TRIPLE-S MANAGEMENT CORP
Form 10-K
March 01, 2019

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, 2018

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, 2018 was $868,796,776 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 22, 2019, 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 26, 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, 2018

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Part I

Item 1. Business

General Description of Business and Recent Developments

Triple-S Management Corporation ("Triple-S", "TSM", the "Company", the "Corporation", "we", "us" or "our") is one of the l significant players in the managed care industry in Puerto Rico, serving approximately 876,000 members, with a 27% market share in terms of premiums written in Puerto Rico for the nine-month period ended September 30, 2018. 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 60 years of experience in the managed care industry. We offer a broad portfolio of managed care and related products in the Commercial, Medicare, and the Government of Puerto Rico health insurance plan (similar to Medicaid) ("Medicaid" or "the Government health plan") 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. Medicaid 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 27, Segment Information, of the audited consolidated financial statements included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

In October 2018, the Centers for Medicare & Medicaid Services ("CMS") published the STAR Ratings for payment year 2020. Our Health Maintenance Organization ("HMO") contract, scored 4.5 overall on a 5.0 STAR rating system, and achieved 4.5 STARS in Part D. Our Preferred Provider Organization ("PPO") contract, saw its rating increased to 4.0 overall. STAR ratings are calculated annually and are subject to change each year.

In 2018, our subsidiary Triple-S Propiedad ("TSP") experienced a reinsurance spillover for the first time since its incorporation 30 years ago. This spillover was related to the losses caused by Hurricane Maria, a strong Category 4 hurricane that impacted Puerto Rico in September 2017. Following the impact of Hurricane Maria, TSP increased its catastrophe protection to maximum losses per event by $200 million, from $715 million in 2017 to $915 million in 2018. In addition, after Hurricane Maria TSP's gross insured values have decreased by approximately 35% which, combined with the increase in catastrophe reinsurance coverage, has strengthened its reinsurance program. See Note 14, Reinsurance Activity, of the notes to the audited consolidated financial statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K. Please refer also to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations – III. Results of Operations – Property and Casualty Segment Operating Results".

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 $175.0 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. Our STAR rating and URAC accreditation evidence the commitment to quality in health services for our

members and affiliates.

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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 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.

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 were implemented in phases beginning in 2018. On December 29, 2017, the Puerto Rico Health Insurance Administration ("ASES" by its Spanish acronym) reviewed the Agreement with Optum and deemed it compliant with the terms of the Government Health Plan Contract executed between ASES and TSS.

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.

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 services 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 certain 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.

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Life Insurance

Total annual premiums in Puerto Rico for the year ended December 31, 2018 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 and an internal salaried sales force. 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, 2018 was approximately $1.6 billion. Property and casualty insurance companies compete for the same accounts through 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 insurance groups or 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. 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 well as in 2018. As a result, premium rates and reinsurance costs increased significantly in 2018 and additional increases are expected in subsequent periods; which will also have an effect in the insurance market in Puerto Rico.

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. Historically, the economy of Puerto Rico has followed the economic trends of the U.S. economy. However, for the past decade 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, which eventually resulted in it defaulting and having to restructure the majority of debt.

On June 30, 2016, the President of the United States signed the Puerto Rico Oversight, Management, and Economic Stability Act ("PROMESA"), which granted the Government of Puerto Rico and its instrumentalities, access to an orderly mechanism to restructure their debts in exchange for significant federal oversight over the Government of Puerto Rico's finances. In general, PROMESA seeks to provide Puerto Rico with fiscal and economic discipline through the creation of an oversight board ("Oversight Board") and two alternative methods to adjust unsustainable debt. The Oversight Board also has the authority to review the fiscal impact of contracts and regulations, as well as prevent the enforcement of laws that are inconsistent with the Government of Puerto Rico's Fiscal Plan ("Fiscal Plan").

In August 2016, President Obama appointed the seven voting members of the Oversight Board through the process established in PROMESA, which authorized the President to select the members from several lists required to be submitted by congressional leaders. On February 15, 2019, the First Circuit of the U.S. Court of Appeals (the "First Circuit") declared such appointments unconstitutional upon concluding that they did not comply with the Appointments Clause of the U.S. Constitution, which requires that principal federal officers be appointed by the President, with the advice and consent of the U.S. Senate. The First Circuit's decision provides that its mandate will not issue for 90 days, so as to allow the President and the U.S. Senate to validate the currently defective appointments or reconstitute the Oversight Board in accordance with the Appointments Clause. The First Circuit did not eliminate otherwise valid actions taken to date by the Oversight Board and provided that the current Oversight Board may continue to operate until the expiration of the 90-day period.

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In the most recent Fiscal Plan certified by the Oversight Board, dated October 23, 2018, the Government estimates a 16.1% contraction in real gross national product ("GNP") in fiscal year 2018 (July 1, 2017–June 30, 2018), without considering the impact of disaster relief funding related to Hurricanes Irma and Maria or the measures and structural reforms proposed by the plan. Taking into account such factors, the Fiscal Plan estimates an 8.0% contraction in real GNP in fiscal year 2018. It also projects that disaster relief funding will have a short-term stimulative effect on Puerto Rico's economy, which, combined with the estimated effects of the proposed measures and reforms, the Fiscal Plan estimates should result in variable GNP growth from fiscal years 2019 through 2022, followed by GNP contraction in fiscal year 2023 as disaster relief funding decreases.

The Fiscal Plan outlines a number of structural reforms and fiscal measures that the Oversight Board deems necessary to improve the Puerto Rico's fiscal balance and economic condition. Such measures include structural reforms, such as labor, ease of doing business, energy sector, and infrastructure reforms, as well as fiscal measures, such as agency consolidations, reductions in budgetary appropriations, and pension reform. The Fiscal Plan and the fiscal plans certified by the Oversight Board for the Government's instrumentalities conclude that they will not be able to meet all of their contractual obligations, even after implementing the measures and reforms contemplated therein.

The Governor and other government officers have publicly expressed their disagreement with several of the measures included in the Fiscal Plan, particularly the pension reform, which contemplates average pension benefit reductions of approximately 10%, and the labor reform, which contemplates the elimination of certain mandatory benefits to public and private employees. The Governor had also previously challenged the Oversight Board's authority with respect to certain matters related to Puerto Rico's budget and a previous version of the fiscal plan before the U.S. District Court for the District of Puerto Rico (the "District Court") in Hon. Ricardo Roselló Nevares v. The Financial Oversight and Management Board for Puerto Rico, Case No. 17-3283 (the "Adversary Proceeding"). The District Court issued an order on August 27, 2018 partially dismissing certain portions of the Adversary Proceeding and, on October 9, 2018, the District Court certified certain aspects such order for interlocutory appeal.

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

Products and Services

Managed Care

Through our subsidiaries TSS and Triple-S Advantage, Inc. ("TSA"), we offer a broad range of managed care products, including HMO plans, PPO plans, Medicare Supplement, Medicare Advantage, and Medicaid plans. Managed care products represented approximately 92% of our consolidated premiums earned before elimination, net for each of the years ended December 31, 2018, 2017 and 2016. We design our products to meet the needs and objectives of a wide range of customers, including employers, professional and trade associations, individuals and government entities. Our customers either contract with us to assume underwriting risk or they self-fund underwriting risk and rely on us for provider network access, medical cost management, claim processing, stop-loss insurance and other administrative services. Our products vary with respect to the level of benefits provided, the costs paid by employers and members, including deductibles and co-payments, and the extent to which our members' access to providers is subject to referral or preauthorization requirements.

Managed care generally refers to a method of integrating the financing and delivery of health care within a system that manages the cost, accessibility and quality of care. Managed care products can be further differentiated by the types of provider networks offered, the ability to use providers outside such networks and the scope of the medical management and quality assurance programs. Our members receive medical care from our networks of providers in exchange for premiums paid by the individuals or their employers, including governmental entities, and, in some

instances, a cost-sharing payment between the employer and the member. We reimburse network providers according to pre-established fee arrangements and other contractual agreements.

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We currently offer the following managed care plans:

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

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

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

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

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

Life Insurance

We offer a wide variety of life, accident, disability and health and annuity products in Puerto Rico through our subsidiary Triple-S Vida, Inc. ("TSV"). 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"). 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 mainly target small to medium size accounts.

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

We maintain a comprehensive reinsurance program as a means of protecting our surplus in the event of a catastrophe. Also, there is reinsurance to protect us from the impact of large unforeseen losses and prevent sudden and unpredictable changes in results of operations and equity. 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, 2018, 43.2% of the premiums written in the Property and Casualty 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 (including local and cable TV, national and regional press, billboards, radio and cinema) and digital media (that range from social, search engine optimization, and search engine marketing). We continue to expand our distribution channels and have relaunched our e-commerce channel for our Individual plan purchases where consumers can evaluate and purchase a health plan completely online, being the first plan in the Island to offer this capability.

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. Another aspect of our marketing initiatives revolves around our recently awarded 4.5 star rating out of a 5-star rating from CMS in our HMO Contract. This new rating should put our Medicare Advantage business in a level playing field with our competitors and allow us to continue to innovate and improve the products we offer our members.

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.

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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 450-person internal sales force (promoters 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.

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 collections. 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 Segment In our Life segment, we offer our insurance products through our own network of both company-employed and independent agents. The majority of our premiums (63% in 2018 and 61.5% in 2017) were placed through our home service distribution channel selling directly to customers in their homes. TSV employs approximately 700 full-time active agents and managers and utilizes approximately 300 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 Segment. In our Property and Casualty 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, 2018, 2017, and 2016 TSIA placed approximately 76%, 69%, 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, 2018	Percentage of Total Enrollment	
Commercial	449,047	51.2	%
Medicare	108,605	12.4	%
Medicaid	318,616	36.4	%
Total	876,268	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.

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Federal Government Employees. For over 50 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.

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 Medicaid and Child Health Insurance subscribers in Puerto Rico, as defined by the government, by contracting with private managed care companies instead of providing health services directly to such population. 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. As of December 31, 2018, this program provided healthcare coverage to over 1.6 million people.

Under the current agreement with ASES, TSS is one of five MCOs that offer medical, mental, pharmacy, and dental health care services on an at-risk basis to the subscribers of the Government of Puerto Rico's health insurance program. With this agreement TSS is now able to serve subscribers who enroll in our plan on an island-wide basis, rather than participating in the specific service regions assigned by ASES. ASES pays TSS a per member per month rate that varies depending on the clinical condition or category of each subscriber. This current agreement was effective November 1, 2018 at which time TSS was assigned by ASES approximately 280,000 subscribers. After this date, subscribers had approximately three months to select their insurance carrier, during which time TSS was able to compete for membership across Puerto Rico. As of December 31, 2018, our Medicaid membership was approximately 319,000 members.

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In previous contracts, the government divided Puerto Rico into eight geographical areas. Each of these geographical areas was awarded through a competitive bid process, to a managed care company doing business in Puerto Rico. Up to October 31, 2018, we provided healthcare services in the Metro-North and West regions to approximately 384,000 members.

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 segment".

Life Insurance

Our Life segment mainly targets individual life and cancer and other dreaded diseases insurance. Our customers consist primarily of individuals, who hold approximately 614,500 policies. We also insure approximately 1,500 groups.

Property and Casualty Insurance

Our Property and Casualty segment mainly 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 segment. For 2018 and 2017 our corporate accounts retention factor was 96% and 92%, 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 and Medicaid sectors 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.

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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 changed to a hard market after the losses generated by the hurricanes in 2017. 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 mainly 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.

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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.

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 92% 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 91% in 2018.

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 ("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 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.

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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.

On August 29, 2017, we entered into a Master Services Agreement in which OptumInsight, Inc. provides 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 industry include national and local managed care plans. At December 31, 2018, we had approximately 876,000 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, 2018.

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 2017, we were the second largest life insurance company in Puerto Rico, as measured by direct premiums, with a market share of approximately 12.2%. 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 24.9% and 25.2% respectively.

Property & Casualty Insurance

The property and casualty insurance market in Puerto Rico is extremely competitive. In addition, soft market conditions prevailed in Puerto Rico for a long period of time, mostly affecting local 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 2017, the commercial markets experienced 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.

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In the nine-month period ended September 30, 2018, we were the fourth largest property and casualty insurance company in Puerto Rico, as measured by direct premiums, with a market share approximating 6.1%.

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. 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.

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Pursuant to the rules and license standards of the BCBSA, TSM guarantees TSS and Triple-S Blue, Inc. ("TSB") contractual and financial obligations to their respective customers. Also, TSS guarantees TSA's contractual and financial obligations to their respective customers. In addition, pursuant to the rules and license standards of the BCBSA, we have agreed to indemnify the BCBSA against any claims asserted against it resulting from our contractual and financial obligations.

Each license requires an annual fee to be paid to the BCBSA. The fee is determined based on a per-contract charge from products using the BCBS name and marks. The annual BCBSA fee for the year 2019 is $1,367,352. During the years ended December 31, 2018 and 2017, we paid fees to the BCBSA in the amount of $1,409,481 and $1,444,069, respectively. The BCBSA is a national trade association of 36 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 centralized services to entities licensed by the BCBSA (the "Member Plans"). Each Member Plan is an independent legal organization and is not responsible for obligations of other BCBSA Member Plans. With a few limited exceptions, we have no right to market products and services using the BCBS name and marks outside our BCBS licensed territory.

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

Trademarks

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

Regulation

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

- grant, suspend and revoke licenses to transact business;

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

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

- initiatives to provide greater access to coverage for uninsured and under-insured populations without adequate funding to health plans or to be funded through taxes or other negative financial levies on health plans;
- other efforts or specific legislative changes to the Medicare or Medicaid program, including changes in the bidding process or other means that materially reduce premiums;
- local government regulatory changes;
- increased government enforcement, or changes in interpretation or application of fraud and abuse laws; and
- regulation that increase the operational burden on health plans or laws that increase a health plan’s exposure to liabilities, including efforts to expand the tort liability of health care plans.

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

- licensure;
- policy forms, including plan design and disclosures;
- premium rates and rating methodologies;
- underwriting rules and procedures;
- benefit mandates;
- eligibility requirements;
- security of electronically transmitted individually identifiable health information;
- geographic service areas;
- 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;

- market conduct;
- utilization review;
- payment of claims, including timeliness and accuracy of payment;
- special rules on contracts to administer government programs;
- transactions with affiliated entities;
- limitations on the ability to pay dividends;
- payment rates to healthcare providers;
- rate review and approval;
- delegation of financial risk and other financial arrangements in rates paid to healthcare providers;
- agent licensing;
- financial condition (including reserves);
- reinsurance;
- business continuity plans;
- issuance of new capital stock shares;
- corporate governance;
- permissible investments; and
- guaranteed issue and renewability.

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

Puerto Rico Insurance Laws

Our insurance subsidiaries are subject to the regulations and supervision of the Commissioner of Insurance. The regulations and supervision of the Commissioner of Insurance consist primarily in the approval of certain policy forms, solvency standards, the nature of and limitations on investments, deposits of securities for the benefit of policyholders, methods of accounting, periodic examinations and the form and content of the financial reports, among others. In general, such regulations are for the protection of policyholders rather than shareholders.

Puerto Rico insurance laws prohibit any person from offering to purchase or sell voting stock of an insurance company 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.

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

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

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

Privacy of Financial and Health Information

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

Managed Care Provider Services

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

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Capital and Reserve Requirements

Local insurers and health maintenance 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 requirements. Our minimum RBC requirement is currently 200%, subject to the compliance with certain regulatory ratios. Non-compliance with required regulatory ratios would subject TSS, TSV, TSB and TSP to a minimum RBC requirement of 300%. As a health maintenance organization TSA is not subject to compliance with regulatory ratios and is therefore always required to maintain a minimum RBC of 200%.

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

The RBC Model Act requires increasing degrees of regulatory oversight and intervention as an insurance company's risk-based capital declines. The level of regulatory oversight ranges from requiring the insurance company to inform and obtain approval from the domiciliary insurance commissioner of a comprehensive financial plan for increasing its risk-based capital to mandatory regulatory intervention requiring an insurance company to be placed under regulatory control, in rehabilitation or liquidation proceeding. The RBC Model Act provides for four different levels of regulatory attention depending on the ratio of the company's total adjusted capital (defined as the total of its statutory capital, surplus, assets valuation reserve and dividend liability) to its risk-based capital. At the "company action level", occurring when a company's total adjusted capital is less than 200% but greater than or equal to 150% of its risk-based capital, a company must submit a comprehensive plan to the regulatory authority which discusses proposed corrective actions to improve its capital position. When a company's adjusted capital is between 200% and 300% and it has a combined ratio greater than 150%, a "company action level" is triggered only if the Puerto Rico Commissioner of Insurance has implemented the health trend test. As of December 31, 2018, 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, 2018, our insurance subsidiaries, except for TSP, met and exceeded the minimum capital requirements established by the Commissioner of Insurance and the BCBSA, as applicable.

As of December 31, 2018, TSP's RBC score was lower than the 200% minimum requirement. As the result of the unfavorable development experienced in the reserves related to Hurricane Maria during 2018, TSP is currently under a plan to increase its statutory surplus and risk-based capital scores ("RBC plan"). This RBC plan includes, among other measures, a $10 million capital infusion from TSM made in November 2018 and the execution of a multi-year high excess cover reinsurance agreement, including both retroactive and prospective coverage, which was signed by TSP on November 2, 2018. The retroactive portion is an adverse development reinsurance providing for a coverage of $50 million in excess of $76.5 million of net losses, representing the adverse development related to Hurricane Maria experienced as of June 30, 2018. The prospective portion of the agreement provides catastrophe umbrella coverage for a five-year period ending March 31, 2023. This reinsurance agreement increased TSP's statutory surplus and

provides catastrophe protection for five years for a portion of our reinsurance program. TSP presented this plan to the Insurance Commissioner and expects to achieve a 200% RBC in the second quarter of 2019. Should TSP not be able to increase its RBC score on a timely basis it could require additional capital infusions and/or the issuance of surplus notes.

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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 a result of the hurricanes affecting Puerto Rico in September 2017, TSP withdrew $10.0 million from the Trust in 2018.

At December 31, 2018 and 2017, the reserve for catastrophes is $37.7 million and $46.6 million, respectively. The supporting trust fund has assets of $40.0 million and $48.4 million as of December 31, 2018 and 2017, respectively. Assets consist primarily of investment in securities available for sale, securities held for maturity, accrued investment income, cash and cash equivalents. The income generated by investment securities deposited in the Trust becomes part of the Trust fund balance and are therefore considered an addition to the reserve. For additional details see Note 17, Catastrophe Loss Reserve and Trust Fund, of the notes to consolidated financial statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

Dividend Restrictions

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

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

Guaranty Fund Assessments

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

Federal Regulation

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

Medicare Generally

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

contractors under contract with CMS. There are approximately 55 million Medicare beneficiaries.

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Medicare is divided into 4 distinct parts:

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

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

- Part C, also known as Medicare Advantage, allows beneficiaries to enroll in private health plans and receive Medicare-covered benefits. Currently, about 17 million Medicare beneficiaries are enrolled in the United States in a Medicare Advantage plan. Under the Patient Protection and Affordable Care Act of 2010 (Pub. L No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), on March 30, 2010 (referred to herein as "ACA"), payments to Medicare Advantage plans are generally being reduced over time, and bonus payments are available to certain plans based on quality ratings. Medicare Advantage plans are required to maintain a medical loss ratio ("MLR") of at least 85%, meaning, very basically, that if Medicare Advantage plans do not spend at least 85% of their revenue on patient care costs, may face various sanctions, including refunds, prohibition on enrolling new members, and contract termination. The Part C premium varies by plan.

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

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

Since the 1980's, as an alternative to the traditional fee-for-service Medicare program, Medicare has also offered Medicare managed care benefits provided through contracted private health plans, currently known as Medicare Advantage plans. Prior to 1997, CMS reimbursed health plans participating in the Medicare program primarily on the basis of the demographic data of the plans' members. Beginning in 1997, CMS gradually phased in a risk adjustment payment methodology that based its monthly premium payments to plans on various clinical and demographic factors. This methodology uses two risk adjustment models: a Hierarchical Condition Category based model and an ESRD model, each applying to the corresponding population. Beginning in 2003, Congress introduced a Medicare managed care approach, which itself has subsequently undergone several changes, and beginning in 2006, Congress introduced the Medicare Part D program, which offered a voluntary outpatient prescription drug benefit to fee-for-service as well as Medicare Advantage beneficiaries. An Rx Hierarchical Condition Category Model is used in the determination of the Part D premium, and a Low Income Subsidy (LIS) is applied to Part D premiums for members that qualify.

Among other things, the ACA mandated several changes, implemented by CMS, to the Medicare Advantage and Medicare Part D programs, including strengthening CMS' ability to remove poor performers from the Medicare Advantage and Part D programs beginning in 2015. Beginning with Medicare contract year 2015, CMS has the authority to terminate its contract with any Medicare Advantage or Part D plan for substantial contract non-compliance, or refuse to renew such plan, if the plan fails to achieve an overall Star Rating of 3.0 stars (out of 5.0) for any consecutive three (3) year period. Although CMS has issued annual Star Ratings for Part D plans since 2007 and for Medicare Advantage plans since 2008, CMS uses Star Ratings issued for Medicare contract years 2013 and beyond in implementing this provision. In April 2015, CMS announced that it would for the first time exercise its authority to terminate low performing Medicare Advantage and Part D plans beginning in 2016. CMS issues Star

Ratings on a prospective basis, typically in the fall preceding the contract year. CMS has the authority to use the lower Star Ratings as a means to invoke its existing authority under Section 1857(c)(2) of the Social Security Act to terminate a contract when CMS determines that the Medicare Advantage or Part D plan has failed to substantially carry out the contract or is carrying out the contract in a manner that is inconsistent with the efficient or effective administration of the Medicare Advantage or Part D program.

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In addition, under the ACA, Medicare Advantage plan payment rates were subject to transitionally phased-in reductions intended to bring Medicare Advantage rates more in line with Medicare fee-for-service rates. The transition began in 2012 and was completed in 2017.

Payments to Medicare Advantage Participating Plans

Since 2006, Medicare Advantage has used a bidding system by which plans submit bids based on costs per enrollee for Part A and Part B covered services. Medicare Advantage also pays plans for providing prescription drug benefits under Part D. Bids are based on estimated costs per enrollee for the Medicare-covered services. The bids are then analyzed against a benchmark established by federal statute, and which vary by county or region. A Medicare Advantage plan's actual payment rate is based on a complex statutory formula that takes into account a number of factors, including the relationship between the plan's bid and the applicable benchmark. When a bid is higher than the benchmark, enrollees generally pay the difference (through an additional premium) between the benchmark and the bid, in addition to any other Medicare premiums. If the bid is lower than the benchmark, the plan and Medicare generally share the difference, and the plan must use its share (known as a "rebate") to provide additional benefits to enrollees. For plans obtaining up to 3.0 STARS, the rebate share to the plan is 50%. When the plan reaches 3.5 or 4.0 STARS, that rebate share rises to 65%, and when the plan reaches 4.5 or 5.0 STARS it rises to 70%.

Plans reaching 4.0 STARS or higher, also receive a 5% quality bonus payment (QBP), which could be doubled for certain qualifying counties. The resulting benchmark plus QBP amount can be reduced to a cap determined for each county, so the effective bonus payment for such qualifying counties could be between 5% and 10%. Rebates and QBPs only apply to Part C premium payments.

STARS Ratings for plans are calculated based on the results achieved by the plan on a contract in terms of measures (48 in the 2019 draft call letter) spanning four categories: Healthcare Effectiveness Data and Information Set (HEDIS) measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) and Health Outcomes Survey (HOS) measures, Administrative measures and Part D measures. CMS assigns from one to five stars for each numeric measure score by applying one of two methods: relative distribution with significance testing (CAHPS) or clustering (all other measures). Case-mix adjustments are applied to the survey results as part of the scoring. CMS has recognized that socio-economic factors create significant variations in results for some metrics. CMS' interim response to address the within-contract disparity in performance associated with a contract's percentages of beneficiaries with low income subsidy and dual eligible (LIS/DE) and disability status revealed in our comprehensive research conducted over multiple years culminated in the creation of the Categorical Adjustment Index (CAI). Each measure is also assigned a relative weight used in the calculation of the Part C, Part D and overall STAR Rating. CMS has also adopted policies to consider the impact of extreme natural disasters in the results, recognizing that the aftermath can present unanticipated barriers to achieving solid results.

Medicaid Generally

Medicaid is a public insurance program intended for low-income individuals and families. Medicaid, as of November 2018, provides coverage to over 73 million Americans, including children, pregnant women, and individuals with disabilities. To participate in Medicaid, states must cover certain groups but have the flexibility to cover other population groups. States may apply to CMS for waivers to provide coverage to populations beyond what is normally covered under the program. States are able to establish eligibility criteria within federal minimum standards. States are allowed to set Medicaid provider payment rates, and may reimburse providers through fee-for-service or managed care. They also have the flexibility to determine the type, amount, duration, and scope of services of their respective Medicaid programs, so long as within federal guidelines, although states are required to cover certain mandatory benefits. In Puerto Rico, the Medicaid program is administered locally by ASES.

