we pay commissions on a monthly basis based on premiums received.

Property and Casualty Insurance Segment. In our property and casualty insurance segment, business is primarily subscribed through approximately 15 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, 2017, 2016 and 2015 TSIA placed approximately 69%, 73% and 73% of TSP's total premium volume, respectively. General agencies contracted by TSP remit premiums net of their respective commission.

Customers

Managed Care

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

Market Sector	Enrollment at December 31, 2017	Percentage of Total Enrollment	
Commercial	475,026	48.6	%
Medicare	118,451	12.1	%
Medicaid	384,462	39.3	%
Total	977,939	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 insurance risk, except to the extent they maintain stop loss coverage. This sector also includes professional and trade associations.

Federal Government Employees. For over 40 years, we have maintained our leadership in providing managed care services to federal government employees in Puerto Rico. We provide our services to these employees under the Federal Employees Health Benefits Program pursuant to a direct contract with OPM and through the Federal Employee Program of the BCBSA. We are one of two companies in Puerto Rico that has such a contract with OPM. Every year, OPM allows other insurance companies to compete for this business, provided such companies comply

with the applicable requirements for service providers. This contract is subject to termination in the event of a non-compliance that is not corrected to the satisfaction of OPM.

Table of Contents

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

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

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

Medicare Advantage Sector

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

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

Medicaid

The government of Puerto Rico has privatized the delivery of services to the medically indigent population in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. The government divided Puerto Rico into eight geographical areas. Each of the eight geographical areas is awarded to a managed care company doing business in Puerto Rico through a competitive bid process. We currently provide healthcare services in the Metro-North and West regions to approximately 384,000 members. As of December 31, 2017, this program provided healthcare coverage to over 1.2 million people.

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

Our agreement with the government of Puerto Rico is subject to termination in the event of a non-compliance event 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. See "Item 1A – Risks Factors – Risks Related to our Business – We are dependent on a small number of government contracts to generate a significant amount of the revenues of our managed care business".

Table of Contents

Life Insurance

Our life insurance customers consist primarily of individuals, who hold approximately 607,400 policies. We also insure approximately 1,560 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. The auto physical damage and auto liability customer bases are primarily of commercial accounts. Personal business are primarily generated with sales of our personal package product, ProPack, that includes coverage for residences, personal property, and automobile. Also, professional liability coverage is offered with hospital and medical malpractice products.

Underwriting and Pricing

Managed Care

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

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

We have been able to maintain relatively high retention rates, which is the percentage of existing clients retained in the renewal process, in the corporate accounts sector of our managed care business. For 2017 and 2016 our corporate accounts retention factor was 92% and 88%, respectively.

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

Life Insurance

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

Property and Casualty Insurance

The property and casualty insurance sector has experienced a soft market in Puerto Rico, principally as a result of economic conditions and reinsurance capacity, which is now changing due to the losses generated by the hurricanes in the current year. 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.

Table of Contents

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

Quality Initiatives and Medical Management

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

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

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

Table of Contents

Provider Arrangements

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

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

We promote the use of electronic claims billing by our providers. Approximately 93% of claims are submitted electronically through our fully automated claims processing system, and our “first-pass rate”, or rate at which a claim is approved for payment when first processed by our system without human intervention, for provider claims has averaged 92% in 2017.

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

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

Physicians. Fee-for-service is our predominant reimbursement methodology for physicians in our PPO products and for 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 agreement 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.

Table of Contents

On August 29, 2017, we entered into a Master Services Agreement in which OptumInsight, Inc. will provide healthcare technology and operations services, including information technology, claims processing and application development, to TSS and its affiliates.

Competition

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

Managed Care

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

Competitors in the managed care segment include national and local managed care plans. At December 31, 2017, we had approximately 978,000 members enrolled in our managed care segment. Our market share in terms of premiums written in Puerto Rico was estimated at approximately 27% for the nine-month period ended September 30, 2017.

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

Life Insurance

We are one of the leading providers of life insurance products in Puerto Rico. In 2016, we were the second largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 10.5%. We are the only life insurance company that distributes our products through home service. However, we face competition in each of our product lines. Excluding annuities, we are the largest company in the life insurance and cancer lines of business, with market shares of approximately to 19.8% and 20.6% respectively.

Property & Casualty Insurance

The property and casualty insurance market in Puerto Rico is extremely competitive. In addition, soft market conditions have prevailed in Puerto Rico for a long period of time. In the local market, such conditions mostly affected commercial risks, precluding rate increases and even provoking lower premiums on both renewals and new business. After the hurricanes causing losses in Puerto Rico during September 2017, the commercial markets are experiencing increases in pricing and modifications on policy conditions, which is the typical reaction in the period following a natural catastrophic event. 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, 2017, we were the fourth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share approximating 8%.

Table of Contents

Blue Cross and Blue Shield License

We have license agreements with BCBSA that permit us the exclusive use of the BCBS name and marks for the sale, marketing and administration of managed care plans and related services in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. We believe that the BCBS name and marks are valuable brands of our products and services in the marketplace. The license agreements, which have a perpetual term (but 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. We also would no longer have access to the networks of providers of the different plans that are members of the Association nor the BlueCard Program. We would expect to lose a significant portion of our membership if we lose these licenses. Loss of these licenses could significantly harm our ability to compete in our markets and could require payment of a significant fee to the BCBSA. Furthermore, if our licenses were terminated, the BCBSA would be free to issue a new license to use the BCBS name and marks to another entity, which could have a material adverse effect on our business, financial condition and results of operations. See "Item 1A Risk Factors–Risks Related to Our Business – The termination or modification of our license agreements to use the BCBS name and marks could have a material adverse effect on our business, financial condition and results of operations."

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

- failure to maintain our total adjusted capital at or above 375% of Health Risk-Based Capital ("HRBC") Authorized Control Level ("ACL") as defined by the National Association of Insurance Commissioners ("NAIC") for the for Primary Licensee (TSM) and Larger BCBS Controlled Affiliate (TSS) and 100% HRBC ACL for the Smaller BCBS Controlled Affiliate (TSA);

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

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

- impending financial insolvency; and

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

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

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

As required by our BCBS license agreements, our articles of incorporation prohibit any institutional investor from owning 10% or more of our voting power, any person that is not an institutional investor from owning 5% or more of our voting power, and any person from beneficially owning shares of our common stock or other equity securities, or a combination thereof, representing a 20% or more ownership interest in us.