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Medicaid is jointly funded by the federal government and state governments. States receive a percentage of their Medicaid program expenditures from the federal government, through a formula known as the Federal Medical Assistance Percentage ("FMAP"). The FMAP varies by state based on factors such as per capita income. The FMAP for Puerto Rico is 55%. FMAPs are adjusted based on a 3-year cycle.

The ACA expanded Medicaid to an eligibility floor of 138% of the federal poverty level ("FPL") beginning in 2014. A 2012 U.S. Supreme Court decision regarding health care reform limited the federal government's ability to enforce Medicaid expansion—meaning that the issue of Medicaid expansion is effectively left to each individual state. Puerto Rico and the other U.S. territories were not included in the Medicaid expansion, instead Congress approved one billion in federal funding for Puerto Rico and the other U.S. territories to establish local affordable insurance exchanges or expand their Medicaid programs, at their option. Puerto Rico elected to use the approximately $925 million made available by Congress for expanding its Medicaid program. The Consolidated Appropriations Act of 2017 (P.L. 115-31) provided Puerto Rico with an additional $295.9 million. In February 2018, as part of the emergency supplemental legislation passed by Congress, Puerto Rico's Medicaid spending cliff was addressed until at least September 2019, following the approval of $4.8 billion in Medicaid funding. This action will bring temporary financial stability to Puerto Rico's Medicaid program, and funding conditions related to compliance with program management standards will further promote stability and predictability.

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. In 2016, there were approximately 11.7 million dual-eligibles, 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 original Medicare benefits. Dual-eligible beneficiaries in Puerto Rico have the option to participate in this model called Platino. Health plans that offer Platino products receive premiums from CMS and the government of Puerto Rico. In this plan the government, rather than the insured, will assume all of the premiums for additional benefits not included in traditional Medicare programs, such as prescription drug benefits. By managing utilization and implementing disease management programs, many Medicare Advantage plans can profitably care for dual-eligible members. The MMA established subsidies and reduced or eliminated deductibles for certain low-income beneficiaries, including dual-eligible individuals. Pursuant to the MMA, dual-eligible individuals receive their drug coverage from the Medicare program rather than the Medicaid program. Companies offering Medicare Part D stand-alone prescription drug plans with bids at or below the regional weighted average bid resulting from the annual bidding process received a pro-rata allocation and auto-enrollment of the dual-eligible beneficiaries within the applicable region.

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

Special Needs Plans

Special Needs Plans are intended to address Medicare beneficiaries with special care needs, particularly those with chronic conditions. Essentially, Medicare Advantage Special Needs Plans ("SNPs") are a type of Medicare Advantage Plan for people with certain chronic diseases and conditions or who have specialized needs (such as people who have both Medicare and Medicaid or people who live in certain institutions). SNPs limit membership to people with

specific diseases or characteristics, and tailor their benefits, provider choices, and drug formularies (list of covered drugs) to best meet the specific needs of the groups they serve.

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

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

Anti-kickback Laws. Insurance providers in Puerto Rico are subject to local and federal anti-kickback laws. These anti-kickback laws prohibit the payment, solicitation, offering or receipt of any form of remuneration (including kickbacks, bribes, and rebates) in exchange for business, and under federal law, the referral of federal healthcare program patients or any item or service that is reimbursed by any federal health care program. In addition, the federal regulations include certain safe harbors that describe relationships that have been determined by CMS not to violate the federal Anti-Kickback Statute. Relationships that do not fall within one of the enumerated safe harbors are not a per se violation of the federal law, but will be subject to enhanced scrutiny by regulatory authorities. The ACA amended the intent requirement of the federal Anti-Kickback Statute, and other healthcare criminal fraud statutes, so that a person or entity no longer needs to have actual knowledge of the federal Anti-Kickback Statute and other healthcare criminal fraud statutes, or the specific intent to violate them, to have committed a violation. The ACA also provided that a violation of the federal Anti-Kickback Statute is grounds for the government or a whistleblower to assert that a claim for payment of items or services resulting from such violation constitutes a false or fraudulent claim for purposes of the federal False Claims Act. Failure to comply with the anti-kickback provisions, and other healthcare criminal fraud statuses, may result in civil damages and penalties, criminal sanctions, and administrative remedies, such as exclusion from the applicable federal health care program, and additional reporting requirements and oversight if subject to a corporate integrity agreement or similar agreement to resolve allegations of non-compliance.

Federal False Claims Act. Federal regulations also strictly prohibit the presentation of false claims or the submission of false information to the federal government. Under the federal False Claims Act, any person or entity that has knowingly presented or caused to be presented a false or fraudulent request for payment from the federal government or who has made a false statement or used a false record in the submission of a claim may be subject to treble damages and penalties of up to $21,916 per claim. The ACA codified the federal government's prior position that claims presented in relationships that violate the federal Anti-Kickback Statute may also be considered to be violations of the federal False Claims Act. Furthermore, the federal False Claims Act permits private citizen "whistleblowers" to bring actions on behalf of the federal government for violations of the False Claims Act and to share in the settlement or judgment that may result from the lawsuit. Financial recoveries from civil health care matters brought under the False Claims Act are significant.

HIPAA, HITECH, and Gramm-Leach-Bliley Act

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

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

In 2015 we entered into two agreements with federal and Puerto Rican regulators to resolve investigations in connection with privacy incidents at our Managed Care segment. The agreements include the payment of a combined amount of $5 million and the adoption of a three year corrective action plan.

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 subsidiaries believe that they are in material compliance with these requirements. In addition, the federal government required healthcare organizations, including health insurers, upgrade to updated and expanded standardized code sets used for describing health conditions by converting from the ICD-9 diagnosis and procedure code set to the ICD-10 diagnosis and procedure code by October 1, 2015. Our conversion from the ICD-9 code set to the ICD-10 code set, which required a substantial investment, was successfully completed.

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

Employee Retirement Income Security Act of 1974

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

Dodd-Frank Act

In 2010, Congress enacted the Dodd-Frank Wall-Street Reform and Consumer Protection Act (the "Dodd-Frank Act") which provides for a number of reforms and regulations in the corporate governance, financial reporting and disclosure, investments, tax and enforcement areas that affect our subsidiaries. Among other things, the Dodd-Frank Act creates a Federal Insurance Office ("FIO") within the U.S. Department of the Treasury with powers that include

information-gathering and subpoena authority. Pursuant to the Dodd-Frank Act, the FIO issues annual reports on the insurance industry. Although the FIO's authority does not extend to health insurance, it extends to other parts of the business, primarily life and property and casualty insurance. The FIO, however, does not have supervisory or regulatory authority over the insurance business.

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

Legislative and Regulatory Initiatives

Puerto Rico Initiatives

On July 23, 2017, the government of Puerto Rico enacted Act 47-2017 ("Act 47"), which, among other things, imposes restrictions on utilization review ("UR") processes related to hospitalizations and the ability of MCOs to conduct internal review processes at any level of appeal. Act 47 also creates a statutory cause of action against MCOs for intervening with the "diagnostic and medical treatment of a patient" making them jointly and severally liable in those cases in which the patient suffers damages as a direct or indirect result of such intervention.

After its enactment, the Oversight Board established by PROMESA, notified the Governor that the Compliance Certification issued by the Government regarding Act 47 failed to provide the required formal estimate of the law's fiscal impact. Moreover, the Oversight Board noted that its preliminary analysis leads it to conclude that Act 47 is significantly inconsistent with the government's Fiscal Plan. As a result, the Oversight Board requested that the Government provide a formal estimate of the impact of the law's implementation on public health care expenditure once the applicable regulation is approved. On February 2, 2019, the Oversight Board notified the Governor that the Compliance Certification for Act 47 remains incomplete and reserved its rights to prevent the enforcement of such act under PROMESA. The Oversight Board also notified the Governor that Regulation No. 9063 promulgated by the Puerto Rico Patient Advocate under Act 47 ("Regulation 9063") was not submitted to the Oversight Board prior to its enactment as required by the Oversight Board's policies. Accordingly, the Oversight Board informed the Governor that it considered Regulation 9063 void until it is reviewed and approved by the Oversight Board in accordance with its policies. We are closely monitoring how Act 47 and Regulation 9063 will impact the Company insofar as the Government has not complied with Oversight Board requirements.

On April 29, 2017, the government of Puerto Rico enacted Act 26-2017 ("Act 26"), which, among other things, calls for a considerable reduction in public corporations' health plan contributions to its employees, to the extent required to comply with the government's Fiscal Plan. Contributions to employees with pre-existing catastrophic, chronic or terminal conditions, however, shall remain the same. Act 26 also authorizes the Puerto Rico Fiscal Agency and Financial Advisory Authority ("AAFAF") to negotiate health insurance coverage for such public employees. Through Administrative Order No. OA-2018-08, as amended by OA-2018-12, AAFAF ordered public corporations to participate in ASES's public employee health plan negotiation process, but authorized them to negotiate and contract with insurers independently, as they currently do. The reductions in health plan contributions contemplated in Act 26 have been postponed until March 31, 2019. However, if and when implemented, the provisions of Act 26 would create uncertainty in the market for public corporation health plans.

Federal Initiatives

On March 23, 2010, the federal health reform legislation, known as the Affordable Care Act, was enacted. Most of the provisions of ACA with more significant effects on the health insurance marketplace went into effect on or before January 1, 2014, including a requirement that insurers guarantee the issuance of coverage to all individuals regardless of health status, strict rules on how health insurance is rated, and the assessment of new taxes and fees, including annual Health Insurance Providers Fee ("HIP Fee"), on health insurers that write certain types of health insurance on U.S. risks. The annual HIP Fee is allocated to health insurers based on the ratio of the amount of an insurer's net

premium revenues written during the preceding calendar year to an adjusted amount of health insurance for all U.S. health risk for those certain lines of business written during the preceding calendar year. The total HIP fee levied on the health insurance industry was $14.3 billion in 2018 and $11.3 billion in 2016. The HIP Fee was waived for 2017 and 2019 calendar years. After 2019, the HIP Fee increases according to an index based on net premium growth. The assessment is being levied on certain health insurers that provide insurance in the assessment year, and is allocated to health insurers based on each health insurer's share of net premiums for all U.S health insurers in the year preceding the assessment. We incurred HIP fees of $50.1 million and $44.2 million during the years ended December 31, 2018 and 2016, respectively.

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In December 2017 Congress passed tax reform legislation that repealed the individual mandate requiring the purchase of health insurance coverage. Finally, in February 2018, Congress passed emergency supplemental legislation that includes significant financial relief for Puerto Rico's Medicaid program.

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

We do not anticipate significant debate regarding the repeal and replacement of the ACA in Washington in the near future, as Democrats assume control of the House of Representatives. However, various federal agencies, including, but not limited to, HHS, DOL, and the U.S. Department of the Treasury have issued and continue to issue Executive Orders and regulations related to the stabilization of the individual insurance market as well as their intentions to repeal the ACA in whole or in part.

As a result of the complexity of ACA, its impacts on health care in the United States and the uncertainty of its future, we cannot currently estimate the ultimate impact of ACA on our business, cash flows, financial condition and results of operations. We will continue to assess ACA’s impact on us as additional regulations and guidance are issued.

As we think about the future of the ACA, some of the more significant ACA issues that currently affect our Managed Care segment, or may in the future, include:

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

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

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

- Provisions that reduce premium payments to Medicare Advantage health plans and that tie such premium to the local Medicare fee for service costs;

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

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

- Increased federal funding to the Medicaid program;

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

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- Provisions that impose annual fees on health insurers;

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

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

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

Budget Control Act

The Budget Control Act of 2011 was enacted to reduce the deficit and avoid default on the national debt. When a joint committee of Congress established to develop debt reduction legislation failed to cut at least $1.5 trillion over the coming 10 years, an automatic process of across-the-board cuts (“sequestration”) split equally between defense and non-defense programs was triggered. Under the sequestration, automatic spending cuts became effective beginning April 1, 2013, and these cuts have been extended through at least 2025 unless additional Congressional action is taken. This resulted in cuts of 2% to Medicare funding. Medicaid programs are not subject to automatic spending cuts. In 2019, Congress will again have to address budget caps to prevent sequestration. This caps discussion will likely include consideration of possible health care payors, which could include Medicare and Medicaid.

Employees

As of December 31, 2018, we had 3,652 full-time employees and 202 temporary employees. TSS has a collective bargaining agreement with the “Unión General de Trabajadores”, which represents approximately 21.6% of two of our Managed Care subsidiaries’ approximately 2,113 regular employees. The collective bargaining agreement expires on November 30, 2019. The Corporation considers its relations with employees to be good.

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Available Information

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

Special Note Regarding Forward-Looking Statements

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

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

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

- trends in health care costs and utilization rates;
- ability to secure sufficient premium rate increases;
- 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;

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- ability to contract with providers and government agencies consistent with past practice;

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

- volatility in the securities markets and investment losses and defaults; and

- general economic downturns, major disasters and epidemics.

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

Item 1A. Risk Factors

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

While we consider the foregoing to be the overarching risks we face in 2018, they are not the only material risks we face. We face numerous other challenges, as described elsewhere in this Annual Report, including below in this “Risk Factors” discussion, and other unanticipated risks may develop.

Risks Relating to our Capital Stock

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

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

Notwithstanding the fact that TSS and its predecessor, SSS, were never in a position to issue new shares to providers as contemplated by the share acquisition agreements because shareholder approval for such issuance was never

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

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

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

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

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

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.

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

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

Sales of a substantial number of shares of our common stock in the public market, or the perception that large sales could occur, could cause the market price of our Class B common stock to decline. Either of these limits our future ability to raise capital through an offering of equity securities. As of December 31, 2018, there were 21,980,168 shares of Class B common stock and 950,968 shares of Class A common stock. Our Class A common stock is no longer subject to contractual lockup; thus, such shares are freely tradable without restriction or further registration under the Securities Act by persons other than our ''affiliates'' within the meaning of Rule 144 under the Securities Act, although such shares will continue not to be listed on the NYSE and will not be fungible with our listed shares of Class B common stock. All or any portion of our shares of Class A common stock may at the sole discretion of our board of directors and after considering relevant factors, including market conditions at the time, be converted to shares of Class B common stock.

Risks Related to Our Business

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

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

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Introduction of new high cost specialty drugs and sudden costs spikes for existing drugs increase the risk that the pharmacy cost assumptions used to develop our rates are not adequate to cover the actual pharmacy costs, which jeopardizes the overall actuarial soundness of our rates. Bearing the high costs of new specialty drugs or the high cost inflation of generic drugs without an appropriate rate adjustment or other reimbursement mechanism adversely impacts our financial conditional and operational results. In addition, evolving state and federal regulation may impact the ability of our health plans to continue to receive existing price discounts on pharmaceutical products for our members. Other factors affecting our pharmaceutical costs include, but are not limited to, geographic variation in utilization of new and existing pharmaceuticals, and changes in discounts. Although we will continue to work with state agencies in an effort to ensure that we receive appropriate and actuarially sound reimbursement for all new drug therapies and pharmaceuticals trends, there can be no assurance that we will always be successful.

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

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

We are dependent on a small number of government contracts to generate a significant amount of the revenues of our Managed Care segment.

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

- Commercial: One of our Managed Care subsidiaries is a qualified contractor to provide managed care coverage to federal government employees within Puerto Rico. Such coverage is provided pursuant to a contract with the OPM that is subject to termination in the event of non-compliance not corrected to the satisfaction of the OPM. During each of the years ended December 31, 2018, 2017, and 2016 premiums generated under this contract represented 5.5%, 5.7%, and 5.8% of our consolidated premiums earned, net, respectively.

Under the commercial business, we also provide health coverage to certain employees of the Government of Puerto Rico and its instrumentalities. Earned premium revenue related to such health plans represented 3.0%, 3.4%, and 3.1% of our consolidated premiums earned, net, respectively.

- 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, 2018, 2017, and 2016, contracts with CMS represented 38.5%, 36.6%, and 35.4% of our consolidated premiums earned, net, 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. The current agreement, which became effective November 1, 2018, requires MCOs to serve subscribers on an island-wide basis, rather than assigning each MCO to specific regions, as under the previous model. The term of the agreement ends on September 30, 2021, which may be extended for an additional year at ASES's option. Under this agreement, TSS is responsible for providing medical, mental, pharmacy and dental healthcare services on an at-risk basis to subscribers who enroll with TSS. ASES will pay TSS a per member per month rate that will vary depending on the particular clinical condition or category of the subscriber. Premium rates will be negotiated for each contract year. The agreement initially assigned Triple-S approximately 280,000 subscribers however, participants had until January 31, 2019 to select their insurance carriers, during which time TSS was able to compete for membership across Puerto Rico. Additionally, participants may change insurance carriers once every year. As of December 31, 2018, our Medicaid membership was approximately 319,000 members. As of October 31, 2018, under the previous agreement with ASES, we provided services to approximately 384,000 eligible members in the Metro North and West regions of Puerto Rico. During the years ended December 31, 2018, 2017 and 2016 Medicaid premiums generated through our agreements with ASES represented 26.4%, 26.6% and 27.1%, respectively.

As discussed above, the Government of Puerto Rico Health Reform Program recently changed its contracting model. In order to maintain the level of premiums generated under the previous agreement, we must succeed in adapting to the new model. While we have successfully increased the membership enrolled in our plan as of December 31, 2018, there can be no assurance that premiums generated under the new agreement will be comparable to those generated during the past years. Furthermore, ASES may recover premiums paid for non-eligible participants. However, we are dependent on ASES, which is in turn dependent on the local Medicaid office, for eligibility data. Historically, ASES has not received updated eligibility data from the local Medicaid office in a timely manner. Therefore, if we are not provided with timely eligibility data and we bill ASES for non-eligible members, ASES could attempt to recoup premiums from us, which could have a significant impact in our consolidated premiums and profitability.

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

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

Our managed care products that involve greater potential risk, such as fully insured arrangements, generally tend to be more profitable than ASO products and those managed care products where employer groups retain the risk, such as self-funded financial arrangements. There has been a trend in recent years among our Commercial customers of moving from fully-insured plans to ASO, or self-funded arrangements. As of December 31, 2018 and 2017, 69% and 68% of our managed care commercial customers, respectively, had fully-insured arrangements and 31% and 32%, respectively, had ASO arrangements. Unfavorable changes in the relative profitability or customer participation among our various products could have a material adverse effect on our business, financial condition, and results of operations.

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

A portion of the claim liabilities recorded by our insurance segments represents an estimate of amounts needed to pay and adjust anticipated claims with respect to insured events that have occurred, including events that have not yet been reported to us. These amounts are based on estimates of the ultimate expected cost of claims and on actuarial estimation techniques. Judgment is required in actuarial estimation to ascertain the relevance of historical payment and claim settlement patterns under each segment's current facts and circumstances. Accordingly, the ultimate liability may be in excess of or less than the amount provided. We regularly compare prior period liabilities to re-estimate

claim liabilities based on subsequent claims development; any difference between these amounts is adjusted in the operations of the period determined. Additional information on how each reportable segment determines its claim liabilities, and the variables considered in the development of this amount, is included elsewhere in this Annual Report on Form 10-K under “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations Critical Accounting Estimates”. Actual experience will likely differ from assumed experience, and to the extent the actual claims experience is less favorable than estimated based on our underlying assumptions, our incurred losses would increase and future earnings could be adversely affected.

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

We are a party to license agreements with the BCBSA that entitle us to the exclusive use of the BCBS name and mark in Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. These license agreements contain certain standards, requirements and restrictions regarding our operations and our use of the BCBS name and mark which may be modified in certain instances by the BCBSA. Changes to the terms of our license agreements may restrict various potential business activities. Failure to comply with the standards, requirements and restrictions established could result in the termination of a license agreement. Events that could cause the termination of a license agreement with the BCBSA include failure to comply with minimum capital requirements imposed by the BCBSA, a change of control or violation of the BCBSA ownership limitations on our capital stock, impending financial insolvency and the appointment of a trustee or receiver or the commencement of any action against a licensee seeking its dissolution. Upon termination of a license agreement, the BCBSA would impose a re-establishment fee upon us, which would allow the BCBSA to entitle another managed care company to use the BCBS name and marks in the service areas we currently serve. This re-establishment fee is currently $98.33 per licensed enrollee. If the re-establishment fee were applied to our total BCBS enrollees as of December 31, 2018, we would be assessed approximately $86.2 million by the BCBSA.

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

Our ability to manage our exposure to underwriting risks in our Life and Property and Casualty segments depends on the availability and cost of reinsurance coverage.

Reinsurance is the practice of transferring part of an insurance company’s liability and premium under an insurance policy to another insurance company. We use reinsurance arrangements to limit and manage the amount of risk we retain, to stabilize our underwriting results and to increase our underwriting capacity. During 2018, 43.2%, or $60.4 million, of the premiums written in the Property and Casualty segment and 5.0%, or $8.8 million, of the premiums written in the Life segment were ceded to reinsurers. Total premiums ceded, on a consolidated basis, represent 2.4%, or $73.6 million of our premiums. The premiums ceded and the availability and cost of reinsurance is subject to changing market conditions and may vary significantly over time. Any decrease in the amount of our reinsurance coverage will increase our risk of loss. We may be unable to maintain our desired reinsurance coverage or obtain other reinsurance coverage in adequate amounts and at favorable rates. If we are unable to renew our expiring coverage or obtain new coverage, it will be difficult for us to manage our underwriting risks and operate our business profitably.

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

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

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

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

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A downgrade in our A.M. Best rating could affect our ability to write new business or renew our existing business in our Property and Casualty segment.

Ratings assigned by A.M. Best are an important factor influencing the competitive position of the property and casualty insurance companies in Puerto Rico. In November 2018, A.M. Best downgraded the rating of our Property and Casualty subsidiary from an "A-" (Excellent) to a "B+"(Good) with negative implications. The rating revision follows the unfavorable reserve development of Hurricane Maria losses experienced by this subsidiary during the second and third quarters of 2018. This rating will remain under review until A.M. Best completes its next annual evaluation of the Company.

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 be further downgraded following their annual evaluation. Since the lines of business that this segment writes and the market in which it operates are particularly sensitive to changes in A.M. Best financial strength ratings, the November 2018 downgrade and any further downgrade of our Property and Casualty segment's rating could limit or prevent us from writing and renewing certain types of business or accounts that requires insurers with stronger ratings.

We are dependent on the success of our relationships with third parties for various services and functions, including PBM services.

We contract with various third parties to perform certain functions and services and provide us with certain information technology systems. Certain of these third parties provide us with significant portions of our business infrastructure and operating requirements, and we could become overly dependent on key vendors, which could cause us to lose core competencies. A termination of our agreements with, or disruption in the performance of, one or more of these service providers could result in service disruptions or unavailability, reduced service quality and effectiveness, increased or duplicative costs or an inability to meet our obligations to our customers. In addition, we may also have to seek alternative service providers, which may be unavailable or only available on less favorable contract terms. Any of these outcomes could adversely affect our business, reputation, cash flows, financial condition and operating results.

TSS entered into a Master Services Agreement ("MSA") with OptumInsight, Inc. ("Optum"), pursuant to which Optum provides healthcare technology and operations services, including information technology, claims processing and application development, to Triple-S and its affiliates. As a result, we are now dependent on Optum for the provision of essential services to our business, and there can be no assurances that the quality of the services will be appropriate or that Optum will be able to continue to provide us with the necessary claims processing and technology services. Potential breakdowns or failures of Optum could harm our business by disrupting our delivery of services, which could have a material adverse impact on our financial condition and results of operations. The aforementioned contract is included as Exhibit 10.29 filed with this Annual Report on Form 10-K.

TSS consolidated PBM services for its Medicare Advantage and Commercial lines of business through an agreement with Abarca Health, effective January 2019. As a result of this consolidation, any issues or failures affecting this vendor could have an impact on a significant portion of our managed care business, which could adversely affect our reputation, financial condition and operating results.

Significant competition and market conditions in Puerto Rico could negatively affect our ability to maintain or increase our profitability.

We are subject to strong competition in each line of business in which we operate. Competition in the insurance industry is based on many factors, including premiums charged, services provided, speed of claim payments and

reputation. This competitive environment has produced and will likely continue to produce significant pressures in our profitability. The industry in which we operate has unique characteristics that, if we are unable to manage adequately, may adversely affect our business, financial conditions and results of operations. Some of the trends and characteristics related to the competition we face in our different lines of business include the following:

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- The managed care market in Puerto Rico is mature. According to the U.S. Census Bureau, Puerto Rico's population decreased by 2.2% between 2000 and 2010; however, the national population rate grew 9.7% during the same period. According to the US Census Bureau, the older population is an important and growing segment of the United States population. Between 2000 and 2010, the population 65 years and older increased at a faster rate (15.1%) than the total U.S. population. In Puerto Rico, for the same period, the population 65 years and older increased by 27.5 %. As a result, the competition for this segment of the market is significant.

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

- Our industry is highly regulated. Future legislation at the federal and local levels may also result in increased competition, especially in the Managed Care segment. While we do not anticipate that any of the current legislative proposals of which we are aware would increase the competition we face, future legislative proposals, if enacted, might do so.

- Market concentration. Concentration in our industry has created an increasingly competitive environment, both for customers and for potential acquisition targets, which may make it difficult for us to grow our business. The parent companies of some of our competitors are larger and have greater financial and other resources than we do. We may have difficulty competing with larger companies, which can create downward price pressures on premium rates.

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

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

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

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

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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.

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

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

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

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

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

As an insurer, we have a substantial investment portfolio that is comprised particularly of debt and equity securities of issuers located in the U.S. As a result, the income we earn from our investment portfolio is largely driven by the level of interest rates in the U.S. financial markets, volatility, uncertainty and/or disruptions in the global capital markets, particularly the U.S. credit markets, and governments' monetary policy. These factors 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 and equity securities we hold in our investment portfolio, and creating net unrealized capital losses that reduce our operating results and/or net realized capital losses in the event we are required to sell some of those investments.

- 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.

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

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

In addition, our insurance subsidiaries are subject to local laws and regulations that require diversification of our investment portfolios and limit the amount of investments in certain riskier investment categories, such as below-investment-grade fixed income securities, mortgage loans, and real estate and equity investments, among others, which could generate higher returns on our investments. Notwithstanding, the Insurance Code of Puerto Rico requires insurers to invest an amount equal to no less than half of the insurer's required capital in Puerto Rico Securities. Since February 2014, the credit ratings of bonds issued by the Government of Puerto Rico and most of Puerto Rico public corporations have been downgraded to below-investment grade. As a result, on March 2014, the Puerto Rico Legislative Assembly enacted legislation allowing insurance companies to hold investments that were acquired at an investment grade rating but subsequently downgraded below-investment grades for period not exceeding three years from the date of acquisition. This legislation also authorizes the Commissioner of Insurance, upon an insurer's request, to provide a three-year extension of the holding period, or an exemption to dispose of the downgraded investment. The Insurance Code requirement that insurers invest in Puerto Rico securities may affect our ability to invest in other securities with a higher investment credit rating, the overall value of our investment portfolio and our financial condition. However, we have obtained a one-year waiver from the Commissioner of Insurance and can now invest in certain non-Puerto Rico securities approved by the Commissioner and continue to be compliant with the Insurance Code. If we fail to comply with these laws and regulations, any investments exceeding regulatory limitations would be treated as non-admitted assets for purposes of measuring statutory surplus and risk-based capital and may adversely affect our financial condition and results of operations.

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

Our principal lines of business are concentrated in Puerto Rico, which is currently in the midst of a severe fiscal and economic crisis. Puerto Rico's gross national product ("GNP") has contracted in real terms since fiscal year 2006.

According to the latest Puerto Rico Planning Board estimates, released in April 2017, Puerto Rico's GNP was projected to decrease by 1.7% and 1.5% in constant dollars for fiscal years 2017 and 2018, respectively. In each case, such analysis does not account for the impact of Hurricanes Irma or Maria in September 2017. The government of Puerto Rico's Fiscal Plan (as hereinafter defined), which accounts for the impact of the hurricanes, estimates an 8% contraction in real GNP during fiscal year 2018. It also projects that disaster relief funding will have a short-term stimulative effect on Puerto Rico's economy, which, combined with the estimated effects of the proposed measures and reforms, the plan estimates will result in variable GNP growth from fiscal years 2019 through 2022, followed by GNP contraction in fiscal year 2023 as disaster relief funding decreases.

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The weakness of Puerto Rico's economy has also adversely affected employment. Total average annual employment, as measured by Department of Labor and Human Resources Household Employment Survey of Puerto Rico, known as the "Household Survey," has decreased approximately 18% during the past decade. The reduction in total employment began in the fourth quarter of fiscal year 2007, when total employment was 1,244,425, and continued consistently until the first half of fiscal year 2015, after which it mostly stabilized. According to the most recent Household Survey, released in October 2018, Puerto Rico's total employment in October 2018 was approximately 1,005,000, a 3% increase from total employment of approximately 974,000 in October 2017. Similarly, such Household Survey reports an unemployment rate of approximately 8% in October 2018, a 2.7% decrease from an unemployment rate of approximately 10.7% in October 2017.

In response to the Puerto Rico's fiscal and financial challenges, the U.S. Congress enacted the Puerto Rico Oversight, Management and Economic Stability Act ("PROMESA") in June 2016. Pursuant to PROMESA, the Financial Oversight and Management Board for Puerto Rico (the "Oversight Board") has certified fiscal plans for the government of Puerto Rico and several of its instrumentalities. The most recent fiscal plan was certified by the Oversight Board on October 23, 2018 (the "Fiscal Plan"). The Fiscal Plan outlines a number of structural reforms and fiscal measures that the Oversight Board deems necessary to improve the Government of Puerto Rico's fiscal balance and economic condition. As part of such measures, the Oversight Board proposed the implementation of a new healthcare model, through additional changes to how the government of Puerto Rico contracts and incentivizes managed care organizations as third-party administrators of it's healthcare program. Pursuant to the Fiscal Plan, the new model will result in annual savings for the government of Puerto Rico of approximately $826 million by fiscal year 2022.

We have significant direct exposure to the government through our contract with ASES, which administers the Medicaid program in Puerto Rico, and certain other business relationships with the government of Puerto Rico and its instrumentalities. As a result, we may be adversely affected by the liquidity problems of such entities, or by a reduction in the size of the government or privatization of public corporations. Moreover, it is uncertain whether the reductions in public corporations' health plan contributions to employees contemplated in Act 26 will be implemented, how they will be implemented, and what effect such reductions will have in our business.

On the other hand, as part of the emergency supplemental legislation passed by Congress, Puerto Rico's Medicaid spending cliff was addressed until at least September 30, 2019, following the approval of $4.8 billion of additional Medicaid funding. This action has brought temporary financial stability to Puerto Rico's Medicaid program, and funding conditions related to compliance with program management standards have further promoted stability and predictability. The government of Puerto Rico and the health care industry are lobbying Congress to address Puerto Rico's Medicaid spending cliff permanently: however, there are no guarantees that these efforts will succeed. If our efforts are not successful, ASES may not be able to fulfill its payment obligations to us under our agreement for the provision of health coverage to government health program participants, which would adversely affect our financial results

Furthermore, our insureds' financial capacity is affected by, among other things, the general economic conditions in Puerto Rico and other adverse conditions affecting Puerto Rico consumers and businesses. The effects of the prolonged recession are reflected as a decrease in insured customers in our commercial line of business and premiums earned, net. Moreover, the measures taken to address the fiscal crisis and those that may have to be taken in the near future, will likely affect many of our insureds, which could result in a lower amount of insureds, insureds moving to lower premium plans, among others. The foregoing could also result in decreased demand for our insurance products or migration to less profitable products.

If global or local economic conditions worsen or the government of Puerto Rico is unable to manage its fiscal and economic challenges, including consummating an orderly restructuring of its debt obligations while continuing to provide essential services, the conditions described above could continue or worsen in ways that are unpredictable and outside of our control. While PROMESA provides the government with tools to restructure Puerto Rico's debt

obligations and that of its instrumentalities, these restructuring tools are new and untested. Furthermore, Fiscal Plan's projections indicate the possibility of significant creditor losses. Both of these factors may make any debt restructuring process a lengthy and highly adversarial process.

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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, possible liability, increase administrative expenses or lead to other adverse consequences any of which could have a material adverse effect on our results of operations or financial condition. 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, 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 violations and resulting possible liability and limitations on our operations, increases in operating expenses or suffer other adverse consequences. In April 2018 we began migrating our Medicare Advantage core claims and clinical management platforms. Due to the challenges facing such transition, which have at times been exacerbated by some of the residual effects of hurricane Maria, it has been unable to pay claims to our providers on a timely fashion and has faced difficulties in sending certain notifications required by CMS regulations with respect to claim payments. The migration issues have also impacted its ability to meet the regulatory terms for the approval of pre-authorizations and corresponding notification to members. Should CMS determine that these operational disruptions constitute a material deviation from the applicable regulation, we could be exposed to severe regulatory sanctions. See “Item 1A Risk Factors–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.” See also “Item 1A. Risk Factors–Risks Relating to the Regulation of Our Industry – 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.”

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.

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

We face risks related to litigation.

We are subject to a variety of legal actions that affect any business, such as employment and employment discrimination-related suits, employee benefit claims, breach of contract actions, tort claims and intellectual property-related litigation. In addition, because of the nature of our business, we are subject to a variety of legal actions relating to our business operations, including the design, management and offering of our products and services, claims relating to the denial of benefits or coverage, medical malpractice actions, allegations of anti-competitive and unfair business activities, provider disputes, broker and agent disputes, and claims by regulatory actions by agencies for non-compliance, among others. Legal proceedings are inherently unpredictable and we cannot ascertain their outcome. We have insurance to cover liabilities relating to litigation; however, insurance coverage may not be sufficient to cover any such liability or our insurers could deny or dispute coverage. Results of regulatory actions could require us to change our business practices and may affect our profitability. Substantial liability relating to legal or regulatory actions could adversely affect our cash flow, results of operations, and financial conditions. See "Item 3. Legal Proceedings."

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, Life, and Property and Casualty 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. If the severity of any such natural disaster exceeds what our catastrophe reinsurance protection, as in the case of Hurricane Maria in September 2017, we may potentially incur material losses. Furthermore, unforeseen major public health issues following these catastrophic events, such as pandemics and epidemics, like mosquito-borne epidemics (Dengue, Zika, etc.), conditions for which vaccines may not exist, are not effective, or have not been widely administered, could have a material adverse effect on our business, financial condition, and results of operations. Claims in our Property and Casualty segment increased in 2017 and 2018 as the result of the losses caused by Hurricanes Irma and Maria in Puerto Rico. The Puerto Rico Insurance Code requires the Company to resolve claims within a period of 90 days. Due to the substantial increase in the volume of claims following a catastrophic event, there is a business risk that not all claims will be resolved within the timeframe stipulated in the Puerto Rico Insurance Code, which may result in penalties imposed by the Commissioner of Insurance of Puerto Rico. Furthermore, there is a risk of an increase in the volume of litigations by insureds who are not satisfied with the insurance payout. See Note 24, Contingencies, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

Present and future covenants in our secured term loans and note purchase agreements may restrict our operations and adversely affect our ability to pursue desirable business opportunities.

The secured term loans 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 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 to

become immediately due and payable, together with accrued and unpaid interest and, cease to make further extensions of credit. If the indebtedness under our secured term loans 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. 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, 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 the acceleration of amounts due thereunder. Indebtedness could also limit our ability to pursue desirable business opportunities, and may affect our ability to maintain an investment grade rating for our indebtedness.

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

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

- identify profitable growth opportunities in current and additional markets;
- transact successful acquisitions, capital investments and other growth initiatives;
- determine the correct value of assets and investments;
- implement adequate pricing and operational structure, including underwriting and claim management processes;
- design attractive and profitable insurance and health products and services;
- recruit required personnel for expanded operations, including officers, agents, brokers, medical providers, and other key personnel;
- obtain regulatory permission required to operate in other jurisdictions or lines of business;
- comply with regulatory requirements;
- integrate acquired business to our operations, including integration of information technology, management and personnel, and administrative systems;
- create the expected return over time; and
- implement new, or modify existing internal monitoring and control systems.

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

fluctuations in foreign currency rates could affect our financial results.

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

As of December 31, 2018 we had approximately $25.4 million and $2.6 million of goodwill and intangible assets recorded on our balance sheet, primarily related to the TSA acquisition, that represent 1.0% of our total consolidated assets and 3.4% 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 than 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”.

The effectiveness of our Company’s strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks our Company.

We expect to face significant business challenges and uncertainties in 2019. Effectiveness of our enterprise strategy, talent management and alignment of talent to our business needs and risks to our brand and reputation present overarching risks to our Company in 2019. There can be no assurance regarding the effectiveness of our enterprise strategy, our ability to manage and align our talent to our business needs or our ability to avoid harm to our brand and reputation. In addition, there can be no assurance that U.S. government fiscal policy, the implementation of the ACA, repeal or other changes to the ACA or additional changes to the U.S. health care system will not require us to revise the ways in which we conduct business, put us at risk of loss of business or materially adversely affect our business, cash flows, financial position or operating results.

Risks Relating to Taxation

If we are considered to be a controlled foreign corporation under the related person insurance income rules or a passive foreign investment company for United States 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.

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.

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If we were a RPII CFC in any taxable year or if the Company was treated as a PFIC for any taxable year, certain adverse consequences could apply to certain U.S. persons that own our shares of Class B common stock.

Legislative and other measures that may be taken by local and federal government taxing authorities could materially increase our tax burden.

In December 2018, the Puerto Rico government signed into law Act 257 of 2018, better known as the Puerto Rico Tax Reform, to amend the Internal Revenue Code for a New Puerto Rico. Approved changes include a reduction from a 39% to a 37.5% maximum corporate tax rate; an increase from 80% to 90% on the amount of net operating loss carryover deduction available to be claimed against current year net income; an expected increase in the amounts of withholding at source for services rendered from 7% to 10%; a limitation in the amount of net operating losses generated by a corporate shareholder allowed to be netted against net income distributed from a flow-through investment, not permitted for taxable years beginning after December 31, 2018; and a revised large taxpayer definition to include flow-through entities and extend the determination of audited financial statement requirements at the group level. The bill also adds requirements for the deductibility of expenses. All of these changes are effective for taxable years beginning January 1, 2019. No further increases to the sales and use tax are contemplated as part of this tax reform. We do not expect the tax reform to adversely impact our tax burden. During the year ended December 31, 2018, we recorded an additional deferred tax expense of $3.4 million related to the impact the lower corporate tax rate had in our net deferred tax assets. We will continue to monitor and analyze the potential impact of the legislation, as any increase in the amount of taxes we pay and the taxation of the customers we serve may have a material adverse effect to our financial condition, results of operations and cash flows.

On December 22, 2017 the US Government enacted PL 115-97, better known as the Tax Cut and Jobs Act (“TCJA”). The TCJA incorporates a series of changes in tax rates at the federal level applicable for taxable years beginning after December 31, 2017 and before January 1, 2026. United States federal corporate income tax rate is reduced from a 35% maximum to a 21% flat rate. While special tax rates on capital gains and qualified dividends remain the same under the TCJA, changes in tax rate at the federal level are expected to have minimal impact on our business, as we are currently taxed only for passive income earned on investments, which continue to be subject to withholding at source at its gross level.

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 the achievement of certain quality performance measures and medical loss ratio requirements;
-

specific legislative or regulatory changes to the Medicare or Medicaid programs, including changes in the bidding process or other means to materially reduce premiums;

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- local government regulatory changes;

- increased government enforcement actions, or changes in the interpretation or application, of fraud and abuse and health information privacy laws; and

- regulations that increase the operational burden on health plans, or 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 and CMS and other agencies, among other things, influence how our insurance subsidiaries conduct business, and place limitations on investments and dividends. Possible penalties for violations of such regulations include fines, orders to cease and desist and possible suspension or termination of licenses. The regulatory powers of the Commissioner of Insurance are mainly 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 for insurance policies, limit our ability to obtain rates or premiums, when needed, 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.

Future regulatory actions by the Commissioner of Insurance or other governmental agencies, including federal authorities, 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. One key piece of the legislation imposes an annual insurance industry assessment, with increasing annual amounts based on premium growth. Such assessment may not be deductible for income tax purposes. If the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this tax, our results of operations, financial position and liquidity may be materially adversely affected.

Also, health plans serving the individual market are subject to the guaranteed issue provisions under which the plans are required to issue coverage to individuals without regard to their health status of pre-existing conditions, which could lead to adverse selection by consumers. On July 16, 2014, the Department of Health and Human Services sent a letter or the Commissioner of Insurance of Puerto Rico notifying that guarantee issue provisions under ACA are not applicable to U.S. territories. However, on July 22, 2013, similar guarantee issue and other market reforms provisions were enacted in Puerto Rico as part of amendments made to the Health Insurance Code of Puerto Rico. Although the Puerto Rico legislature is considering additional legislation to provide insurance companies more flexibility to comply with the additional requirements enacted in 2013, it is uncertain whether such legislation will in fact be enacted or the effect of any such additional legislation may have on our business. If we are unable to adapt our premium structure to address the guaranteed issue requirement, our results of operations, financial position and liquidity may be materially adversely affected.

In the years since its enactment, there have been, and continue to be, significant developments in, and continued legislative activity around, attempts to repeal or repeal and replace the ACA. For example, on October 12, 2017, President Trump signed an executive order requiring the implementation of regulations that would exempt certain association plans from complying with ACA requirements, easing restrictions on certain short-term health plans and health reimbursement arrangements and limiting hospital and insurance company consolidation while promoting competition and choice. Additionally, on January 22, 2018, President Trump signed a continuing resolution on

appropriations for fiscal year 2018 that suspends the implementation of the annual insurance industry assessment for tax year 2019. In February 2018 the Administration revealed a notice of proposed rulemaking to support short term, limited duration scope policies, and additional activity related to the individual market is anticipated through state waivers. While Congress is no longer actively seeking to repeal and replace the ACA, additional changes are expected this year, largely through Administrative Actions.

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As part of the emergency supplemental legislation passed by Congress, Puerto Rico's Medicaid spending cliff was addressed until at least September 30, 2019, because of the approval of $4.8 billion in Medicaid funding. Although we believe this legislation, together with the ACA, may provide us with significant opportunities to grow our business, the implementation of 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 frequent change and can expose us to penalties for non-compliance. If we fail to comply with these laws and regulations, we could be subject to criminal fines, civil penalties or other sanctions, including the termination of our Medicare Advantage contracts. In addition, maintaining compliance with such laws and regulations as they change may, in some cases, entail substantial direct costs.

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

Historically, TSA plans have received annual Star Ratings higher than three stars. CMS provides an increase to the rebate share in the bid from 50% to 65% when a program reaches 3.5 STARS, and to 70% when a plan reaches 4.5 STARS. Also, a 5% quality bonus is provided to plans with Star Ratings of 4.0 or more. As of December 31, 2018, TSA's HMO plan achieved 4.5 overall on a 5.0 star rating system and TSA's PPO plan increased its overall rating to 4.0 stars on a 5.0-star rating system effective for product offerings in the year 2020.

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

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

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

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

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

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

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

Failure to prevent, detect or control systems related to regulatory compliance or the failure of employees to comply with our internal policies, including data systems security or unethical conduct by managers and employees, could

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

In addition, provider or member fraud that is not prevented or detected could impact our medical costs or those of our self-insured customers. Further, during an economic downturn, our segments, including our Life 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.

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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, including cybersecurity threats, or detect and prevent privacy and security incidents, including those related to cybersecurity, 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 multiple and/or new privacy and security laws, regulations and requirements may result in increased operating costs, and may constrain our ability to manage our business model. In addition, HHS has expanded its HIPAA audit program to assess compliance efforts not only by covered entities, but also business associates. Although we are not aware of HHS plans to audit any of our covered entities or business associates, an audit resulting in findings or allegations of non-compliance could have a material adverse effect on our results of operations, financial position and cash flows. We are also subject to stricter breach notification requirements than those imposed on covered entities by virtue of HIPAA in terms of having to provide ASES with notice of a breach within twenty-four (24) hours. These and other regulatory aspects make compliance with applicable health information laws more difficult. For these reasons, our total compliance costs may increase in the future.

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

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

Medicare Advantage managed care plans are paid based off a CMS-calculated “benchmark” amount, and plans submit competitive bids that reflect the costs they expect to incur in providing the base Medicare benefits. A Medicare Advantage plan’s actual payment rate is based on a complex statutory formula that takes into account a number of factors, including the relationship between the plan’s bid and the benchmark. In addition, under the ACA, Medicare Advantage plan payment rates were subject to transitionally phased in reductions intended to bring Medicare

Advantage rates more in line with Medicare fee-for-service rates, which was fully phased in 2017. Medicare generally will rebate a portion of the amount by which the benchmark amount exceeded the accepted bid for certain plans. For plans achieving star rating of at least 3.5 stars, the portion of the savings retained by the plan is higher. For plans achieving star ratings of at least 4 stars, the starting benchmark amount from which the savings is computed is also higher (a "quality bonus"). If the bid is greater than the benchmark, the plan will be required to charge a premium to enrollees equal to the difference between the bid and the benchmark, which could affect our ability to attract enrollees. CMS reviews the methodology and assumptions used in bidding with respect to medical and administrative costs, profitability and other factors. CMS could challenge such methodology or assumptions or seek to cap or limit plan profitability. CMS also could administratively seek to implement certain methodological changes to the Medicare Advantage rate calculations that could result in functionally lower payment rates, and may have a material adverse effect on our revenue, financial position, results of operations or cash flow.

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

On January 30, 2019, CMS released its draft Advance Notice and Call Letter for Medicare Advantage reimbursement in 2020. This draft notices contains important provisions that sustain the Puerto Rico MA program, including the zero claims adjustment. The draft letter doesn't include additional adjustments that may be necessary to address the benchmark and payment disparity, but we expect to submit comments to CMS to continue to make changes in that direction. The call letter will be finalized in early April.

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

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

CMS is making significant changes to the manner in which it determines risk adjustment payments, including possible retroactive reveries, introducing a new model for 2020 and continue to shift towards encounter based risk scores (EDS). As a result of the risk adjustment process and CMS's ability to modify the manner in which it applies such risk adjustments, it is difficult to predict with certainty our future revenue or profitability. In addition, our own risk scores for any period may result in favorable or unfavorable adjustment to payment from CMS and our Medicare payment revenue.

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

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.

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

If we are deemed to have violated the Insurance Holding Company System Regulatory Act, 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 its holding 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 its issued and outstanding stock, or of the total issued and outstanding stock of an insurance holding company, without the prior approval of the Commissioner of Insurance. Our amended and restated articles of incorporation (the articles) prohibit any institutional investor from owning 10% or more of our voting power and any person that is not an institutional investor from owning 5% or more of our voting power. We cannot, however, assure you that ownership of our securities will remain below these thresholds. To the extent that a person, including an institutional investor, acquires shares in excess of these limits, our articles provide for the Company to take certain actions, including refusing to give effect to a transfer or instituting proceedings to enjoin or rescind a transfer, in order to avoid a violation of the ownership limitation in the articles. If the Commissioner of Insurance determines that a change of control has occurred without the Commissioner's prior approval, we could be subject to fines and penalties, and in some instances the Commissioner of Insurance would have the discretion to revoke our operating licenses.

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

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

Puerto Rico insurance laws and the regulations promulgated by the Commissioner of Insurance, among other things, impose minimum capital requirements to our insurance subsidiaries, thereby restricting the amount of earnings that can be distributed by our insurance subsidiaries to us. Although our healthcare and Life subsidiaries 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 actions, including involuntary rehabilitation or liquidation processes, or require us to provide financial assistance, either through subordinated loans or capital infusions, to ensure they maintain their minimum statutory capital requirements. During the last quarter of 2018, and as a result of unfavorable reserve developments related to Hurricane Maria, the Company made a capital contribution to its Property and Casualty subsidiary in the amount of $10 million, as part of the subsidiary's plan to increase its capital and surplus to meet minimum capital requirements under risk based capital provisions.

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.”

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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."

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

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

See also "Risks Relating to the Regulation of Our Industry If we are deemed to have violated the Insurance Holding Company System Regulatory Act, 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 issuance of shares of capital stock of an insurer or its parent company and make a determination as to the fairness of the transaction. Also, a director of an insurer must meet certain requirements imposed by Puerto Rico insurance laws.

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

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

We own a seven story building located at 1441 F.D. Roosevelt Avenue, in San Juan, Puerto Rico, and two adjacent buildings, as well as the adjoining parking lot, which is mainly used by the Managed Care segment. In addition, we own five floors of a fifteen-story building located at 1510 F.D. Roosevelt Avenue, in Guaynabo, Puerto Rico, which is mainly used by the Property and Casualty segment. We also own land and a multi-segment customer service center in the municipalities of Mayagüez and Ponce, Puerto Rico. In addition to the properties described above, we or our subsidiaries are parties to operating leases that are entered into in the ordinary course of business. 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, Puerto Rico. These properties are subject to liens under our credit facilities. In connection with our entrance to the Costa Rican market, we acquired a two-story building located in the city of San José, Costa Rica, which is used by the Life segment. See “Item 7—Management’s Discussion and Analysis of Financial Condition and Results of Operation – Liquidity and Capital Resources”.

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

Item 4. Mine Safety Disclosures

None.

Part II

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

Market Information

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

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

	High	Low
2018		
First quarter	$28.66	$22.75
Second quarter	44.01	25.65
Third quarter	40.44	18.65
Fourth quarter	22.16	15.45
2017		
First quarter	$21.79	$16.49
Second quarter	18.86	15.81
Third quarter	25.41	15.05
Fourth quarter	29.43	23.33

On February 20, 2019 the closing price of our Class B common stock on the NYSE was $21.32.

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Holders

As of February 20, 2019, there were 950,968 and 21,975,287 shares of Class A and Class B common Stock outstanding, respectively. The number of our holders of Class A common stock as of February 20, 2019 was approximately 812. The number of our holders of Class B common stock as of February 20, 2019 was approximately 3,098.

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 18, Stockholders’ Equity, of the Notes to Consolidated Financial Statements, included in “Item 8, Financial Statements and Supplementary Data”, of this Annual Report on Form 10-K.

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

Securities Authorized for Issuance Under Equity Compensation Plan

See Note 21, Share-Based Compensation, of the Notes to Consolidated Financial Statements, included in “Item 8, Financial Statements and Supplementary Data”, of this Annual Report on Form 10-K.

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Performance Graph

The following graph compares the price performance of our Class B common stock for the period from January 1, 2014 through December 31, 2018, with the price performance over such period of (i) the Standard and Poor's 500 Stock Index (the "S&P 500 Index") and (ii) the Standard & Poor's 500 Managed Health Care Index (the "S&P MHC Index"). The comparison assumes an investment of $100 on January 1, 2014 in each of our Class B common stock, the S&P 500 Index, and the S&P MHC Index. The performance graph is not necessarily indicative of future performance.

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

Ticker	Name	1/2/2014	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018
GTS US Equity	TRIPLE-S MANAGEMENT CORP	100.00	124.47	124.47	107.76	129.36	90.53
SPX Index	S&P 500 INDEX	100.00	112.39	111.57	122.21	145.94	136.84
S5MANH Index	S&P MHC Index	100.00	133.54	160.83	189.83	270.36	296.44

Recent Sales of Unregistered Securities

Not applicable.

Purchases of Equity Securities by the Issuer

There was no share repurchase activity during the three months ended December 31, 2018.

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Item 6. Selected Financial Data

Statement of Earnings Data

(Dollar amounts in millions, except per share data)	2018	2017	2016	2015	2014
Years ended December 31,					
Premiums earned, net	$2,938.6	$2,826.9	$2,890.6	$2,783.2	$2,128.6
Administrative service fees	14.7	16.5	17.9	44.7	119.3
Net investment income	61.9	51.6	48.9	45.2	47.5
Other operating revenues	5.8	3.7	3.5	3.7	4.2
Total operating revenues	3,021.0	2,898.7	2,960.9	2,876.8	2,299.6
Net realized investments gains	0.3	10.8	17.4	18.9	18.2
Net unrealized investment losses on equity investments	(36.5)	-	-	-	-
Other income, net	11.3	6.6	6.5	7.0	2.3
Total revenues	2,996.1	2,916.1	2,984.8	2,902.7	2,320.1
Benefits and expenses:					
Claims incurred	2,527.6	2,353.1	2,472.2	2,318.7	1,747.6
Operating expenses	554.7	477.2	493.9	518.7	497.2
Total operating costs	3,082.3	2,830.3	2,966.1	2,837.4	2,244.8
Interest expense	6.9	6.8	7.6	8.2	9.3
Total benefits and expenses	3,089.2	2,837.1	2,973.7	2,845.6	2,254.1
(Loss) income before taxes	(93.1)	79.0	11.1	57.1	66.0
Income tax (benefit) expense	(29.8)	24.5	(6.3)	5.1	0.7
Net (loss) income	(63.3)	54.5	17.4	52.0	65.3
Net loss attributable to non-controlling interest	-	-	-	(0.1)	(0.4)
Net (loss) income attributable to TSM	$(63.3)	$54.5	$17.4	$52.1	$65.7
Basic net (loss) income per share (1):	$(2.76)	$2.27	$0.71	$2.03	$2.42
Diluted net (loss) income per share:	$(2.76)	$2.26	$0.71	$2.02	$2.41

Balance Sheet Data

	2018	2017	2016	2015	2014
Years ended December 31,					
Cash and cash equivalents	$117.5	$198.9	$103.4	$197.8	$110.0
Total assets	$2,766.5	$3,116.8	$2,219.0	$2,206.1	$2,145.7
Long-term borrowings	$28.9	$32.1	$35.1	$36.8	$74.5
Total stockholders' equity	$821.9	$913.4	$863.2	$847.5	$858.6

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Additional Managed Care Data (2)

	2018		2017		2016		2015		2014	
Years ended December 31,										
Medical loss ratio	84.5	%	85.6	%	88.6	%	86.2	%	85.9	%
Operating expense ratio	16.0	%	13.6	%	14.0	%	15.1	%	18.5	%
Medical membership (period end)	876,268		977,939		1,017,372		1,094,444		2,139,484	

(1) Further details of the calculation of basic and diluted earnings per share are set forth in Notes 2 and 22 of the audited consolidated financial statements for the years ended December 31, 2018, 2017 and 2016.

(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, 2018 and 2017, and consolidated results of operations for 2018, 2017 and 2016. References to the terms "we", "our" or "us" used throughout this Management's Discussion and Analysis of Financial Condition and Results of Operations (“MD&A”), refer to TSM and unless the context otherwise requires, its direct and indirect subsidiaries. This analysis should be read in its entirety and in conjunction with the consolidated financial statements, notes and tables included elsewhere in this Annual Report on Form 10-K.

The structure of our MD&A is as follows:

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I. Overview

We are one of the most significant players in the managed care industry in Puerto Rico and have 60 years of experience in this industry. We offer a broad portfolio of managed care and related products in the Commercial, Medicare, and the Government of Puerto Rico health insurance plan (similar to Medicaid) ("Medicaid" or "the Government health plan") 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 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. Medicaid is funded by the Government of Puerto Rico and the U.S. Government.

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We have the exclusive right to use the BCBS name and mark throughout Puerto Rico, the U.S. Virgin Islands, Costa Rica, the British Virgin Islands and Anguilla. As of December 31, 2018 we serve approximately 876,000 members across all regions of Puerto Rico. For the years ended December 31, 2018 and 2017 respectively, our Managed Care segment represented approximately 92% of our total consolidated premiums earned, net. We also participate in the life and property and casualty insurance markets in Puerto Rico.

We participate in the managed care market through our subsidiaries, TSS, TSB and TSA. TSS, TSA, and TSB are BCBSA licensees.

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

The Commissioner of Insurance of the Government of Puerto 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, Statutory Accounting, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

2018 Consolidated Highlights

Key developments in our business during 2018 are described below:

- Consolidated premiums earned, net increased 4.0% year over year, to $2.9 billion, primarily reflecting higher Managed Care premiums;

- Managed Care premiums increased 3.8% when compared to last year, primarily reflecting growth in Medicare premiums following the Company's achievement of a four-star rated Medicare Advantage HMO contract this year, resulting in a 5% bonus applied to the benchmark used in the premium calculation, as well as an increase in the 2018 Medicare reimbursement rates. This increase was partially offset by lower membership.

- Consolidated claims for the year were $2.5 billion, up 7.4% over last year, primarily reflecting the $128.7 million unfavorable prior period reserve development in the Property and Casualty segment related to Hurricane Maria losses. Hurricane Maria was a category 4 hurricane that impacted Puerto Rico in September 2017. In addition, in 2017 the Managed Care segment experienced significantly lower utilization in the aftermath of Hurricanes Irma and Maria. The consolidated loss ratio was up 280 basis points, to 86.0%, and the MLR decreased 110 basis points, to 84.5%.

- Consolidated operating expenses for the year were $554.7 million and the operating expense ratio was 18.8%.

- Net loss for the year was $63.3 million, a decrease from a net income of $54.5 million for the prior year, primarily reflecting the unfavorable prior period reserve development in the Property and Casualty segment related to the aforementioned hurricanes, the lower Managed Care utilization experienced in 2017 due to the aftermath of the hurricanes, and the impact of the net unrealized losses on equity investments. The unrealized loss on equity investments is due to the implementation effective January 1, 2018 of new accounting guidance that requires the change in unrealized gain (loss) of equity investments, previously recognized through comprehensive income, to be recorded through earnings.

Overview details

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

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(Dollar amounts in millions)	Years ended December 31, 2018	2017	2016
Premiums earned, net:			
Managed care	$2,689.1	$2,590.0	$2,648.5
Life insurance	168.6	161.8	156.9
Property and casualty insurance	83.5	77.2	87.9
Intersegment premiums earned	(2.6)	(2.1)	(2.7)
Consolidated premiums earned, net	$2,938.6	$2,826.9	$2,890.6
Administrative service fees:			
Managed care	$19.1	$21.6	$22.4
Intersegment administrative service fees	(4.4)	(5.1)	(4.5)
Consolidated administrative service fees	$14.7	$16.5	$17.9
Operating income (loss):			
Managed care	$26.5	$55.0	$(36.8)
Life insurance	19.9	19.4	21.5
Property and casualty insurance	(110.1)	(6.0)	12.1
Intersegment and other	2.0	-	(2.0)
Consolidated operating (loss) income	$(61.3)	$68.4	$(5.2)

Revenue

General. Our revenue consists primarily of (i) premium revenue generated from our Managed Care segment, (ii) administrative service fees received for services provided to self-insured employers, (iii) premiums we generate from our Life and Property and Casualty segments, and (iv) investment income.

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

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

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.

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

Investment Income. Investment income consists of interest and dividend income from investment securities. See Note 5, Net Investment Income, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

Expenses

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

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

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

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II. Membership

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

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

	As of December 31,		
	2018	2017	2016
Commercial [1]	449,047	475,026	509,157
Medicare	108,605	118,451	110,297
Medicaid	318,616	384,462	397,918
Total	876,268	977,939	1,017,372

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

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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, 2018, 2017 and 2016. 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)	2018	2017	2016
Years ended December 31,			
Revenues:			
Premiums earned, net	$2,938.6	$2,826.9	$2,890.6
Administrative service fees	14.7	16.5	17.9
Net investment income	61.9	51.6	48.9
Other operating revenues	5.8	3.7	3.5
Total operating revenues	3,021.0	2,898.7	2,960.9
Net realized investment gains	0.3	10.8	17.4
Net unrealized investment losses on equity investments	(36.5)	-	-
Other income, net	11.3	6.6	6.5
Total revenues	2,996.1	2,916.1	2,984.8
Benefits and expenses:			
Claims incurred	2,527.6	2,353.1	2,472.2
Operating expenses	554.7	477.2	493.9
Total operating costs	3,082.3	2,830.3	2,966.1
Interest expense	6.9	6.8	7.6
Total benefits and expenses	3,089.2	2,837.1	2,973.7
(Loss) income before taxes	(93.1)	79.0	11.1
Income (benefit) tax expense	(29.8)	24.5	(6.3)
Net (loss) income	(63.3)	54.5	17.4
Net loss attributable to non-controlling interest	-	-	-
Net (loss) income attributable to TSM	$(63.3)	$54.5	$17.4

Year ended December 31, 2018 compared with the year ended December 31, 2017

Operating Revenues

Premiums earned, net increased by $111.7 million, or 4.0%, to $2.9 billion. This increase primarily reflects higher premiums in the Managed Care segment by $99.1 million. Most of the growth in managed care premiums was experienced in the Medicare business, reflecting the achievement of a four-star rated Medicare Advantage HMO contract this year, resulting in a 5% bonus applied to the benchmark used in the premium calculation, as well as an increase in the 2018 Medicare reimbursement rates. This increase was partially offset by lower managed care membership.

Administrative service fees decreased $1.8 million, or 10.9%, mainly due to lower membership enrolled in this business.

Net investment income increased $10.3 million, or 20.0%, to $61.9 million as a result of higher invested balances and interest rates.

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Net unrealized investment losses on equity investments

The $36.5 million in consolidated net unrealized investment losses on equity investments reflects the impact of new accounting guidance implemented effective January 1, 2018, which requires the change in unrealized gain (loss) of equity investments, previously recorded through comprehensive income, to be recorded through earnings.

Claims Incurred

Consolidated claims incurred increased by $174.5 million, or 7.4%, to $2.5 billion, mostly driven by an increase in the Property and Casualty segment gross losses related to Hurricane Maria, a category 4 hurricane that impacted Puerto Rico in September 2017, causing the segment to exceed its applicable catastrophe reinsurance coverage limits and resulting in $128.7 million unfavorable reserve development recorded in 2018. In addition, in 2017 the Managed Care segment experienced significantly lower utilization following the hurricanes that occurred during that year, this hurricane-related drop in utilization is estimated to have lowered the Managed Care segment's claims by approximately $55 million. The 2017 period also includes $14.8 million of losses related to Hurricanes Irma and Maria recognized by the Property and Casualty segment. The consolidated loss ratio increased by 280 basis points to 86.0%.

Operating Expenses

Consolidated operating expenses increased by $77.5 million, or 16.2%, to $554.7 million. The higher operating expenses are mostly the result of the reinstatement of the HIP Fee of $50.1 million and higher professional services and personnel costs related to the ongoing managed care initiatives. The consolidated expense ratio increased 200 basis points to 18.8%.

Income taxes

Consolidated income tax benefit for the year ended December 31, 2018 was $29.8 million, compared to an expense of $24.5 million during the last year, primarily due to a change in the effective tax rate of certain deferred tax liabilities in the Company's Property and Casualty segment in order to reflect the expected tax rate at which they will reverse, and a change in the enacted tax rate, from 39% to 37.5%, following the Puerto Rico income tax reform enacted in December 2018. These changes increased the deferred tax expense by approximately $9.5 million. The consolidated income tax expense also reflects the tax impact of net unrealized losses on equity investments and the lower operating income of the Managed Care segment.

Year ended December 31, 2017 compared with the year ended December 31, 2016

Operating Revenues

Premiums earned, net decreased by $63.7 million, or 2.2%, to $2.8 billion. This decrease primarily reflects lower premiums in the Managed Care segment by $58.5 million mainly due to lower membership in the segment's Medicaid and Commercial businesses, the impact of the suspension of the HIP fee pass through, and lower Medicare additional risk score revenue. These decreases were partially offset by higher average premium rates in the Commercial and Medicaid businesses as well as by higher Medicare membership. Property and casualty premiums decreased by $10.7 million year over year, mostly reflecting the $9.2 million estimated catastrophe reinsurance reinstatement costs following the impact of Hurricanes Irma and Maria in September 2017.

Administrative service fees decreased $1.4 million, or 7.8%, mainly due to lower membership enrolled in this business.

Net investment income increased $2.7 million, or 5.5%, to $51.6 million mostly as a result of higher invested balances.

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Claims Incurred

Consolidated claims incurred decreased by $119.1 million, or 4.8%, to $2.4 billion, mostly due to lower claims in the Managed Care segment offset by an increase in claims in the Property and Casualty segment. The decrease in managed care claims primarily reflects lower claims incurred across all businesses in the segment driven by the estimated decrease in utilization as a consequence of the aforementioned hurricanes, lower enrollment in the Commercial and Medicaid enrollment, and favorable fluctuations in the prior period reserve developments in the Commercial and Medicare businesses. The Property and Casualty segment's estimated net retained losses related to Hurricanes Irma and Maria were approximately $14.8 million after the application of reinsurance. The consolidated loss ratio decreased by 230 basis points to 83.2%. Excluding the impact of prior-period reserve developments, and moving the Medicare risk score revenue and other revenue adjustments to the corresponding period, the managed care MLR for the year was 83.7%, 100 basis points lower than the same metric from the prior year.

Operating Expenses

Consolidated operating expenses decreased by $16.7 million, or 3.4%, to $477.2 million. The lower operating expenses are mostly the result of the decrease in the HIP Fee of $44.2 million due to the 2017 moratorium offset by increase in personnel costs, professional services, and business promotion expenses totaling approximately $30.4 million.

Income taxes

Consolidated income taxes increased by $30.8 million, to a net expense of $24.5 million. The year over year change in income taxes primarily results from an increase in the taxable income from the Managed Care segment, which has a higher effective tax rate than our other segments.

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Managed Care Segment Operating Results

We offer our products in the Managed Care segment to three distinct market sectors in Puerto Rico: Commercial, Medicare Advantage and Medicaid. For the year ended December 31, 2018, the Commercial, Medicare and Medicaid sectors represented 26.6%, 38.5% and 26.4% of our consolidated premiums earned, net, respectively.

(Dollar amounts in millions)	2018	2017	2016
Operating revenues:			
Medical premiums earned, net:			
Commercial	$782.8	$803.3	$841.4
Medicare	1,130.3	1,035.3	1,023.9
Medicaid	776.0	751.4	783.2
Medical premiums earned, net	2,689.1	2,590.0	2,648.5
Administrative service fees	19.1	21.6	22.4
Net investment income	23.8	16.6	15.1
Total operating revenues	2,732.0	2,628.2	2,686.0
Medical operating costs:			
Medical claims incurred	2,272.5	2,218.3	2,347.5
Medical operating expenses	433.0	354.9	375.3
Total medical operating costs	2,705.5	2,573.2	2,722.8
Medical operating income (loss)	$26.5	$55.0	$(36.8)
Additional data:			
Member months enrollment:			
Commercial:			
Fully-insured	3,775,441	3,981,347	4,209,920
Self-funded	1,732,219	1,967,668	2,144,621
Total Commercial member months	5,507,660	5,949,015	6,354,541
Medicare member months	1,337,061	1,457,363	1,394,272
Medicaid member months	4,555,702	4,631,316	4,829,729
Total member months	11,400,423	12,037,694	12,578,542
Medical loss ratio	84.5%	85.6%	88.6%
Operating expense ratio	16.0%	13.6%	14.1%

Year ended December 31, 2018 compared with the year ended December 31, 2017

Medical Operating Revenues

Medical premiums earned increased by $99.1 million, or 3.8%, to $2.7 billion. This increase is principally the result of the following:

- Medical premiums generated by the Commercial business decreased by $20.5 million, or 2.6%, to $782.8 million. This fluctuation primarily reflects lower fully-insured enrollment during the year of approximately 206,000 member months offset in part by $12.1 million related to the reinstatement of the HIP fee pass-through in 2018 and higher average premium rates.

- Medical premiums generated by the Medicare business increased by $95.0 million, or 9.2%, to $1,130.3 million, primarily reflecting an increase in the 2018 Medicare reimbursement rates fee-for-service benchmark for the first time since 2012, an increase in rates as the result of attaining a four-star rating in the Company's 2018 HMO product, and higher average membership risk score. These increases were partially offset by lower enrollment of

approximately 120,000 member months.

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- Medical premiums generated by the Medicaid business increased by $24.6 million, or 3.3%, to $776.0 million. This increase primarily reflects higher premiums rates effective July 1, 2017 and $14.5 million related to the reinstatement of the HIP fee pass-through. These increases were offset in part by a lower enrollment by approximately 76,000 in member months and the impact of the profit sharing accrual, which lowered 2018 premiums by $4.3 million. The lower membership reflects the lower membership assigned by ASES when implementing the current Medicaid contract, which was effective November 1, 2018. At the effective date of the current agreement TSS was assigned by ASES approximately 280,000 subscribers. After this date, subscribers had approximately three months to select their insurance carrier, during which time TSS was able to compete for membership across Puerto Rico. As of December 31, 2018, our Medicaid membership was approximately 319,000 members.

Medical Claims Incurred

Medical claims incurred increased by $54.2 million, or 2.4%, to $2.3 billion. The MLR of the segment decreased 110 basis points during the 2018 period, to 84.5%. These fluctuations are primarily attributed to the net effect of the following:

- The medical claims incurred of the Commercial business increased by $22.3 million, or 3.6%, during the 2018 period and its MLR, at 82.4%, was 490 basis points higher than the same period last year primarily reflecting the decrease in utilization in the 2017 period caused by Hurricanes Irma and Maria. The hurricane related decrease in utilization was estimated to lower 2017 claims by approximately $27.8 million, or 340 basis points of last year's MLR. Adjusting for the effect of prior period reserve development in 2018 and 2017 period as well as adjusting for the 2017 hurricane related impact in utilization, the Commercial MLR would have been approximately 83.4%, 330 basis points higher than last year, reflecting claim trends higher than premium trends.

- The medical claims incurred of the Medicare business increased by $33.1 million, or 3.6%, during the 2018 period and its MLR decreased by 450 basis points, to 83.2%. The hurricane related decrease in utilization was estimated to lower 2017 claims by approximately $25.1 million, or 240 basis points of last year's MLR. Adjusting for the effect of prior period reserve development in the 2018 and 2017 periods, moving the risk score revenue to it corresponding period, as well as adjusting for the 2017 hurricane related impact in utilization, the Medicare MLR would have been approximately 83.9%, 640 basis points lower than last year, primarily reflecting the higher premium rates in the 2018 period as well as cost containment initiatives implemented during the year.

- The medical claims incurred of the Medicaid business decreased by $1.1 million, or 0.2%, during the 2018 period and its MLR decreased by 300 basis points, to 88.5%. The hurricane related decrease in utilization was estimated to lower 2017 claims by approximately $2.2 million, or 30 basis points of last year's MLR. Adjusting for the effect of prior period reserve developments and the 2018 profit sharing accrual, the Medicaid MLR would have been approximately 87.8%, 420 basis points lower than the adjusted MLR for last year mostly reflecting the impact of higher premium rates in 2018 and cost containment initiatives.

Medical Operating Expenses

Medical operating expenses increased by $78.1 million, or 22.0%, to $433.0 million. The operating expense ratio increased by 240 basis points to 16.0% in 2018. The higher operating expenses and expense ratio are mostly driven by the reinstatement of the HIP fee in 2018, resulting in an increase of $50.1 million, and professional services and personnel costs related to ongoing operational and clinical initiatives.

Year ended December 31, 2017 compared with the year ended December 31, 2016

Medical Operating Revenues

Medical premiums earned decreased by $58.5 million, or 2.2%, to $2.6 billion. This decrease is principally the result of the following:

- Medical premiums generated by the Commercial business decreased by $38.1 million, or 4.5%, to $803.3 million. This fluctuation primarily reflects lower fully-insured enrollment during the year of approximately 228,600 member months and $14.5 million related to the suspension of the HIP fee pass-through; offset by an increase in average premium rates of approximately 5%.

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- Medical premiums generated by the Medicare business increased by $11.4 million, or 1.1%, to $1,035.3 million, primarily reflecting an increase in member months enrollment of approximately 63,100 lives. This increase is partially offset by lower additional risk score revenue by $30.9 million as well as lower average premium rates due to a reduction in the 2017 Medicare reimbursement rates.

- Medical premiums generated by the Medicaid business decreased by $31.8 million to $751.4 million. This decrease primarily reflects lower fully-insured member months enrollment by approximately 198,400 lives, $10.8 million related to the suspension of the HIP fee pass-through as a result of the 2017 moratorium and, the impact of the 2.5% excess profit accrual that increased 2016 premiums by $10.9 million. Decreases are partially offset by a $12.2 million increase in premium collections related to our compliance with the contract's quality incentive metrics and the impact of the new premium rates that were effective July 1, 2017, which increased average premium rates by approximately 9%.

Medical Claims Incurred

Medical claims incurred decreased by $129.2 million, or 5.5%, to $2.2 billion. The MLR of the segment decreased 300 basis points during the 2017 period, to 85.6%. These fluctuations are primarily attributed to the net effect of the following:

- The medical claims incurred of the Commercial business decreased by $94.5 million, or 13.2%, during the 2017 period and its MLR, at 77.5%, was 770 basis points lower than the same period last year. Adjusting for the effect of prior period reserve developments, the Commercial MLR would have been 77.9%, 590 basis points lower than the adjusted MLR for last year, primarily reflecting the estimated decrease in utilization caused by Hurricanes Irma and Maria in September 2017 as well as the ongoing claim trends that are lower than our premium trends following the continuity of our underwriting discipline. The estimated decrease in utilization related to the aforementioned hurricanes account for approximately 340 of the 590 basis-points decrease in the adjusted MLR.

- The medical claims incurred of the Medicare business decreased by $16.6 million, or 1.8%, during the 2017 period and its MLR decreased by 260 basis points, to 87.7 %. Adjusting for the effect of prior period reserve developments in 2017 and 2016 and moving the additional risk score revenue adjustments to their corresponding period, the Medicare MLR would have been approximately 88.4%, about 80 basis points lower than last year. The estimated decrease in utilization caused by Hurricanes Irma and Maria mitigated the impact of the higher trends in Part B drugs and pharmacy benefits experienced by this business as well as the improvement of benefits in 2017 products taking advantage of the HIP fee moratorium. The estimated decrease in utilization related to the aforementioned hurricanes lowered by approximately 240 basis points the adjusted MLR.

- The medical claims incurred of the Medicaid business decreased by $18.2 million, or 2.6%, during the 2017 period and its MLR increased by 140 basis points, to 91.5%. Adjusting for the effect of prior period reserve developments in 2017 and 2016, as well as for the impact of the 2.5% excess profit accrual and this year's quality incentive premiums, the Medicaid MLR would have been approximately 91.8%, about 180 basis points higher than last year. The higher MLR primarily reflects increased pharmacy and outpatient claim trends, partially offset by the estimated decrease in utilization caused by Hurricanes Irma and Maria, which lowered the adjusted MLR by 30 basis points, and the impact of the higher premium rates that were effective July 1, 2017.

Medical Operating Expenses

Medical operating expenses decreased by $20.4 million, or 5.4%, to $354.9 million. The operating expense ratio decreased by 50 basis points to 13.6% in 2017. The lower operating expenses and expense ratio are mostly the result of the decrease in the HIP Fee of $44.2 million due to the 2017 moratorium offset by increase in personnel costs, professional services and business promotion expenses totaling approximately $28.1 million.

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Life Segment Operating Results

(Dollar amounts in millions)	2018	2017	2016
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums earned	$175.3	$166.4	$161.3
Assumed earned premiums	2.1	4.2	4.4
Ceded premiums earned	(8.8)	(8.8)	(8.8)
Premiums earned, net	168.6	161.8	156.9
Net investment income	25.6	24.8	24.9
Total operating revenues	194.2	186.6	181.8
Operating costs:			
Policy benefits and claims incurred	99.0	87.3	86.9
Underwriting and other expenses	75.3	79.9	73.4
Total operating costs	174.3	167.2	160.3
Operating income	$19.9	$19.4	$21.5
Additional data:			
Loss ratio	58.7 %	54.0 %	55.4 %
Expense ratio	44.7 %	49.4 %	46.8 %

Year ended December 31, 2018 compared with the year ended December 31, 2017

Operating Revenues

Premiums earned, net increased by $6.8 million, or 4.2% to $168.6 million, mainly as the result of higher sales and improved policy retention in the Individual Life and Cancer lines of business.

Policy Benefits and Claims Incurred

Policy benefits and claims incurred increased by $11.7 million, or 13.4%, to $99.0 million, mostly resulting from higher number of deaths benefits paid in the Individual Life line of business, an increased average cost of claims in the Cancer line of business, and higher actuarial reserves following improved portfolio persistency. The segment's loss ratio increased 470 basis points, to 58.7%.

Underwriting and Other Expenses

Decrease in underwriting and other expenses of $4.6 million, or 5.8%, to $75.3 million mostly results from a lower amortization of deferred acquisition costs and value of business acquired assets reflecting the segment's improved portfolio persistency. As a result, the segment's operating expense ratio improved to 44.7%, or 470 basis points.

Year ended December 31, 2017 compared with the year ended December 31, 2016

Operating Revenues

Premiums earned, net increased by $4.9 million, or 3.1% to $161.8 million, as the result of premium growth in the segment's Individual Life and Cancer lines of business, as well as growth in the Costa Rica operations.

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Policy Benefits and Claims Incurred

Policy benefits and claims incurred increased by $0.4 million, or 0.5%, to $87.3 million, mostly reflecting a higher volume of business during the year, particularly in the Cancer and Individual Life lines of business, which claims increased by $2.7 million, offset by a decrease of $2.3 million in actuarial reserves.

Underwriting and Other Expenses

Increase in underwriting and other expenses of $6.5 million, or 8.9%, to $79.9 million mostly reflects higher commissions following the segment's premium growth mentioned above. In addition, the segment has incurred in higher development and marketing expenses related to the expansion of the Costa Rica operations. As a result, the segment's operating expense ratio increased to 49.4%, or 260 basis points.

Property and Casualty Segment Operating Results

(Dollar amounts in millions)	2018	2017	2016
Years ended December 31,			
Operating revenues:			
Premiums earned, net:			
Premiums written	$139.8	$143.8	$133.1
Premiums ceded	(60.4)	(62.3)	(46.0)
Change in unearned premiums	4.1	(4.3)	0.8
Premiums earned, net	83.5	77.2	87.9
Net investment income	10.8	9.5	8.9
Total operating revenues	94.3	86.7	96.8
Operating costs:			
Claims incurred	159.9	50.8	40.8
Underwriting and other operating expenses	44.5	41.9	43.9
Total operating costs	204.4	92.7	84.7
Operating (loss) income	$(110.1)	$(6.0)	$12.1
Additional data:			
Loss ratio	191.5 %	65.8 %	46.4 %
Expense ratio	53.3 %	54.3 %	49.9 %

Year ended December 31, 2018 compared with the year ended December 31, 2017

Operating Revenues

Total premiums written decreased by $4.0 million, or 2.8%, to $139.8 million, driven by lower sales of Commercial Package products, mostly the result of selective and disciplined underwriting of Commerical risks.

The premiums ceded to reinsurers decreased by $1.9 million, or 3.0%. Prior year premiums ceded include approximately $9.2 million of catastrophe reinsurance reinstatetement costs. The 2018 includes an increase in cessions in the Commercial quota share agreement from 30% in 2017 to 35% effective April 2018, as well as higher reinsurance costs for facultative and nonproportional property reinsurance.

The $8.4 million increase in the change in unearned premiums reflects the segments lower premiums written in 2018.

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Claims Incurred

Claims incurred increased by $109.1 million, or 214.8%, to $159.9 million mostly driven by an increase in gross losses related to Hurricane Maria, causing the segment to exceed the applicable catastrophe reinsurance coverage limits and resulting in a $128.7 million unfavorable reserve development. As loss information emerged, reserves have been updated to reflect a worsening in the loss expectations for Hurricane Maria. As a result, the segment's loss ratio increased to 191.5% during this period. In 2017 we recognized $14.8 million of hurricane related net losses.

Underwriting and Other Expenses

Underwriting and other operating expenses increased by $2.6 million, or 6.2%, to $44.5 million mostly due to higher acquisition expenses, professional services, and personnel costs. The operating expense ratio decreased by 100 basis points, to 53.3% in 2018.

Year ended December 31, 2017 compared with the year ended December 31, 2016

Operating Revenues

Total premiums written increased by $10.7 million, or 8.0%, to $143.8 million, driven by higher sales of Commercial Property and Commercial Liability products, mainly as a result of the acquisition of a large account, as well as to higher sales of Personal package products.

The premiums ceded to reinsurers increased by $16.3 million, or 35.4%, mostly reflecting higher premiums written in Commercial products during 2017 as well as adjustments related to the catastrophe reinsurance, including $9.2 million for catastrophe reinsurance reinstatement costs.

The change in unearned premiums mostly reflects the segments higher premiums written in 2017.

Claims Incurred

Claims incurred increased by $10.0 million, or 24.5%, to $50.8 million mostly driven by $14.8 million of net losses related to Hurricanes Irma and Maria. As a result, the segment's loss ratio increased by 1,940 basis points, to 65.8% during this period.

Underwriting and Other Expenses

Underwriting and other operating expenses decreased by $2.0 million, or 4.6%, to $41.9 million mostly due to lower personnel costs and net commissions. The operating expense ratio increased by 440 basis points, to 54.3% in 2017.

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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)	2018	2017	2016
Sources (uses) of cash:			
Cash provided by operating activities	$7.5	$288.9	$6.5
Net purchases of investment securities	(12.6)	(154.6)	(80.9)
Net capital expenditures	(19.8)	(21.4)	(4.8)
Proceeds from long-term borrowoings	-	24.3	-
Payments of long-term borrowings	(3.2)	(27.1)	(1.7)
Proceeds from policyholder deposits	18.5	13.6	18.2
Surrenders of policyholder deposits	(26.7)	(22.1)	(21.9)
Repurchase and retirement of common stock	(22.4)	(20.2)	(21.4)
Other	(22.7)	14.1	11.6
Net (decrease) increase in cash and cash equivalents	$(81.4)	$95.5	$(94.4)

Year ended December 31, 2018 compared to year ended December 31, 2017

Cash flow from operating activities decreased by $281.4 million for the year ended December 31, 2018 as compared to the year ended December 31, 2017, mostly reflecting Property and Casualty hurricane related claim payments, last year's collection of advances from reinsurers, and the 2018 HIP Fee payment; offset in part by higher premium collections.

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

In August 2017, the Company's Board of Directors authorized a $30.0 million repurchase program of its Class B common stock (2017 Repurchase Program) and in February 2018 the Company's Board of Directors authorized a $25.0 million expansion of this program. 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. During the year 2018, the Company repurchased and retired 903,888 shares of our Class B Common Stock shares at an average per share price of $24.76, for an aggregate cost of $22.4 million.

Increase in Other is due to the change in outstanding checks in excess of bank balances.

Year ended December 31, 2017 compared to year ended December 31, 2016

Cash flow from operating activities increased by $279.7 million for the year ended December 31, 2017 as compared to the year ended December 31, 2016, principally due to, lower claims paid, a decrease in cash paid to suppliers and employees; partially offset by lower premium collections.

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

Net capital expenditures increased by $16.6 million for the year ended December 31, 2017 mostly related to information technology initiatives in the Managed Care segment.

During the year 2017, we received the remaining $24.3 million from a loan with a commercial bank related with a credit agreement entered into in December 2016. These proceeds were used to prepay the outstanding principal amount of $24.0 million of the 6.6% senior unsecured notes.

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During the year 2017, the Company repurchased and retired 861,415 shares of our Class B Common Stock shares under the 2017 Repurchase Program. Repurchases were made at an average per share price of $23.38, for an aggregate cost of $20.2 million.

Stock Repurchase Program

The Company repurchases shares through open market transactions, in accordance with Rule 10b-18 of the Securities Exchange Act of 1934, as amended, under repurchase programs authorized by the Board of Directors. Shares purchased under share repurchase programs are retired and returned to authorized and unissued status. See Note 19, Stock Repurchase Program, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

Financing and Financing Capacity

We have several short-term facilities available to address timing differences between cash collections and disbursements. These short-term facilities are mostly in the form of arrangements to sell securities under repurchase agreements. As of December 31, 2018, we had $60.0 million of available credit under these facilities. There are no outstanding short-term borrowings under these facilities as of December 31, 2018.

On December 28, 2016, TSM entered into a $35.5 million credit agreement with a commercial bank in Puerto Rico. The agreement consists of three term loans: (i) Term Loan A in the principal amount of $11.2 million, (ii) Term Loan B in the principal amount of $20.2 million and (iii) Term Loan C in the principal amount of $4.1 million. Term Loan A matures in October 2023 while the Term Loans B and C mature in January 2024. Term Loan A was used to refinance a previous $41.0 million secured loan payable with the same commercial bank. Pursuant to the credit agreement, interest is payable on the outstanding balance of the Loan at the following annual rate: (i) 1% over LIBOR for Term Loan A, (ii) 2.75% over LIBOR for Term Loan B, and (iii) 3.25% over LIBOR for Term Loan C. The loan includes 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 and dividends. Failure to meet these covenants may trigger the accelerated payment of the outstanding balance. As of December 31, 2018 we are in compliance with these covenants.

On April 18, 2017, TSA entered into a $10.0 million revolving loan agreement with a commercial bank in Puerto Rico. This line of credit has an interest rate of 30-day LIBOR plus 25 basis points contains certain financial and non-financial covenants that are customary for this type of facility. This line of credit had an original maturity date of April 17, 2018 and was renewed for an additional year, maturing on April 30, 2019.

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

Contractual Obligations

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

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

- Alternative investments – The Company has $80.5 million of unfunded capital commitments related to alternative investments. These commitments were excluded from this disclosure due to the undetermined timing of their cash flows.
- 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, 2018, we had $83.0 million in unearned premiums.

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- Policyholder deposits – The cash outflows related to these instruments are not included because they do not have defined maturities, such that the timing of payments and withdrawals is uncertain. There are currently no significant policyholder deposits in paying status. As of December 31, 2018, our policyholder deposits had a carrying amount of $174.1 million.
- Other long-term liabilities – Due to the indeterminate nature of their cash outflows, $79.4 million of other long-term liabilities are not reflected in the following table, consisting of $31.3 million of liability for pension benefits, $3.2 million in deferred tax liabilities, and $44.9 million in liabilities to the Federal Employees' Health Benefits Plan Program.

		Contractual obligations by year					
(Dollar amounts in millions)	Total	2019	2020	2021	2022	2023	Thereafter
Long-term borrowings (1)	$33.0	$4.1	$4.2	$4.0	$3.9	$3.5	$ 13.3
Operating leases	11.3	5.2	3.0	1.7	1.2	0.2	-
Purchase obligations (2)	257.2	221.8	13.5	6.9	4.1	4.0	6.9
Claim liabilities (3)	611.8	483.7	95.0	7.8	9.5	6.3	9.5
Estimated obligation for future policy benefits (4)	670.6	131.2	117.6	111.7	105.7	100.2	104.2
	$1,583.9	$846.0	$233.3	$132.1	$124.4	$114.2	$ 133.9

(1) As of December 31, 2018, our long-term borrowings consist of a credit agreement entered with a commercial bank in Puerto Rico. 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 $2.0 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, 2018. 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 $325.0 million of reserves had been ceded at December 31, 2018.

(4) Our Life 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, 2018 and are gross of any reinsurance recoverable. The $670.6 million total estimated cash flows for all years in the table is different from the liability of future policy benefits of $361.5 million included in our audited consolidated financial statements principally due to the time value of money. Actual cash payments to policyholders could differ significantly from the estimated cash payments as presented in this table due to differences between actual experience and the assumptions used in the estimation of these payments.

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Off-Balance Sheet Arrangements

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

Restriction on Certain Payments by the Corporation's Subsidiaries

Our insurance subsidiaries are subject to the regulations of the Commissioner of Insurance of Puerto Rico. These regulations, among other things, require insurance companies to maintain certain levels of capital, thereby restricting the amount of earnings that can be distributed by the insurance subsidiaries to TSM. As of December 31, 2018, our insurance subsidiaries, except for TSP, were in compliance with such minimum capital requirements. TSP is currently under a plan to increase its statutory capital and surplus and RBC scores. Please refer to "Item 1. Business – Capital and Reserve Requirements".

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

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

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

Solvency Regulation

To monitor the solvency of the operations, the BCBSA requires us, TSS, TSA, and TSB to comply with certain specified levels of Risk Based Capital ("RBC"). RBC is designed to identify weakly capitalized companies by comparing each company's adjusted surplus to its required surplus (RBC ratio). The RBC ratio reflects the risk profile of insurance companies. At December 31, 2018, TSM and TSS estimated RBC ratio was above the 375% minimum BCBSA RBC requirement to avoid monitoring. At December 31, 2018, TSA estimated RBC ratio was above the minimum BCBSA RBC requirement of 100% for smaller controlled affiliate.

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

Other Contingencies

Legal Proceedings

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

Given the inherent unpredictability of these matters, it is possible that an adverse outcome in certain matters could, from time to time, have an adverse effect on our operating results and/or cash flows. For a description of our legal proceedings, see Note 24, Contingencies, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

Guarantee Associations and Other Regulatory Commitments

To operate in Puerto Rico, insurance companies, such as our insurance subsidiaries, are required to participate in guarantee associations, which are organized to pay policyholders contractual benefits on behalf of insurers declared insolvent. These associations levy assessments, up to prescribed limits, on a proportional basis, to all member insurers in the line of business in which the insolvent insurer was engaged. In accordance with insurance laws and regulations, assessments are recoverable through policy surcharges. In January 2019, a local property and casualty insurance company entered a liquidation process, accordingly, the property and casualty guarantee fund has initiated the process to settle unpaid claims and return unearned premiums of the insolvent insurer. The guarantee fund currently has not determined and imposed assessments to cover claims and return premiums. Annual assessments are limited to 2% of direct premiums written, as defined. During 2018, 2017 and 2016, no assessment or payment was made for this contingency. 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.

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Pursuant to the Puerto Rico Insurance Code, our Property and Casualty 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 segment shares risks with other member companies and, accordingly, is contingently liable in the event the syndicate cannot meet their obligations. During 2018, 2017 and 2016, 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 December 2018, SIMED declared a distribution to its members; the Company's share of this distribution was $2.9 million, which is presented with other income in the accompanying consolidated statement of earnings.

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 2018 and 2016, the Association distributed to the Company an amount based on the good experience of the business amounting to $0.2 million and $0.5 million, respectively. In June 2017, the Association declared a special dividend of $70 million as authorized by a recent amendment to the Act creating the Association. The distribution was subject to a unique and special tax rate of 50%. The dividend was paid net of its related tax in December 2018. The share of the Property and Casualty segment in this distribution was $2.4 million.

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 $9 thousand in 2018 and $1 thousand in 2017 and 2016.

V. Critical Accounting Estimates

Our consolidated financial statements and accompanying notes included in this Annual Report on Form 10-K have been prepared in accordance with GAAP applied on a consistent basis. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. We continually evaluate the accounting policies and estimates we use to prepare our consolidated financial statements. In general, management's estimates are based on historical experience and various other assumptions it believes to be reasonable under the circumstances. The following is an explanation of our accounting policies considered most significant by management. These accounting policies require us to make estimates and assumptions that affect the amounts reported in the consolidated 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 consolidated financial statements because their application places the most significant demands on management's judgment, with financial reporting results relying on estimation about the effect of matters that are inherently uncertain. For all these policies, management cautions that future events may not necessarily develop as forecasted, and that the best estimates routinely require adjustment. Management believes that the amounts provided for these critical accounting estimates are adequate.

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Claim Liabilities

Claim liabilities by segment as of December 31, 2018 were as follows:

(Dollar amounts in millions)

Managed care	$393.7
Property and casualty insurance	496.9
Life insurance	46.2
Consolidated	$936.8

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

We recognize claim liabilities as follows:

Managed Care Segment

At December 31, 2018, claim liabilities for the Managed Care segment amounted to $393.7 million and represented 42.0% of our total consolidated claim liabilities and 20.3% 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.

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

Circumstances to be considered in developing our best estimate of reserves include changes in enrollment, utilization levels, unit costs, mix of business, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, regulatory and legislative requirements, claim processing patterns, and claim submission patterns. A comparison or prior period liabilities to re-estimated claim liabilities based on subsequent claims development is also considered in making the liability determination. In the actuarial process, the methods and assumptions are not changed as reserves are recalculated, but rather the availability of additional paid claims information drives our changes in the re-estimate of the unpaid claim liability. Changes in such development are recorded as a change to current period benefit expense. The re-estimates or recasts are done monthly for the previous four calendar quarters. On average, about 91% of the claims are paid within three months after the last day of the month in which they were incurred and about 5% are within the next three months, for a total of 96% 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 consolidated statement of earnings and financial position could be impacted in future periods. Changes to prior year estimates may result in an increase in claims incurred or a reduction of claims incurred in the period the change is made. Further, due to the considerable variability of health care costs, adjustments to claims liabilities are made in each period and are sometimes significant as compared to the net income recorded in that period. Prior year development of claim liabilities is recognized immediately upon the actuary’s judgment that a portion of the prior year liability is no longer needed or that an additional liability should have been accrued. Health care trends are monitored in conjunction with the claim reserve analysis. Based on these analyses, rating trends are adjusted to anticipate future changes in health care cost or utilization. Thus, the Managed Care segment incorporates those trends as part of the development of premium rates in an effort to keep premium rating trends in line with claims trends.

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As described above, completion factors and claims trend factors can have a significant impact on the determination of our claim liabilities. The following example provides the estimated impact on our December 31, 2018 claim liabilities, assuming the indicated hypothetical changes in completion and trend factors:

(Dollar amounts in millions)

Completion Factor [1] (Decrease) Increase		Claims Trend Factor [2] (Decrease) Increase	
In completion factor	In unpaid claim liabilities	In claims trend factor	In unpaid claim liabilities
-1.2%	$ 20.3	1.5%	$ 17.6
-0.8%	13.4	1.0%	11.7
-0.4%	6.7	0.5%	5.9
0.4%	(6.7)	-0.5%	(5.9)
0.8%	(13.3)	-1.0%	(11.7)
1.2%	(19.7)	-1.5%	(17.6)

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

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

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

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The following table shows the variance between the segment's incurred claims for current period insured events and the incurred claims for such years had they been determined retrospectively (the "Incurred claims related to current period insured events" for the year shown plus or minus the "Incurred claims related to prior period insured events" for the following year as included in Note 11, Claim Liabilities and Claim Adjustment Expenses, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K). This table shows that the segments' estimates of this liability have approximated the actual development.

(Dollar amounts in millions)	2017	2016	2015
Years ended December 31,			
Total incurred claims:			
As reported [1]	$2,231.1	$2,356.6	$2,216.3
On a retrospective basis	2,195.1	2,343.8	2,207.3
Variance	$36.0	$12.8	$9.0
Variance to total incurred claims as reported	1.6 %	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 2018 estimate of medical claims payable will be known during 2019.

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 Segment

At December 31, 2018, claim liabilities for the life segment amounted to $46.2 million and represented 5.0% of total consolidated claim liabilities and 2.4% of our total consolidated liabilities.

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

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Property and Casualty Segment

At December 31, 2018, claim liabilities for the Property and Casualty segment amounted to $496.9 million and represented 53.0% of the total consolidated claim liabilities and 25.6% of our total consolidated liabilities. Claims liabilities related to losses caused by Hurricanes Irma and Maria amount to approximately $415.9 million.

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. Hurricane losses initially include the use of models from industry recognized firms having data, historical and current information about the events, to estimate ultimate losses. These estimates are supplemented by internal estimates of other costs deemed necessary to develop the ultimate losses. As loss information emerges, claims are separated between those with solid estimates and the remained claims. Additional reserves are provided based on paid loss experience for unreported, potential development, and loss expenses.

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

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

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

At December 31, 2018, the claim liabilities of the Property and Casualty segment fall within the actuarial reserve range determined by the actuaries. Management reviews the results of the reserve estimates in order to determine any appropriate adjustments in the recording of reserves. Adjustments to reserve estimates are made after management's consideration of numerous factors, including but not limited to the magnitude of the difference between the actuarial indication and the recorded reserves, improvement or deterioration of actuarial indications in the period, the maturity of the accident year, trends observed over the recent past and the level of volatility within a particular line of business. In general, changes are made more quickly to more mature accident years and less volatile lines of business. Varying the net expected loss ratio by +/-1% in all lines of business for the six most recent accident years would increase/decrease the claims incurred by approximately $5.0 million.

Liability for Future Policy Benefits

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

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Liabilities for future policy benefits for whole life and term insurance products and active life reserves for accident and health products are computed by the net level premium method, using interest assumptions ranging from 3.90% 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. Deferred annuity reserves are carried at the account value.

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

Deferred Policy Acquisition Costs and Value of Business Acquired

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

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

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

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

realizable value, whichever is lower.

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Impairment of Investments

Impairment of an investment exists if a decline in the estimated fair value is below the amortized cost of the security. Management regularly monitors and evaluates the difference between the cost and estimated fair value of fixed maturity investments and other invested assets. 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 we 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 fixed maturity security or other invested asset below cost is other than temporary, the carrying amount of the security is reduced to its fair value according to current accounting guidance. The new cost basis of an impaired security is not adjusted for subsequent increases in estimated fair value. In periods subsequent to the recognition of an other-than-temporary impairment, the impaired security is accounted for as if it had been purchased on the measurement date of the impairment. For debt securities, the discount (or reduced premium) based on the new cost basis may be accreted into net investment income in future periods based on prospective changes in cash flow estimates, to reflect adjustments to the effective yield.

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

During the year ended December 31, 2018, we were not required to recognize an other-than-temporary impairment. During the years ended December 31, 2017 and 2016, we recognized other-than-temporary impairments on equity securities amounting to $49 thousand and $1.4 million, respectively. The impairment analysis indicated that, none of the securities whose carrying amount exceeded its estimated fair value was considered other-than-temporarily impaired as of that date; however, several factors are beyond management's control, such as the following: financial condition of the issuers, movement of interest rates, specific situations within corporations, among others. Over time, the economic and market environment may provide additional insight regarding the estimated fair value of certain securities, which could change management's judgment regarding impairment. This could result in realized losses related to other-than-temporary declines being charged against future income.

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

A detail of the gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, 2018 and 2017 is included in Note 3, Investment in Securities, of the Notes to Consolidated Financial Statements, included in “Item 8, Financial Statements and Supplementary Data”, of this Annual Report on Form 10-K.

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Allowance for Doubtful Receivables

We estimate the amount of uncollectible receivables in each period and establish an allowance for doubtful receivables considering, among other things, the continued deterioration of the local economy, the exposure to government accounts and the challenging business environment in the Island. The allowance for doubtful receivables amounted to $42.0 million and $35.9 million as of December 31, 2018 and 2017, respectively. As of December 31, 2018 and 2017, the Company had premiums and other receivables of $54.3 million and $81.8 million, respectively, from the Government of Puerto Rico, including its agencies, municipalities, and public corporations. The related allowance for doubtful receivables as of December 31, 2018 and 2017 was $21.0 million and $16.4 million, respectively. The amount of the allowance is based on the aging of unpaid accounts, information about the customer's creditworthiness and other relevant information. The estimates of uncollectible accounts are revised each period, and changes are recorded in the period they become known. In determining the allowance, we use predetermined percentages applied to aged account balances, as well as individual analysis of large accounts. These percentages are based on our collection experience and are periodically evaluated. A significant change in the level of uncollectible accounts would have a material effect on our results of operations.

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

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

Goodwill and Other Intangible Assets

Our consolidated goodwill and other intangible assets at December 31, 2018 were $25.4 million and $2.6 million, respectively. At December 31, 2017 the consolidated goodwill and other intangible assets were $25.4 million and $3.6 million, respectively. The goodwill and other intangible assets balance for both years were primarily related to the acquisition of TSA in 2011. As of December 31, 2018 and 2017, the goodwill related to TSA was $25.0 million. As of December 31, 2018 and 2017 other intangible assets related to the TSA acquisition were $2.6 million and $3.5 million, respectively.

We account for goodwill and intangible assets with indefinite lives in accordance with Accounting Standard Codification (ASC) No. 350, Goodwill and Other Intangible Assets, which specifies the types of acquired intangible assets that are required to be recognized and reported separately from goodwill. Under this guidance, goodwill is not amortized but is tested for impairment at least annually and more frequently if events and circumstances indicate that the asset might be impaired. An impairment loss is recognized to the extent that the carrying amount exceeds the asset's fair value. For goodwill, the impairment determination is made at the reporting unit level and consists of two steps.

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

is determined by allocating the fair value of the reporting unit in a manner similar to a purchase price allocation. The residual fair value after this allocation is the implied fair value of the reporting unit goodwill.

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

We completed our annual impairment tests of existing goodwill during the fourth quarter of 2018 and 2017. Limited interim impairment tests are also performed when potential impairment indicators exist or other changes in our business occur. If we do not achieve our earnings objectives or the cost of capital rises significantly, the assumptions and estimates underlying these impairment evaluations could be adversely affected and result in future impairment charges that would negatively impact our operating results. On the other hand, since October 2016 the TSA HMO contract scored 4.0 overall on a 5.0 star rating system, increasing 1.0 versus the prior year, and achieved 5 stars in Part D, which generated additional premiums in 2018. Furthermore, in October 2018, the TSA HMO product increased its overall score to 4.5 stars and the PPO contract increased its overall score to 4.0 stars, which are expected to further increase Medicare premiums for 2020. The result of the impairment test performed in 2018 and 2017 indicated that the fair value of the TSA unit exceeded its carrying value by approximately 62% and 26%, respectively.

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

Other Significant Accounting Policies

We have other accounting policies that are important to an understanding of the consolidated financial statements. See Note 2, Significant Accounting Policies, of the Notes to Consolidated Financial Statements, included in "Item 8, Financial Statements and Supplementary Data", of this Annual Report on Form 10-K.

VI. Recently Issued Accounting Standards

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

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

Market Risk Exposure

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

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

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

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

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

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

Interest Rate Risk

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

Equity Price Risk

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

Risk Measurement

Our investment securities are a source of market risk. As of December 31, 2018 approximately 77% of our investment portfolio consisted of fixed maturity securities. The remaining balance is comprised of equity securities and alternative investments. Our fixed maturity securities classified as available-for-sale and alternative investments 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. Fixed maturity securities classified as held-to-maturity are recorded at amortized cost and adjusted for the amortization or accretion of premiums or discounts. Equity securities are recorded at fair value and changes in fair value are included in earnings. 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 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, if cash flows information is available. The following table sets forth the result of this analysis for the years ended December 31, 2018 and 2017. The analysis does not consider any action that management can take to mitigate the impact of changes in market rates.

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(Dollar amounts in millions)

Change in Interest Rates	Expected Fair Value	Amount of Decrease	% Change
December 31, 2018:			
Base Scenario	$ 1,202.0		
+100bp	1,148.2	(53.8)	(4.5)%
+200bp	1,097.9	(104.1)	(8.7)%
+300bp	1,049.4	(152.6)	(12.7)%
December 31, 2017:			
Base Scenario	$ 1,219.3		
+100bp	1,163.4	(55.9)	(4.6)%
+200bp	1,111.7	(107.6)	(8.9)%
+300bp	1,062.4	(156.9)	(13.0)%

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 less likely given historical precedents. Although we classify 99.8% of our fixed maturity securities as available-for-sale, our cash flows and the intermediate duration of our investment portfolio should allow us to hold securities until maturity, thereby avoiding the recognition of losses, should interest rates rise significantly.

Equity Price Risk

Our equity securities are composed of mutual funds whose underlying assets are comprised of domestic equity securities, domestic preferred equity securities, international equity securities and higher risk fixed income instruments. The fixed income mutual funds invest mainly in loan participations and high yield debt. The securities in these funds are issued 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.

Our investments in mutual funds exposes us to equity price risk and credit risk. We manage these exposures 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, 2018 and 2017, the hypothetical loss in the fair value of these investments would have been approximately $27.9 million and $34.2 million, respectively.

Alternative Price Risk

Our alternative investments in the available-for-sale portfolio are comprised of commitments to limited liability partnerships. These private funds call capital over time and invest in various asset classes such as traditional private equity, infrastructure equity, real estate debt and corporate debt. These investments are unrated, illiquid and expose us to a variety of underlying risks. We manage these exposures by closely monitoring the performance of these funds. The fair value of alternative investments is estimated using the net asset value of the Company’s ownership interest in the partnerships as a practical expedient to determining an independent fair value.

Assuming an immediate decrease of 10% in the market value of our equity securities as of December 31, 2018 and 2017, the hypothetical loss in the fair value of these investments would have been approximately $7.4 million and $3.5 million, respectively.

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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, 2018 and 2017 and for each of the three years ended December 31, 2018, 2017 and 2016 see Index to consolidated financial statements in "Item 15. Exhibits and Financial Statements Schedules" to this Annual Report on Form 10-K.

Selected Quarterly Financial Data

	2018				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$752,034	$741,770	$ 742,445	$ 702,342	$2,938,591
Administrative service fees	3,348	4,066	3,802	3,485	14,701
Net investment income	13,755	15,707	16,168	16,279	61,909
Other operating revenues	1,071	1,588	1,575	1,560	5,794
Total operating revenues	770,208	763,131	763,990	723,666	3,020,995
Net realized investment gains (losses)	2,942	(921)	(956)	(767)	298
Net unrealized investment (losses) gains on equity investments	(16,199)	(776)	5,632	(25,203)	(36,546)
Other income, net	1,163	494	1,943	7,712	11,312
Total revenues	758,114	761,928	770,609	705,408	2,996,059
Benefits and expenses					
Claims incurred	618,989	692,138	648,580	567,906	2,527,613
Operating expenses	133,134	134,612	141,026	145,943	554,715
Total operating costs	752,123	826,750	789,606	713,849	3,082,328
Interest expense	1,690	1,825	2,000	1,388	6,903
Total benefits and expenses	753,813	828,575	791,606	715,237	3,089,231
Income (loss) before taxes	4,301	(66,647)	(20,997)	(9,829)	(93,172)
Income tax expense (benefit)	387	(27,901)	(3,430)	1,078	(29,866)
Net income (loss)	3,914	(38,746)	(17,567)	(10,907)	(63,306)
Less: Net income (loss) attributable to non-controlling interest	-	1	-	(5)	(4)
Net income (loss) attributable to TSM	$3,914	$(38,747)	$ (17,567)	$ (10,902)	$(63,302)
Basic net income (loss) per share	$0.17	$(1.68)	$ (0.77)	$ (0.48)	$(2.76)
Diluted net income (loss) per share	$0.17	$(1.68)	$ (0.77)	$ (0.48)	$(2.76)

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	2017				
	March 31	June 30	September 30	December 31	Total
Revenues					
Premiums earned, net	$702,273	$722,891	$ 714,325	$ 687,443	$2,826,932
Administrative service fees	4,379	4,548	3,391	4,196	16,514
Net investment income	12,016	12,698	12,395	14,506	51,615
Other operating revenues	965	1,121	941	633	3,660
Total operating revenues	719,633	741,258	731,052	706,778	2,898,721
Net realized investment gains (losses):					
Total other-than-temporary impairment losses on securities	-	-	-	(49)	(49)
Net realized gains, excluding other-than-temporary impairment losses on securities	336	4,054	3,753	2,737	10,880
Total net realized investment gains	336	4,054	3,753	2,688	10,831
Other income, net	2,525	587	3,409	12	6,533
Total revenues	722,494	745,899	738,214	709,478	2,916,085
Benefits and expenses					
Claims incurred	620,863	611,297	583,625	537,316	2,353,101
Operating expenses	110,946	118,720	119,145	128,402	477,213
Total operating costs	731,809	730,017	702,770	665,718	2,830,314
Interest expense	1,686	1,721	1,709	1,678	6,794
Total benefits and expenses	733,495	731,738	704,479	667,396	2,837,108
(Loss) income before taxes	(11,001)	14,161	33,735	42,082	78,977
Income tax (benefit) expense	(6,658)	1,456	11,824	17,874	24,496
Net (loss) income	(4,343)	12,705	21,911	24,208	54,481
Less: Net loss attributable to non-controlling interest	1	-	1	3	5
Net (loss) income attributable to TSM	$(4,342)	$12,705	$ 21,912	$ 24,211	$54,486
Basic net (loss) income per share	$(0.18)	$0.52	$ 0.91	$ 1.02	$2.27
Diluted net (loss) income per share	$(0.18)	$0.52	$ 0.91	$ 1.01	$2.26

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

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

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of Triple S Management Corporation and subsidiaries (the "Company") as of December 31, 2018, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control — Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements and financial statements schedules as of and for the year ended December 31, 2018, of the Company and our report dated February 28, 2019, expressed an unqualified opinion on those financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Managements Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

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

Definition and Limitations of Internal Control over Financial Reporting

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 (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of 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.

/s/ DELOITTE & TOUCHE LLP

San Juan, Puerto Rico
February 28, 2019

Stamp No. E360670
affixed to original.

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Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

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

Based on this evaluation, our chief executive officer and chief financial officer have concluded that as of December 31, 2018, 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 consolidated financial statements in accordance with GAAP and that receipts and expenditures of the Company are being made only in accordance with authorizations of management and directors of the Company; and
- provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of the Company's assets that could have a material effect on the consolidated financial statements.

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

Management, under the supervision and with the participation of the chief executive officer and chief financial officer, assessed the effectiveness of the Company's internal control over financial reporting as of December 31, 2018 based on criteria described in the "Internal Control—Integrated Framework" issued by the Committee of Sponsoring Organizations of the Treadway Commission ("COSO") on May 14, 2013. Based on that assessment and those criteria, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2018 to provide reasonable assurance regarding the reliability of financial reporting and the preparation of the Company's consolidated financial statements for external reporting purposes in accordance with GAAP.

The effectiveness of our internal control over financial reporting as of December 31, 2018 has been audited by Deloitte & Touche, LLP, an independent registered public accounting firm, as stated in their report which is included in this Annual Report on Form 10-K.

Changes in Internal Control Over Financial Reporting

No changes in our internal control over financial reporting (as such term is defined in the Exchange Act Rule 13a-15(f)) occurred during the fiscal quarter ended December 31, 2018 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 2019 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 2019 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 2019 Annual Meeting of Shareholders, which will be filed with the SEC pursuant to Regulation 14A within 120 days after the end of our last fiscal year.

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

The information required by this Item is incorporated herein by reference from our definitive Proxy Statement for our 2019 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 2019 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.

Part IV

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, 2018 and 2017
F-3	Consolidated Statements of Earnings for the years ended December 31, 2018, 2017 and 2016
F-4	Consolidated Statements of Comprehensive Income for the years ended December 31, 2018, 2017 and 2016
F-5	Consolidated Statements of Stockholders' Equity for the years ended December 31, 2018, 2017 and 2016
F-6	Consolidated Statements of Cash Flows for the years ended December 31, 2018, 2017 and 2016
F-7	Notes to Consolidated Financial Statements – December 31, 2018, 2017 and 2016

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

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Schedule VI – Supplementary Information Concerning Consolidated Property and Casualty Insurance Operations

Schedule I – Summary of Investments was omitted because the information is disclosed in the notes to the audited consolidated financial statements.

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Item 16. Form 10-K Summary

None

The exhibits listed on the Exhibits Index starting on page 94 of this report are filed herewith or are incorporated herein by reference.

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(i)(d)	Amendments to Article Tenth and Thirteenth of the Amended and Restated Articles of Incorporation of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3(i)(d) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 (File No. 001-33865)).
3(i)(e)	Composite Amended and Restated Articles of Incorporation of Triple-S Management Corporation (incorporated herein by reference to Exhibit 3(i)(e) to TSM's Quarterly Report on Form 10-Q for the quarter ended March 31, 2017 (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	Amendment to the Contract between Administración de Seguros de Salud de Puerto Rico (ASES) and Triple-S Salud, Inc. to administer the provision of physical & behavioral health services under the Government Health Plan Program (incorporated herein by reference to Exhibit 10.1 to TSM's Annual Report on Form 10-K for the year ended December 31, 2017 (File No. 001-33865)).
10.2	Amendment to Extend Contract for the Provision of Physical & Behavioral Health Services under the Government Health Plan Program dated as of June 30, 2018, by and between the Administración de Seguros de Salud de Puerto Rico and Triple-S Salud, Inc. (incorporated herein by reference to Exhibit 10.1 to TS M's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018 (File No. 001-33865)).
10.4	Federal Employees Health Benefits Contract (incorporated herein by reference to Exhibit 10.5 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).
10.5	Credit Agreement with FirstBank Puerto Rico in the amount of $41,000,000 (incorporated herein by reference to Exhibit 10.6 to TSM's General Form of Registration of Securities on Form 10 (File No. 001-33865)).

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

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Exhibits	Description
10.17	Addendum Number One to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(a) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.18	Addendum Number Two to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(b) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.19	Addendum Number Three to the Software License and Maintenance Agreement between Quality Care Solutions, Inc, and TSS (incorporated herein by reference to Exhibit 10.15(c) to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.20	Work Order Agreement between Quality Care Solutions, Inc. and TSS (incorporated herein by reference to Exhibit 10.16 to TSM's Annual Report on Form 10-K for the year ended December 31, 2007 (File No. 001-33865)).
10.21	Agreement between the Administracion de Seguros de Salud de Puerto Rico and Triple-S Salud, Inc. for the Provision of Physical & Behavioral Health Services under the Government Health Plan Program dated as of September 21, 2018, (incorporated herein by reference to Exhibit 10.1 to TSM's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018 (File No. 001-33865)).
10.22	Agreement between the Puerto Rico Health Insurance Administration and TSS for the provision of the physical & behavioral health services under the Government Health Plan Program (incorporated herein by reference to Exhibit 10.1 to TSM's Annual Report on Form 10-K for the year ended December 31, 2014 (File No. 001-33865)).
10.23	Settlement and Release Agreement between Triple-S Management Corporation, Triple-S Salud, Inc., and the Health Insurance Administration of Puerto Rico (incorporated herein by reference to Exhibit 10.22 to TSM's Annual Report on Form 10-K for the year ended December 31, 2015 (File No. 001-33865)).
10.24	Resolution Agreement between Triple-S Management Corporation, Triple-S Salud, Inc., and the Department of Health and Human Services (incorporated herein by reference to Exhibit 10.23 to TSM's Annual Report on Form 10-K for the year ended December 31, 2015 (File No. 001-33865)).
10.25	Employment Contract between Roberto García-Rodríguez and TSM (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on December 26, 2018 (File No. 001-33865)).
10.26	Credit Agreement dated December 28, 2016 by and between Triple-S Management Corporation and FirstBank Puerto Rico (incorporated herein by reference to Exhibit 10.1 to TSM's Current Report on Form 8-K filed on December 30, 2016 (File No. 001-33865)).
10.27	TSM 2017 Incentive Plan (incorporated herein by reference to Exhibit 99.1 to TSM's Form S-8 dated May 11, 2017 (File No. 001-33865)).
10.28	Amendment to Extend Contract for the Provision of Physical & Behavioral Health Services under the Government Health Plan Program (incorporated herein by reference to Exhibit 10.1 to TSM's Quarterly Report on Form 10-Q for the quarter ended June 30, 2017 (File No. 001-33865)).

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Exhibits	Description
10.29	Master Services Agreement, dated as of August 29, 2017, by and between Triple-S Salud, Inc. and OptumInsight, Inc. (incorporated herein by reference to Exhibit 10.2 to TSM's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017 (File No. 001-33865)).
10.30	Amendment to Extend Contract for the Provision of Physical & Behavioral Health Services under the Government Health Plan Program dated as of September 28, 2017, by and between the Administracion de Seguros de Salud de Puerto Rico and Triple-S Salud, Inc. (incorporated herein by reference to Exhibit 10.1 to TSM's Quarterly Report on Form 10-Q for the quarter ended September 30, 2017 (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 (Deloitte & Touche LLP).
31.1*	Certification of the President and Chief Executive Officer required by Rule 13a-14(a)/15d-14(a).
31.2*	Certification of the Vice President of Finance and Chief Financial Officer required by Rule 13a-14(a)/15d-14(a).
32.1*	Certification of the President and Chief Executive Officer required pursuant to 18 U.S. Section 1350.
32.2*	Certification of the Vice President of Finance and Chief Financial Officer required pursuant to 18 U.S. Section 1350.
99.1	Incentive Compensation Recoupment Policy (incorporated herein by reference to Exhibit 99.1 to TSM's Annual Report on Form 10-K for the year ended December 31, 2010 (File No. 001-33865)).

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

* Filed herein.

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SIGNATURES

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

Triple-S Management Corporation
Registrant

By: /s/ Roberto García-Rodríguez Date: February 28, 2019
Roberto García-Rodríguez
President and Chief Executive Officer

By: /s/ Juan J. Román-Jiménez Date: February 28, 2019
Juan J. Román-Jiménez
Executive Vice President
and Chief Financial Officer

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

By: /s/ Luis A. Clavell-Rodríguez Date: February 28, 2019
Luis A. Clavell-Rodríguez
Director and Chairman of the Board

By: /s/ Cari M. Domínguez Date: February 28, 2019
Cari M. Domínguez
Director and Vice-Chairman of the Board

By: /s/ David H. Chafey, Jr. Date: February 28, 2019
David H. Chafey, Jr.
Director

By: /s/ Jorge L. Fuentes-Benejam Date: February 28, 2019
Jorge L. Fuentes-Benejam
Director

By: /s/ Antonio F. Faría-Soto Date: February 28, 2019
Antonio F. Faría-Soto
Director

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By: /s/ Manuel Figueroa-Collazo Date: February 28, 2019
Manuel Figueroa-Collazo
Director

By: /s/ Joseph A. Frick Date: February 28, 2019
Joseph A. Frick
Director

By: /s/ Roberto Santa María-Ros Date: February 28, 2019
Roberto Santa María-Ros
Director

By: /s/ Gail B. Marcus Date: February 28, 2019
Gail B. Marcus
Director

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Triple-S Management
Corporation and Subsidiaries
Consolidated Financial Statements
December 31, 2018, 2017, and 2016

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Report of Independent Registered Public Accounting Firm

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of Triple-S Management Corporation and subsidiaries (the "Company") as of December 31, 2018 and 2017, the related consolidated statements of earnings, comprehensive income, stockholders' equity, and cash flows, for each of the three years in the period ended December 31, 2018, and the related notes and the schedules listed in the Index at Item 15 (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2018 and 2017, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2018, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2018, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2019, expressed an unqualified opinion on the Company's internal control over financial reporting.

Change in Accounting Principle

As discussed in Note 2 to the financial statements, the Company has changed its method of accounting for unrealized holding gains and losses on equity investments in 2018 due to the adoption of Financial Accounting Standards Board Accounting Standards Update 2016-01, Recognition and measurement of financial assets and financial liabilities.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on the Company's consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ DELOITTE & TOUCHE LLP

San Juan, Puerto Rico
February 28, 2019

Stamp No. E360669
affixed to original.

We have served as the Company's auditor since 2015.

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Triple-S Management Corporation and Subsidiaries
Consolidated Balance Sheets
December 31, 2018 and 2017
(dollar amounts in thousands, except share data)

Assets	2018	2017
Investments and cash		
Fixed maturities available for sale, at fair value (amortized cost of $1,168,369 in 2018 and $1,171,651 in 2017)	$1,199,402	$1,216,788
Fixed maturities held to maturity, at amortized cost (fair value of $2,619 in 2018 and $2,475 in 2017)	2,492	2,319
Equity investments, at fair value (cost of $265,858 in 2018 and $292,459 in 2017)	279,164	342,308
Other invested assets, at net asset value (amortized cost of $72,627 in 2018 and $34,670 in 2017)	74,015	34,985
Policy loans	9,469	9,077
Cash and cash equivalents	117,544	198,941
Total investments and cash	1,682,086	1,804,418
Premium and other receivables, net	628,444	899,327
Deferred policy acquisition costs and value of business acquired	215,159	200,788
Property and equipment, net	81,923	74,716
Deferred tax asset	79,010	65,123
Goodwill	25,397	25,397
Other assets	48,229	46,996
Total assets	$2,760,248	$3,116,765
Liabilities and Stockholders’ Equity		
Claim liabilities	$936,789	1,106,876
Liability for future policy benefits	361,495	339,507
Unearned premiums	82,990	86,349
Policyholder deposits	174,110	176,534
Liability to Federal Employees’ Health Benefits and Federal Employees' Programs	44,926	52,287
Accounts payable and accrued liabilities	275,228	354,894
Deferred tax liability	3,245	21,891
Long term borrowings	28,883	32,073
Liability for pension benefits	31,274	33,672
Total liabilities	1,938,940	2,204,083
Commitments and contingencies		
Stockholders’ equity		
Triple-S Management Corporation stockholders' equity Common stock Class A, $1 par value. Authorized 100,000,000 shares; issued and outstanding 950,968 at December 31, 2018 and 2017	951	951
Common stock Class B, $1 par value. Authorized 100,000,000 shares; issued and outstanding 21,980,492 and 22,627,077 shares at December 31, 2018 and 2017, respectively	21,980	22,627
Additional paid-in capital	34,021	53,142
Retained earnings	761,970	785,390
Accumulated other comprehensive income, net	3,062	51,254
Total Triple-S Management Corporation stockholders' equity	821,984	913,364

Non-controlling interest in consolidated subsidiary	(676)	(682)
Total stockholders' equity	821,308	912,682
Total liabilities and stockholders’ equity	$2,760,248	$3,116,765

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

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Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Earnings
December 31, 2018, 2017, and 2016
(dollar amounts in thousands, except per share data)

	2018	2017	2016
Revenues:			
Premiums earned, net	$2,938,591	$2,826,932	$2,890,641
Administrative service fees	14,701	16,514	17,843
Net investment income	61,909	51,615	48,913
Other operating revenues	5,794	3,660	3,461
Total operating revenues	3,020,995	2,898,721	2,960,858
Net realized investment gains (losses):			
Total other-than-temporary impairment losses on securities	-	(49)	(1,434)
Net realized gains, excluding other-than-temporary impairment losses on securities	298	10,880	18,813
Total net realized investment gains	298	10,831	17,379
Net unrealized investment losses on equity investments	(36,546)	-	-
Other income, net	11,312	6,533	6,569
Total revenues	2,996,059	2,916,085	2,984,806
Benefits and expenses:			
Claims incurred, net of reinsurance	2,527,613	2,353,101	2,472,191
Operating expenses	554,715	477,213	493,894
Total operating costs	3,082,328	2,830,314	2,966,085
Interest expense	6,903	6,794	7,635
Total benefits and expenses	3,089,231	2,837,108	2,973,720
(Loss) income before taxes	(93,172)	78,977	11,086
Income tax (benefit) expense	(29,866)	24,496	(6,345)
Net (loss) income	(63,306)	54,481	17,431
Less: Net loss attributable to non-controlling interest	4	5	7
Net (loss) income attributable to Triple-S Management Corporation	$(63,302)	$54,486	$17,438
Earnings per share attributable to Triple-S Management Corporation			
Basic net (loss) income per share	$(2.76)	$2.27	$0.71
Diluted net (loss) income per share	$(2.76)	$2.26	$0.71

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

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Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Comprehensive Income
December 31, 2018, 2017, and 2016
(dollar amounts in thousands)

	2018	2017	2016
Net (loss) income	$(63,306)	$54,481	$17,431
Other comprehensive (loss) income, net of tax:			
Net unrealized change in fair value of available for sale securities, net of taxes	(9,048)	13,867	(107)
Defined benefit pension plan:			
Actuarial gain (loss), net	738	(5,028)	18,232
Prior service credit, net	-	20	(1,353)
Total other comprehensive income, net of tax	(8,310)	8,859	16,772
Comprehensive (loss) income	(71,616)	63,340	34,203
Comprehensive loss attributable to non-controlling interest	4	5	7
Comprehensive (loss) income attributable to Triple-S Management Corporation	$(71,612)	$63,345	$34,210

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

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Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Stockholders' Equity
December 31, 2018, 2017, and 2016
(dollar amounts in thousands)

	Class A Common Stock	Class B Common Stock	Additional Paid-in Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Triple-S Management Corporation Stockholders' Equity	Non-controlling Interest in Consolidated Subsidiary	Total Stockholders' Equity
Balance, December 31, 2015	$ 951	$ 24,048	$ 83,438	$ 713,466	$ 25,623	$ 847,526	$ (670)	$ 846,856
Share-based compensation	-	223	2,576	-	-	2,799	-	2,799
Stock issued upon exercise of stock options	-	4	51	-	-	55	-	55
Repurchase and retirement of common stock	-	(954)	(20,473)	-	-	(21,427)	-	(21,427)
Comprehensive income (loss)	-	-	-	17,438	16,772	34,210	(7)	34,203
Balance, December 31, 2016	$ 951	$ 23,321	$ 65,592	$ 730,904	$ 42,395	$ 863,163	$ (677)	$ 862,486
Share-based compensation	-	167	6,909	-	-	7,076	-	7,076
Repurchase and retirement of common stock	-	(861)	(19,359)	-	-	(20,220)	-	(20,220)
Comprehensive income (loss)	-	-	-	54,486	8,859	63,345	(5)	63,340
Balance, December 31, 2017	$ 951	$ 22,627	$ 53,142	$ 785,390	$ 51,254	$ 913,364	$ (682)	$ 912,682
Share-based compensation	-	287	3,070	-	-	3,357	-	3,357
Repurchase and retirement of common stock	-	(934)	(22,191)	-	-	(23,125)	-	(23,125)
Comprehensive income (loss)	-	-	-	(63,302)	(8,310)	(71,612)	6	(71,606)
Cumulative effect adjustment due to implementation of ASU 2016-01	-	-	-	39,882	(39,882)	-	-	-
Balance, December 31, 2018	$ 951	$ 21,980	$ 34,021	$ 761,970	$ 3,062	$ 821,984	$ (676)	$ 821,308

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

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Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Cash Flows
December 31, 2018, 2017, and 2016
(dollar amounts in thousands)

	2018	2017	2016
Cash flows from operating activities			
Net (loss) income	$(63,306)	$54,481	$17,431
Adjustments to reconcile net income to net cash provided by operating activities			
Depreciation and amortization	13,535	13,198	14,120
Net amortization of investments	3,976	10,114	8,671
Additions to the allowance for doubtful receivables	11,321	1,462	1,601
Deferred tax benefit	(32,078)	(9,916)	(8,326)
Net realized investment gains on sale of securities	(298)	(10,831)	(17,379)
Net unrealized loss on equity investments	36,546	-	-
Interest credited to policyholder deposits	5,722	5,677	3,794
Share-based compensation	3,357	7,076	2,463
(Increase) decrease in assets			
Premium and other receivables, net	259,561	(614,424)	(5,320)
Deferred policy acquisition costs and value of business acquired	(12,258)	(6,596)	(7,286)
Deferred taxes	946	4,946	(4,799)
Other assets	(1,470)	5,117	(9,009)
Increase (decrease) in liabilities			
Claim liabilities	(170,087)	618,933	(3,822)
Liability for future policy benefits	21,988	18,275	31,702
Unearned premiums	(3,359)	7,039	(950)
Liability to FEHBP	(7,361)	17,917	7,675
Accounts payable and accrued liabilities	(59,276)	166,450	(24,095)
Net cash provided by operating activities	7,459	288,918	6,471

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

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Triple-S Management Corporation and Subsidiaries
Consolidated Statements of Cash Flows
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(dollar amounts in thousands)

	2018	2017	2016
Cash flows from investing activities			
Proceeds from investments sold or matured			
Securities available for sale:			
Fixed maturities sold	$1,302,810	$463,232	$400,848
Fixed maturities matured	24,945	18,893	56,988
Securities held to maturity:			
Fixed maturities matured	8,182	2,712	1,538
Equity investments sold	203,841	59,963	109,049
Other invested assets sold	3,714	-	-
Acquisition of investments			
Securities available for sale			
Fixed maturities	(1,343,346)	(560,304)	(482,252)
Securities held to maturity			
Fixed maturities	(8,356)	(2,197)	(1,445)
Equity investments	(156,486)	(134,834)	(163,119)
Other invested assets	(47,221)	-	-
Other investments	(705)	(2,064)	(2,493)
Net disbursements for policy loans	(392)	(513)	(663)
Net capital expenditures	(19,840)	(21,359)	(4,750)
Net cash used in investing activities	(32,854)	(176,471)	(86,299)
Cash flows from financing activities			
Change in outstanding checks in excess of bank balances	(22,243)	12,683	12,250
Repayments of long-term borrowings	(3,236)	(2,836)	(1,742)
Repurchase and retirement of common stock	(22,377)	(20,220)	(21,371)
Net proceeds from revolving line of credit	-	1,964	-
Proceeds from policyholder deposits	18,531	13,557	18,224
Surrenders of policyholder deposits	(26,677)	(22,082)	(21,923)
Net cash used in financing activities	(56,002)	(16,934)	(14,562)
Net (decrease) increase in cash and cash equivalents	(81,397)	95,513	(94,390)
Cash and cash equivalents			
Beginning of year	198,941	103,428	197,818
End of year	$117,544	$198,941	$103,428

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

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Triple-S Management Corporation and Subsidiaries
Notes to Consolidated Financial Statements
December 31, 2018, 2017, and 2016
(dollar amounts in thousands, except per share and share data)

1. Nature of Business

Triple-S Management Corporation (the 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: (1) Triple-S Salud, Inc. (TSS) and Triple-S Advantage, Inc. (TSA), are 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 Triple-S Blue, Inc. (TSB), 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), is engaged in the underwriting of property and casualty insurance policies. The Company, TSS and TSA are members of the Blue Cross and Blue Shield Association (BCBSA). The Company and the above mentioned subsidiaries are subject directly or indirectly to the regulations of the Commissioner of Insurance of the Commonwealth of Puerto Rico (the Commissioner of Insurance), the General Superintendence of Insurance of Costa Rica, the U.S. Virgin Islands (USVI), the British Virgin Islands (BVI) Financial Services Commission, and the Anguilla Financial Services Commission.

The Company also owns a controlling interest in a health clinic in Puerto Rico, as part of our strategic initiatives. Besides its current operations, this health clinic owns controlling interests in other health clinics throughout the island.

Through our subsidiary TSS, we provide services to participants of the Commonwealth of Puerto Rico Health Insurance Plan (similar to Medicaid) (Medicaid). On September 21, 2018, TSS entered into a contract with the Puerto Rico Health Insurance Administration (ASES by its Spanish acronym), as one of the five managed care organizations (MCOs), that offer health care services to Medicaid and Child Health Insurance subscribers for the government of Puerto Rico's revised Medicaid health insurance program. The contract is effective from November 1, 2018 up to September 30, 2021, which term may be extended an additional year at ASES's option. The revised delivery model requires MCOs to serve subscribers in an island-wide basis, rather than through the assignment of specific regions within the Island. Under the new agreement, TSS is responsible for the provision of medical, mental, pharmacy, and dental healthcare services on an at-risk basis to subscribers who enroll with TSS. ASES will pay TSS a per member per month rate that will vary depending on the clinical condition or category of the subscriber and initially assigned TSS approximately 280,000 subscribers across the Island. Since April 1, 2015 up to the effective date of the new contract, TSS provided medical, mental, pharmacy and dental healthcare services to Medicaid subscribers in the Metro-North and West regions of the government of Puerto Rico's health insurance program, which included approximately 400,000 subscribers, on an at-risk basis.

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.

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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. 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.

Cash Equivalents
The Company considers all highly liquid debt instruments with maturities of three months or less at the date of acquisition to be cash equivalents. Cash and cash equivalents are recorded at cost, which approximates fair value. Cash equivalents of $49,233 and $87,572 at December 31, 2018 and 2017, respectively, consist principally of money market funds and certificates of deposit with original maturities of three months or less.

Investments

Fixed maturities
Investment in debt securities at December 31, 2018 and 2017 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, residential mortgage-backed securities, and collateralized mortgage obligations. The Company classifies its debt securities in one of two categories: available-for-sale or held-to-maturity. Securities classified as held-to-maturity are those securities in which the Company has the ability and intent to hold until maturity. All other securities not included in held-to-maturity are classified as available-for-sale.

Available-for-sale securities are recorded at fair value. The fair values of debt securities (both available-for-sale and held-to-maturity investments) 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, 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 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.

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 may differ from original estimates and may result in material adjustments to amortization or accretion recorded in future periods.

Equity investments

Investment in equity securities at December 31, 2018 and 2017 consists of mutual funds whose underlying assets are comprised of domestic equity securities, international equity securities and higher risk fixed income instruments. Equity investments are recorded at fair value. The fair values of equity investments are mainly based on quoted market prices for those or similar investments at the reporting date. For a specific equity investment, the fair value is estimated using the net asset value (NAV) of the Company's ownership interest in the partnership. Following the implementation on January 1, 2018 of Accounting Standard Update (ASU) 2016-01, Recognition and Measurement of Financial Assets and Financial Liabilities, unrealized holding gains and losses, on equity investments are included in earnings. Realized gains and losses from the sale of equity investments are included in earnings and are determined on a specific identification basis.

Other invested assets

Other invested assets at December 31, 2018 and 2017 consist mainly of alternative investments in partnerships which invest in several private debt and private equity funds. Portfolios are diversified by vintage year, stage, geography, business sectors and number of investments. These investments are not redeemable with the funds. Distributions from each fund are received as the underlying investments of the funds are liquidated. It is estimated that the underlying assets of the funds will be liquidated in the next 5 to 12 years. The fair values of the investments in this class have been estimated using the net asset value (NAV) of the Company's ownership interest in the partnerships. Total unfunded capital commitments for these positions as of December 31, 2018 amounted to $80,484. The remaining average commitments period is approximately three years.

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 cancelled at the end of the grace period at the option of the Company.

Premiums for the Medicaid business are based on a bid contract with ASES and billed in advance of coverage period. Under the risk-based Medicaid contract that expired on October 31, 2018, there is an excess profit agreement which stipulates that the profit of TSS for each fiscal year of the contract term shall not exceed two and a half percentage (2.5%) of the fixed amount paid by ASES for each member. In the event that the profit exceeds this amount, TSS and ASES shall share the excess profit in proportions of fifty percent (50%), subject to the compliance by TSS with certain quality metrics. ASES retains the right to determine the outcome of the excess profit agreement that is based on audited financial statements of the contracted services submitted annually by TSS and the validation of the incurred-but-not-reported reserve by ASES's actuary. We estimate on a monthly basis any estimated amount due to ASES and reflect any adjustments to premium revenue in current operations. As the runout of the contract progresses and additional information becomes available, any change in the estimated accrual will be recorded in the operating results of the period in which the information becomes available. We report any estimated net amounts due to ASES within accounts payable and accrued liabilities in the consolidated balance sheets. As of December 31, 2018, the Company had accrued an estimated profit sharing due to ASES of $4,294. There was no accrued profit sharing due to ASES as of December 31, 2017.

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The Medicaid contract that became effective November 1, 2018 includes a minimum medical loss ratio (MLR) provision where the Company has to remit to ASES the excess of the target MLR of 92% over the actual MLR for any given contract year and would be reflected as an adjustment to premium revenue in current operations. The target established in the contract follows regulation requirements of the Centers for Medicare and Medicaid Services (CMS) for Medicaid managed care contracts codified in 42 CFR part 438. As of December 31, 2018, there was no accrued amount due to ASES related to this provision.

Premiums for the Medicare Advantage (MA) business are based on a bid contract with CMS and billed in advance of the coverage period. We recognize premium revenue in the period in which we are obligated to provide services to our members. We record premiums earned but not received as premiums receivable and record premiums received in advance of the period of service as unearned premiums in the consolidated balance sheets. Unearned premiums are recognized as revenue throughout the related coverage period. MA contracts are renewed annually and 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. We recognize periodic changes to risk-adjusted premiums as revenue when the amounts are determinable and collection is reasonably assured, which is possible as additional diagnosis code information is reported to CMS, when the ultimate settlements are received from CMS, or we receive notification of such settlement amounts. The data provided to CMS to determine members' risk scores is subject to audit by CMS even after the annual settlements occur, which may result in the refund of premiums to CMS. As additional information becomes available, the recorded estimate is revised and reflected in operating results in the period in which it becomes available.

Prescription drug coverage is offered to Medicare eligible beneficiaries as part of MA plans (MA-PD). Premiums are based on a bid contract with CMS that considers the estimated costs of providing prescription drug benefits to enrolled participants. MA-PD 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. 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.

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, including the continued deterioration of the local economy, the exposure to government accounts, and the challenging business environment in the island. This evaluation is performed individually on larger accounts and includes the use of all available information such as the customer's credit worthiness and other relevant information. Actual losses could differ from these estimates. Receivables are charged-off against their respective allowance accounts when deemed to be uncollectible.

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

In the life and accident and health segment, deferred acquisition costs (DAC) consist of commissions and certain expenses related to the successful acquisition of 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 benefits and 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, from 3.90% to 5.75% for 2018 and 2017, and 5.15% for 2016, 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 estimated 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 updated for current and future issues which may result in a change or release of deferred policy acquisition costs amortization through the consolidated statements of earnings.

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 segment.

In the property and casualty segment, 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 10 years
Leasehold improvements	10 years
Office furniture	7 years
Computer software	3 to 5 years
Computer equipment, equipment, and automobiles	3 to 5years

Long-Lived Assets, including Goodwill

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. 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. During 2018, 2017 and 2016, impairment tests on intangible assets were performed and based on the results of the tests no impairment was recorded.

Goodwill and intangible assets that have indefinite useful lives are tested at least annually for impairment, and are tested for impairment more frequently if events or 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 may perform a qualitative analysis under certain circumstances, or perform a two-step quantitative analysis. In the qualitative analysis, the Company determines if it is more likely than not that the fair value of a reporting unit is less than its carrying amount by assessing current events and circumstances. If there are factors present indicating potential impairment, the Company would proceed to the two-step quantitative analysis. 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.

The annual impairment test is based on an evaluation of estimated future discounted cash flows. The Company also uses the market approach as part of their impairment analysis. The estimated discounted cash flows are based on the best information available, including supportable assumptions and projections we believe are reasonable. Our discounted cash flow estimates use discount rates that correspond to a weighted-average cost of capital consistent with a market-participant view. The discount rates are consistent with those used for investment decisions and take into account the operating plans and strategies of our operating segments. Certain other key assumptions utilized, including changes in membership, premium, health care costs, operating expenses, fees, assessments and taxes and effective tax rates, are based on estimates consistent with those utilized in our annual budgeting and planning process that we believe are reasonable. However, if we do not achieve the results reflected in the assumptions and estimates, our goodwill impairment evaluations could be adversely affected, and we may impair a portion of our goodwill, which would adversely affect our operating results in the period of impairment. Impairments, if any, would be classified as an operating expense.

Claim Liabilities

Managed care claim liabilities mostly represent the Company's estimate of medical costs incurred but not yet 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. Claim liabilities are the most significant estimate included in our consolidated financial statements. Such estimate is developed consistently using standard actuarial methodologies based upon key assumptions, which vary by business segment. The most significant assumptions used in the development of managed care claim liabilities include current payment experience, trend factors, and completion factors. Managed care trend factors in our standard actuarial methodologies include contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefit changes, expected health care cost inflation, seasonality patterns, maturity of lines of business, changes in membership and other factors.

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

The Company contracts with various independent practice associations (IPAs) for certain medical care services provided to certain policies subscribers. The IPAs are compensated on a capitation basis and capitation payables are included within claim liabilities. Capitation is amounts paid to the aforementioned IPAs on a fixed-fee per member per month basis.

Claim liabilities also include unpaid claims and loss-adjustment expenses of the life and accident and health segment 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 segment 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. 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. Assumptions are established at the time the policy is issued and are generally not changed during the life of the policy. The Company periodically reviews the adequacy of reserves for these policies on an aggregate basis using actual experience. If actual experience is significantly adverse compared to the original assumptions and a premium deficiency is determined to exist, any remaining unamortized DAC balance would be expensed to the extent not recoverable and the establishment of a premium deficiency reserve may be required. The interest rate assumption ranges between 3.90% and 5.75% for all years in issue.

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 $2,615,

$2,798, and $3,182, during the years ended December 31, 2018, 2017, and 2016, respectively, is included within the interest expense in the accompanying consolidated statements of earnings.

Policyholder account balances for universal life and interest sensitive products are equal to policy account values. The policy account primarily comprises cumulative deposits received and interest credited to the policyholder less cumulative contract benefits, surrenders, withdrawals, maturities and contract charges for mortality or administrative expenses. Interest rates credited to policyholder account balances during 2018 and 2017 ranged from 2.0% to 4.5% for universal life and interest sensitive products. The universal life and interest sensitive products represented $83,563 and $75,956 of the policyholder deposits balance on the consolidated balance sheets as of December 31, 2018 and 2017, respectively.

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.

Prospective 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 under prospective reinsurance treaties 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 and are presented within premium and other receivables, net in the accompanying consolidated balance sheets. Accounts payable and accrued liabilities within the accompanying consolidated balance sheets include $2,712 and $110,850 of advances received for hurricane related claims as of December 31, 2018 and 2017, respectively.

Retroactive reinsurance reimburses a ceding company for liabilities incurred as a result of past insurable events covered under contracts subject to the reinsurance. In certain instances, reinsurance contracts cover losses both on a prospective basis and on a retroactive basis and where practical the Company bifurcates the prospective and retrospective elements of these reinsurance contracts and accounts for each element separately. Initial gains in connection with retroactive reinsurance contracts are deferred and amortized into income over the settlement period while losses are recognized immediately. When changes in the estimated amount recoverable from the reinsurer or in the timing of receipts related to that amount occur, a cumulative amortization adjustment is recognized in earnings in the period of the change so that the deferred gain reflects the balance that would have existed had the revised estimate been available at the inception of the reinsurance transaction. The Company uses the recovery method to amortize any deferred gain, which is included within the claims incurred in the accompanying consolidated statements of earnings. The recovery method provides an amortization in proportion to the estimated recoveries made as of each reporting date as a percentage of total estimated recoveries.

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 circumstances occurs.

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

Health Insurance Providers Fee

The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act mandates an annual Health Insurance Providers Fee (HIP Fee). The annual HIP Fee becomes payable to the U.S. Treasury once the entity provides health insurance for any U.S. health risk each applicable calendar year. The initial estimated annual fee is accrued as of January 1, with a corresponding deferred cost that is amortized over 12 months on a straight-line basis. The fee payment is due on September 30 of each year. The Company incurred approximately $50,100 and $44,100 of such fees in 2018 and 2016, respectively, which are presented within operating expenses in the accompanying consolidated statements of earnings. The HIP Fee was waived for all health insurance providers during the year ended December 31, 2017.

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 consolidated 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 consolidated 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 consolidated financial statements over the vesting period.

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 Adopted Accounting Standards

On January 5, 2016, the FASB issued guidance to enhance the reporting model for financial instruments to provide users of financial statements with more decision-useful information (Accounting Standard Update (ASU) 2016-01). Among the many targeted improvements to U.S. GAAP are (1) requiring equity investments, except those accounted for under the equity method of accounting or those that result in consolidation of the investee, to be measured at fair value with changes in fair value recognized in net income; (2) simplifying the impairment assessment of equity investments without readily determinable fair values by requiring a qualitative assessment to identify impairment; (3) eliminating the requirement to disclose the fair value of financial instruments measured at amortized cost for entities that are not public business entities; and (4) clarifying that an entity should evaluate the need for a valuation allowance on a deferred tax asset related to available-for-sale securities in combination with the entity's other deferred tax assets. This guidance applies to all entities that hold financial assets or owe financial liabilities. The Company also adopted guidance issued by FASB on March 9, 2018 that removes the previous guidance for Other Than Temporary Impairment of Certain Investments in Equity Securities as required by SEC Staff Accounting Bulletin (SAB) No. 117 and SEC Release No. 33-9273, since it is no longer applicable. For public companies, these amendments became effective for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. The Company adopted this guidance for equity securities effective January 1, 2018. A cumulative-effect adjustment of $39,882 was made from accumulated other comprehensive income to the beginning retained earnings at the implementation date.

On February 28, 2018, the Financial Accounting Standard Board (FASB) issued guidance for Technical Corrections and Improvement to Financial Instruments – Overall: Recognition and Measurement of Financial Assets and Financial Liabilities. Areas for correction or improvement include (1) equity securities without a readily determinable fair value—discontinuation, (2) equity securities without a readily determinable fair value—adjustments, (3) forward contracts and purchased options, (4) presentation requirements for certain fair value option liabilities, (5) fair value option liabilities denominated in a foreign currency, and (6) transition guidance for equity securities without a readily determinable fair value. For public companies, these amendments, became effective on a prospective basis, for fiscal years beginning after December 15, 2017, including interim periods within those fiscal years. For public entities with fiscal years beginning between December 15, 2017 and June 15, 2018 adoption of these amendments was not effective until the interim period beginning after June 15, 2018. The Company adopted this guidance effective June 30, 2018. The adoption of this guidance did not have a material impact on the presentation of the Company's consolidated results of operations.

Future Adoptions of Accounting Standards

On February 25, 2016, the Financial Accounting Standards Board (FASB) issued guidance to increase transparency and comparability among organizations by requiring the recognition of a lease right-of-use (ROU) asset and a lease liability, initially measured at the present value of the lease payment on the balance sheet, for both finance and operating leases with lease terms of more than 12 months. The classification of finance or operating will determine whether lease expense is recognized based on an effective interest method or on a straight-line basis over the term of the lease, respectively. Lessors are required to account for leases using an approach that is substantially equivalent to existing guidance for sales-type leases, direct financing leases and operating leases. In July 2018, the FASB issued the following guidance "Leases – Targeted Improvements" and "Codification Improvement to Leases" to assist in the implementation of leases and address certain technical corrections and improvement to the recently issued lease standard. Amendments include an additional transition method that allows entities to apply the new standard on the adoption date and recognize a cumulative effect adjustment to the opening balance of retained earnings, as well as a new practical expedient for lessors and other implementation considerations. For public companies, the amended guidance is effective for fiscal years beginning after December 15, 2018, including interim periods within those fiscal years. The Company will adopt the standard effective January 1, 2019 using a modified prospective approach by recording a cumulative effect adjustment to beginning retained earnings at the implementation date for leases existing as of that date. The Company does not expect the standard to have a material impact in its consolidated balance sheet following the recognition of ROU assets and lease liabilities for its operating leases. We do not expect the adoption of this guidance to have a material impact on our consolidated statement of earnings or cash flows. In addition, the Company implemented control processes and procedures, as necessary, based on changes resulting from the new standard.

On June 16, 2016, the FASB issued guidance to provide financial statement users with more decision-useful information about the expected credit losses on financial instruments and other commitments to extend credit held by a reporting entity at each reporting date by replacing the incurred loss impairment methodology in current U.S. GAAP with a methodology that reflects expected credit losses and requires consideration of a broader range of reasonable and supportable information to inform credit loss estimates. For public companies, these amendments are effective for fiscal years beginning after December 15, 2019, including interim periods within those fiscal years. The Company does not expect a material impact from the implementation of this guidance.

On January 26, 2017, the FASB issued guidance to simplify the manner in which an entity is required to evaluate goodwill for impairment by eliminating Step 2 from the goodwill impairment test. Step 2 measures a goodwill impairment loss by comparing the implied fair value of a reporting unit's goodwill with the carrying amount of that goodwill. Instead, under the amendments in this guidance, an entity should (1) perform its annual or interim goodwill impairment test by comparing the fair value of a reporting unit with its carrying amount, and (2) recognize an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value, with the understanding that the loss recognized should not exceed the total amount of goodwill allocated to that reporting unit. Additionally, this guidance removes the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment and, if it fails such qualitative test, to perform Step 2 of the goodwill impairment test. For public companies, these amendments, which should be applied on a prospective basis, are effective for fiscal years beginning after December 15, 2019, including interim periods within those fiscal years.

On July 16, 2018, the FASB issued guidance Codification Improvements which represents changes to clarify, correct errors in, or make minor improvements to the Codification. The change addresses conflicts or unclear intent in the

following areas: (1) Comprehensive Income – Overall, (2) Debt – Modifications and Extinguishments, (3) Distinguishing Liabilities from Equity – Overall, (3) Compensation – Stock Compensation – Income Taxes, (4) Derivatives and Hedging – Overall – Other Presentation Matters, (5) Fair Value Measurement – Overall and (6) Financial Services – Brokers and Dealers – Liabilities and Financial Services – Depository and Lending. Some of the amendments in this update do not require transition guidance and are effective immediately. However, many of the amendments do have transition guidance, effective for public companies for annual periods beginning after December 15, 2018. The guidance will be implemented effective January 1, 2019. The Company does not expect a material impact from the implementation of this guidance.

On August 15, 2018, the FASB issued guidance for Financial Services – Insurance: Targeted Improvements to the Accounting for Long-Duration Contracts which provides meaningful improvements to the existing recognition, measurement, presentation, and disclosure requirements for long-duration contracts issued by an insurance entity. The amendments improve the timeliness of recognizing changes in the liability for future policy benefits for long-duration contracts by requiring that underlying cash flow assumptions are reviewed and updated at least annually to current estimates without a provision for adverse deviation. The resulting change to the liability for future policy benefits related to the assumption changes will be recognized within earnings. The discount rate used to discount future cash flows will be updated both annually and at each interim period based on the yield of an upper-medium grade fixed-income instrument. The resulting change in the liability for Future Policy Benefits will be reported through Other Comprehensive Income. The guidance also introduces a new concept for market risk benefits for certain contracts which protect the contract holder from other-than-normal capital market risk and which expose the insurance company to such risks. These contracts will be required to be measured at fair value with the corresponding changes in value reported through net income. Additionally, the amendment simplifies the amortization of deferred acquisition costs and other balances amortized in proportion to premiums, gross profits, or gross margins, and requires that those balances be amortized on a constant level basis over the expected term of the related contracts. This guidance also requires increased and enhanced disclosure requirements for long-duration contracts and related balances. For public companies, these amendments will be applied for fiscal years beginning after December 15, 2020. The Company is currently evaluating the impact the adoption of this guidance may have in its consolidated financial statements.

On August 27, 2018, the FASB issued guidance for Fair Value Measurement – Disclosure Framework – Changes to the Disclosure Requirement for Fair Value Measurement. This update focuses on improving the effectiveness of disclosures in the notes to the financial statements by facilitating clear communication of the information required by U.S. GAAP that is most important to users of each entity's financial statements. Specifically certain disclosure requirements are removed (the amount of, and reasons for, transfer between Level 1 and Level 2 of the fair value hierarchy; the policy for timing of transfers between levels; the valuation processes for Level 3 fair value measurements) while it modifies and adds certain other disclosures (the changes in unrealized gains and losses for the period included in other comprehensive income for recurring Level 3 fair value measurements held at the end of the reporting period, and the range and weighted average of significant unobservable inputs used to develop Level 3 fair value measurements). The amendments regarding changes in unrealized gains and losses, the range and weighted average of significant unobservable inputs used to develop Level 3 fair value measurements, and the narrative description of measurement uncertainty should be applied prospectively for only the most recent period in the initial fiscal year of adoption. All other amendments should be applied retrospectively to all periods presented upon their effective date. For public companies, these amendments will be applied for fiscal years beginning after December 15, 2019. The adoption of this guidance should not have a material impact on the presentation of the Company's consolidated result of operations.

On August 28, 2018, the FASB issued guidance for Compensation – Retirement Benefits – Defined Benefit Plans – General which addresses changes to the disclosure requirement for defined benefit plans. The amendments in this guidance modify the disclosure requirements for employers that sponsor defined benefit pension or other postretirement plans. Specifically certain disclosure requirements are removed (i.e. the amounts of accumulated other comprehensive income expected to be recognized as components of net periodic benefit cost over the next fiscal year, related party disclosures concerning the amount of future annual benefits covered by an insurance and annuity contracts and significant transactions between the employer and related parties and the plan) while certain other disclosures are added (i.e. the weighted-average interest crediting rates for cash balance plans and other plans with

promised interest crediting rates, an explanation for the reasons for significant gains and losses related to changes in the benefit obligation for the period). For public companies, these amendments, will be applied for fiscal years beginning after December 15, 2020. The adoption of this guidance should not have a material impact on the presentation of the Company's consolidated result of operations.

(dollar amounts in thousands, except per share and share data)

On August 29, 2018, the FASB issued guidance for Intangibles – Goodwill and Other – Internal-Use Software. Guidance addresses customer's accounting for implemented costs incurred in a cloud computing arrangement that is a service contract and aims to reduce complexity in the accounting for costs of implementing a cloud computing service arrangement. The amendments require a customer in a hosting arrangement that is a service contract to determine which implementation costs to capitalize as an asset related to service contract and which costs to expense. Additionally, it requires the customer to expense the capitalized implementation costs over the term of the hosting arrangement. For public companies, these amendments, will be applied on a prospective basis, for fiscal years beginning after December 15, 2019, including interim periods within those fiscal years. The adoption of this guidance should not have a material impact on the presentation of the Company's consolidated result of operations.

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

3. Investment in Securities

The amortized cost for debt securities and cost for alternative investments, gross unrealized gains, gross unrealized losses, and estimated fair value for the Company's investments in securities by major security type and class of security as of December 31, were as follows:

	2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Fixed maturities available for sale				
Obligations of government- sponsored enterprises	$21,470	$ 120	$ (1)	$21,589
U.S. Treasury securities and obligations of U.S. government instrumentalities	174,675	2,349	-	177,024
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	8,295	-	-	8,295
Municipal securities	692,205	18,112	(538)	709,779
Corporate bonds	186,085	9,724	(239)	195,570
Residential mortgage-backed securities	75,373	1,298	-	76,671
Collateralized mortgage obligations	10,266	208	-	10,474
Total fixed maturities available for sale	$1,168,369	$ 31,811	$ (778)	$1,199,402

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	2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities available for sale				
Fixed maturities				
Obligations of government- sponsored enterprises	$1,431	$ 13	$ -	$1,444
U.S. Treasury securities and obligations of U.S. government instrumentalities	118,858	41	(550)	118,349
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	8,059	34	-	8,093
Municipal securities	771,789	30,468	(1,467)	800,790
Corporate bonds	217,046	17,767	(489)	234,324
Residential mortgage-backed securities	32,465	2	(355)	32,112
Collateralized mortgage obligations	22,003	10	(337)	21,676
Total fixed maturities	1,171,651	48,335	(3,198)	1,216,788
Equity securities				
Mutual Funds	292,459	50,072	(223)	342,308
Alternative investments	34,670	559	(244)	34,985
Total equity securities	327,129	50,631	(467)	377,293
Total	$1,498,780	$ 98,966	$ (3,665)	$1,594,081

	2018			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Fixed maturities held to maturity				
U.S. Treasury securities and obligations of U.S.government instrumentalties	$617	$ 125	$ -	$ 742
Residential mortgage-backed securities	190	2	-	192
Certificates of deposits	1,685	-	-	1,685
Total	$2,492	$ 127	$ -	$ 2,619

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	2017			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Estimated Fair Value
Securities held to maturity				
U.S. Treasury securities and obligations of U.S. government instrumentalties	$617	$ 154	$ -	$ 771
Residential mortgage-backed securities	191	2	-	193
Certificates of deposits	1,511	-	-	1,511
Total	$2,319	$ 156	$ -	$ 2,475

	2018			
	Amortized cost	Gross unrealized gains	Gross unrealized losses	Estimated fair value
Other invested assets - Alternative investments	$72,627	$ 2,042	$ (654)	$ 74,015

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Gross unrealized losses on investment securities and the estimated fair value of the related securities, aggregated by investment category and length of time that individual securities have been in a continuous unrealized loss position as of December 31, were as follows:

	2018								
	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	Nu of Sec
Fixed maturities available for sale									
Obligations of government-sponsored enterprises	$1,469	$(1)	1	$-	$-	-	$1,469	$(1)	1
Municipal securities	62,328	(349)	10	17,648	(189)	3	79,976	(538)	13
Corporate bonds	52,539	(239)	18	-	-	-	52,539	(239)	18
Total fixed maturities	$116,336	$(589)	29	$17,648	$(189)	3	$133,984	$(778)	32
Other invested assets - Alternative investments	$7,399	$(351)	3	$10,447	$(303)	2	$17,846	$(654)	5

	2017								
	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	Numbe of Securit
Securites available for sale									
Fixed maturities									
U.S. Treasury securities and obligations of U.S. governmental instrumentalities	$96,617	$(550)	7	$-	$-	-	96,617	(550)	7
Municipal securities	162,731	(1,467)	27	-	-	-	162,731	(1,467)	27
Corporate bonds	80,374	(489)	16	-	-	-	80,374	(489)	16
Residential mortgage-backed securities	31,736	(355)	19	-	-	-	31,736	(355)	19
Collateralized mortgage obligations	13,630	(239)	3	7,294	(98)	2	20,924	(337)	5
Total fixed maturities	$385,088	$(3,100)	72	$7,294	$(98)	2	$392,382	$(3,198)	74
Equity securities									
Mutual funds	42,983	(223)	6	-	-	-	42,983	(223)	6
Alternative investments	9,986	(212)	5	3,162	(32)	1	13,148	(244)	6
Total equity securities	52,969	(435)	11	3,162	(32)	1	56,131	(467)	12

Total for securities available for sale	$438,057	$(3,535)	83	$10,456	$(130)	3	$448,513	$(3,665)	86

The Company regularly monitors and evaluates the difference between the amortized cost and estimated fair value of fixed maturity securities. For fixed maturity securities with a fair value below amortized 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, (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, 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 Company's analysis, along with the judgment that must be applied in the analysis, it is possible that the Company 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 the Company determined during its analysis, which may lead to a different impairment conclusion in future periods.

If after monitoring and analyzing impaired securities, the Company determines that a decline in the estimated fair value of any available-for-sale or held-to-maturity security below cost is other-than-temporary, the carrying amount of the security is reduced to its fair value 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. 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 Company's process for identifying and reviewing available for sale and other 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.

- For any securities with a gross unrealized investment loss we might review and evaluate 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.

- 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.

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

The Company reviews the available for sale and other invested assets portfolios under the Company's impairment review policy. Given market conditions and the significant judgments involved, there is a continuing risk that declines in fair value may occur and material other-than-temporary impairments may be recorded in future periods. The Company 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 Municipal Securities: The unrealized losses of these 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 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.

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. Because the decline in estimated fair value is principally attributable to changes in interest rates; because 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.

(dollar amounts in thousands, except per share and share data)

Alternative Investments: As of December 31, 2018, alternative investments with unrealized losses are not considered other-than-temporarily impaired based on market conditions and the length of time the funds have been in a loss position.

Maturities of investment securities classified as available for sale and held to maturity at December 31, 2018 were as follows:

	Amortized Cost	Estimated Fair Value
Securities available for sale		
Due in one year or less	$18,707	$18,809
Due after one year through five years	355,334	357,777
Due after five years through ten years	428,212	435,669
Due after ten years	280,477	300,002
Residential mortgage-backed securities	75,373	76,671
Collateralized mortgage obligations	10,266	10,474
	$1,168,369	$1,199,402
Securities held to maturity		
Due in one year or less	$1,685	$1,685
Due after ten years	617	742
Residential mortgage-backed securities	190	192
	$2,492	$2,619

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 $7,982 and $5,229 (fair value of $8,217 and $5,571) at December 31, 2018 and 2017, 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).

(dollar amounts in thousands, except per share and share data)

4. Realized and Unrealized Gains

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

	2018	2017	2016
Realized gains (losses)			
Fixed maturity securities:			
Securities available for sale			
Gross gains	$3,730	$1,460	$3,086
Gross losses	(18,627)	(2,176)	(2,744)
Total fixed maturity securities	(14,897)	(716)	342
Equity investments:			
Gross gains	16,045	12,154	19,674
Gross losses	(2,290)	(558)	(1,203)
Gross losses from other-than-temporary impairments	-	(49)	(1,434)
Total equity investments	13,755	11,547	17,037
Other invested assets:			
Gross gains	1,492	-	-
Gross losses	(52)	-	-
Total other invested assets	1,440	-	-
Net realized gains on securities	$298	$10,831	$17,379

	2018	2017	2016
Changes in unrealized gains (losses)			
Recognized in accumulated other comprehensive income (loss)			
Fixed maturities – available for sale	$(14,104)	$(2,203)	$1,953
Other invested assets	1,073	-	-
Equity securities	-	20,514	2,172
Not recognized in the consolidated financial statements			
Fixed maturities – held to maturity	$(29)	$(20)	$(19)

The change in deferred tax asset (liability) on unrealized gains (losses) recognized in accumulated other comprehensive income during the years 2018, 2017, and 2016 was $2,292, $(3,846), and $(1,085), respectively.

As of December 31, 2018 and 2017 no individual investment in securities exceeded 10% of stockholders' equity.

(dollar amounts in thousands, except per share and share data)

5. Net Investment Income

Interest and/or dividend income for the years ended December 31 were are as follows:

	2018	2017	2016
Fixed maturities	$43,873	$38,414	$37,139
Equity securities	12,261	10,728	9,666
Other invested assets	1,679	-	-
Policy loans	754	709	619
Cash equivalents and interest-bearing deposits	1,407	798	257
Other	1,935	966	1,232
Total	$61,909	$51,615	$48,913

6. Premium and Other Receivables, Net

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

	2018	2017
Premium	$94,613	$103,027
Self-funded group receivables	31,184	39,859
FEHBP	14,030	13,346
Agent balances	30,224	32,818
Accrued interest	12,426	14,331
Reinsurance recoverable	399,202	661,679
Other	88,807	70,150
	670,486	935,210
Less allowance for doubtful receivables:		
Premium	32,487	26,490
Other	9,555	9,393
	42,042	35,883
Premium and other receivables, net	$628,444	$899,327

As of December 31, 2018 and 2017, the Company had premiums and other receivables of $54,329 and $81,838, respectively, from the Government of Puerto Rico, including its agencies, municipalities and public corporations. The related allowance for doubtful receivables as of December 31, 2018 and 2017 were $20,984 and $16,436, respectively.

Reinsurance recoverable as of December 31, 2018 and 2017 includes $350,353 and $613,000 related to expected catastrophe losses covered by the Property and Casualty segment’s reinsurance program, reflecting the anticipated gross losses related to Hurricanes Irma and Maria, which made landfall in Puerto Rico during the month of September 2017.

(dollar amounts in thousands, except per share and share data)

7. 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 is summarized as follows:

	DPAC	VOBA	Total
Balance, December 31, 2015	$161,731	$28,917	$190,648
Additions	47,742	-	47,742
VOBA interest at an average rate of 5.15%	-	1,381	1,381
Amortization	(40,848)	(4,136)	(44,984)
Net change	6,894	(2,755)	4,139
Balance, December 31, 2016	168,625	26,162	194,787
Additions	48,701	-	48,701
VOBA interest at an average rate of 5.17%	-	1,253	1,253
Amortization	(39,605)	(4,348)	(43,953)
Net change	9,096	(3,095)	6,001
Balance, December 31, 2017	177,721	23,067	200,788
Additions	51,144	-	51,144
VOBA interest at an average rate of 5.11%	-	1,120	1,120
Amortization	(35,005)	(2,888)	(37,893)
Net change	16,139	(1,768)	14,371
Balance, December 31, 2018	$193,860	$21,299	$215,159

A portion of the amortization of the DPAC and VOBA is recorded as an amortization expense and included within the operating expenses in the accompanying consolidated statements of earnings. The remaining portion of the DPAC and VOBA amortization includes the unrealized investment gains and losses that would have been amortized if such gains and losses had been realized, which for the years ended December 31, 2018 and 2017 amounted to $2,113 and $598, respectively, and is included within the unrealized gains on securities component of other comprehensive income.

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:	
2019	$2,939
2020	2,064
2021	1,845
2022	1,630
2023	1,697

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(dollar amounts in thousands, except per share and share data)

8. Property and Equipment, Net

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

	2018	2017
Land	$10,976	$10,976
Buildings and leasehold improvements	68,424	64,856
Office furniture and equipment	39,421	35,070
Computer equipment and software	137,183	116,244
Automobiles	795	701
	256,799	227,847
Less accumulated depreciation and amortization	174,876	153,131
Property and equipment, net	$81,923	$74,716

The Company recognized depreciation expense on property and equipment of $12,583, $11,930, and $12,335 for the years ended December 31, 2018, 2017, and 2016, respectively.

9. Goodwill

Certain business combination transactions have resulted in goodwill, which represents the excess of the acquisition cost over the fair value of net assets acquired, and is assigned to reporting units. Goodwill recorded as of December 31, 2018 and 2017 was $25,397 which is all attributable to the Medicare Advantage reporting unit within the Managed Care segment.

As required by accounting guidance, the 2018, 2017 and 2016 annual goodwill impairment tests were performed, and based on the results of the tests, no impairment charge was required. If the Company does not achieve its earnings objectives or the cost of capital raises significantly, the assumptions and estimates underlying these impairment tests could be adversely affected and result in future impairment charges that would negatively impact its operating results. Cumulative goodwill impairment charges were $2,369 as of December 31, 2018 and 2017. All cumulative goodwill impairment is related to the health clinic reporting unit which has been fully impaired.

10. 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, as defined by current accounting guidance for fair value measurements and disclosures, 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 Corporation uses observable inputs when available. Fair value is based upon quoted market prices when available. The Corporation 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.

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, 2018 and 2017.

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 is as follows:

Fair Value Measurements Using Significant Unobservable Inputs (Level 3)	
	2018
Balance as of January 1,	$-
Realized gains	-
Unrealized in other accumulated comprehensive income	-
Purchases	3,805
Sales	-
Capital Distributions	-
Balance as of December 31,	$3,805

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.

(dollar amounts in thousands, except per share and share data)

The following table summarizes fair value measurements by level at December 31, for assets measured at fair value on a recurring basis:

	2018			
	Level 1	Level 2	Level 3	Total
Fixed maturity securities available for sale				
Obligations of government-sponsored enterprises	$-	$21,589	$-	$21,589
U.S. Treasury securities and obligations of U.S. government instrumentalities	177,024	-	-	177,024
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	-	8,295	-	8,295
Municipal securities	-	709,779	-	709,779
Corporate bonds	-	195,570	-	195,570
Residential agency mortgage-backed securities	-	76,671	-	76,671
Collaterized mortgage obligations	-	10,474	-	10,474
Total fixed maturities	$177,024	$1,022,378	$-	$1,199,402
Equity investments	$147,348	$128,011	$3,805	$279,164

	2017			
	Level 1	Level 2	Level 3	Total
Securities available for sale				
Fixed maturity securities				
Obligations of government-sponsored enterprises	$-	$1,444	$ -	$1,444
U.S. Treasury securities and obligations of U.S. government instrumentalities	118,349	-	-	118,349
Obligations of the Commonwealth of Puerto Rico and its instrumentalities	-	8,093	-	8,093
Municipal securities	-	800,790	-	800,790
Corporate bonds	-	234,324	-	234,324
Residential agency mortgage-backed securities	-	32,112	-	32,112
Collaterized mortgage obligations	-	21,676	-	21,676
Total fixed maturities	$118,349	$1,098,439	$ -	$1,216,788
Equity securities	$193,159	$149,149	$ -	$342,308

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 use previously 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.

In addition to the preceding disclosures on assets recorded at fair value in the consolidated balance sheets, accounting 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.

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A summary of the carrying value and fair value by level of financial instruments not recorded at fair value on our consolidated balance sheets at December 31 are as follows:

	2018 Carrying Value	Fair Value Level 1	Level 2	Level 3	Total
Assets:					
Policy loans	$9,469	$-	$9,469	$ -	$9,469
Liabilities:					
Policyholder deposits	$174,110	$-	$174,110	$ -	$174,110
Long-term borrowings:					
Loans payable to bank - variable	29,114		29,114	-	29,114
Total liabilities	$203,224	$-	$203,224	$ -	$203,224

	2017 Carrying Value	Fair Value Level 1	Level 2	Level 3	Total
Assets:					
Policy loans	$9,077	$-	$9,077	$ -	$9,077
Liabilities:					
Policyholder deposits	$176,534	$-	$176,534	$ -	$176,534
Long-term borrowings:					
Loans payable to bank - variable	32,350	-	32,350	-	32,350
Total liabilities	$208,884	$-	$208,884	$ -	$208,884

(dollar amounts in thousands, except per share and share data)

11. Claim Liabilities and Claim Adjustment Expenses

A reconciliation of the beginning and ending balances of claim liabilities in 2018, 2017 and 2016 is as follows:

	2018		
	Managed Care	Other Business Segments *	Consolidated
Claim liabilities at beginning of year	$367,357	$739,519	$1,106,876
Reinsurance recoverable on claim liabilities	-	(633,099)	(633,099)
Net claim liabilities at beginning of year	367,357	106,420	473,777
Claims incurred			
Current period insured events	2,308,516	103,368	2,411,884
Prior period insured events	(36,015)	120,961	84,946
Total	2,272,501	224,329	2,496,830
Payments of losses and loss-adjustment expenses			
Current period insured events	1,982,372	57,260	2,039,632
Prior period insured events	263,260	46,469	309,729
Total	2,245,632	103,729	2,349,361
Net claim liabilities at end of year	394,226	227,020	621,246
Reinsurance recoverable on claim liabilities	-	315,543	315,543
Claim liabilities at end of year	$394,226	$542,563	$936,789

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	2017		
	Managed Care	Other Business Segments *	Consolidated
Claim liabilities at beginning of year	$349,047	$ 138,896	$ 487,943
Reinsurance recoverable on claim liabilities	-	(38,998)	(38,998)
Net claim liabilities at beginning of year	349,047	99,898	448,945
Claims incurred			
Current period insured events	2,231,052	118,012	2,349,064
Prior period insured events	(12,782)	(8,975)	(21,757)
Total	2,218,270	109,037	2,327,307
Payments of losses and loss-adjustment expenses			
Current period insured events	1,940,410	64,051	2,004,461
Prior period insured events	259,550	38,536	298,086
Total	2,199,960	102,587	2,302,547
Net claim liabilities at end of year	367,357	106,348	473,705
Reinsurance recoverable on claim liabilities	-	633,171	633,171
Claim liabilities at end of year	$367,357	$ 739,519	$ 1,106,876

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	2016		
	Managed Care	Other Business Segments *	Consolidated
Claim liabilities at beginning of year	$348,297	$ 143,468	$ 491,765
Reinsurance recoverable on claim liabilities	-	(40,714)	(40,714)
Net claim liabilities at beginning of year	348,297	102,754	451,051
Claims incurred			
Current period insured events	2,356,594	103,049	2,459,643
Prior period insured events	(9,047)	(7,157)	(16,204)
Total	2,347,547	95,892	2,443,439
Payments of losses and loss-adjustment expenses			
Current period insured events	2,083,552	58,091	2,141,643
Prior period insured events	263,245	40,657	303,902
Total	2,346,797	98,748	2,445,545
Net claim liabilities at end of year	349,047	99,898	448,945
Reinsurance recoverable on claim liabilities	-	38,998	38,998
Claim liabilities at end of year	$349,047	$ 138,896	$ 487,943

* Other Business Segments include the Life Insurance and Property and Casualty segments, as well as intersegment eliminations.

The actual amounts of claims incurred in connection with insured events occurring in a prior period typically differ from estimates of such claims made in the prior period. Amounts included as incurred claims for prior period insured events reflect the aggregate net amount of these differences.

The unfavorable developments in the claims incurred and loss-adjustment expenses for prior period insured events in 2018 is driven by an adverse development of approximately $128,678 in the Property and Casualty segment losses related to Hurricane Maria, partially offset by better than expected utilization trends in the Managed Care segment. The favorable developments in the claims incurred and loss-adjustment expenses for prior period insured events for 2017 and 2016 are primarily due to better than expected utilization trends in the Managed Care segment. Reinsurance recoverable on unpaid claims is reported within the 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 $30,783, $25,794, and $28,752 that is included within the consolidated claims incurred during the years ended December 31, 2018, 2017 and 2016, respectively.

The following is information about incurred and paid claims development, net of reinsurance, as of December 31, 2018, as well as cumulative claim frequency. Additional information presented includes total incurred-but-not-reported liabilities plus expected development on reported claims is included within the net incurred claims amounts.

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The information about incurred and paid claims development for the year ended December 31, 2015 and previous years are presented as supplementary information and are unaudited where indicated. The average annual percentage payout of incurred claims by age as of December 31, 2018, is presented as required supplementary information.

Managed Care

The Company estimates its liabilities for unpaid claims 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. This process includes comparing the historical claims incurred dates to the actual dates on claims payment. Completion factors are applied to claims paid through the consolidated financial statements date to estimate the claim expense incurred for the current period. The liability for claim adjustment expenses consists of adjustments made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed.

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance — As of December 31, 2018

			(in thousands)	
Incurred Year	2017	2018	Total of IBNR Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
2017	$ 2,231,052	2,216,578	65,459	17,652
2018		2,308,516	325,857	18,259
	Total	$4,525,094		

Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance

Incurred Year	2017	2018
2017	$1,940,410	2,151,406
2018		1,982,372
	Total	$4,133,778
All outstanding liabilities before 2017, net of reinsurance		2,910
Liabilities for claims and claim adjustment expenses, net of reinsurance		$394,226

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Property and Casualty

Claims liability for property and casualty 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 expense for investigating and setting claims.

All Lines
in thousands

Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance

Incurred Year	Incurred amount (unaudited)										As of December 31, 2018 Total of IBNR Plus Expected Development on Reported Claims	Cumulative Number of reported claims
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018		
2009	51,778	51,760	50,848	51,298	51,564	51,315	51,485	51,293	51,563	$51,439	$99	16,089
2010		54,226	54,090	55,266	56,400	57,115	57,386	57,242	56,960	56,981	135	18,012
2011			51,315	50,287	51,105	50,776	51,895	52,099	51,729	51,684	168	20,919
2012				49,040	49,856	48,900	49,817	48,945	48,186	47,731	392	20,217
2013					52,343	51,030	49,606	49,168	48,229	47,550	785	22,360
2014						48,430	45,410	43,707	42,547	41,457	916	22,044
2015							45,067	40,175	37,271	35,505	1,094	20,069
2016								48,127	44,294	41,168	2,788	19,397
2017									60,694	187,376	15,519	47,415
2018										40,619	15,563	15,876
									Total	$601,510		

Cumulative Paid claims and Allocated Claim Adjustment Expenses, Net of Reinsurance

Incurred Year	(unaudited)									
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
2009	23,843	35,327	41,810	45,838	48,637	49,709	50,196	50,371	50,594	$50,680
2010		27,118	38,964	45,409	49,808	52,890	54,027	54,996	55,715	56,253
2011			24,534	34,835	41,606	44,996	47,908	49,598	50,457	50,761
2012				22,677	33,620	40,406	43,663	45,607	46,094	46,441
2013					21,376	33,249	38,979	42,840	44,252	45,234
2014						18,752	28,657	33,809	36,875	37,857
2015							17,063	24,935	28,040	30,729

2016	20,099	28,996	32,820
2017		28,414	41,855
2018			16,555
			$409,185
All outstanding liabilities before 2009, net of reinsurance			1,623
Liabilities for claims and claims adjustment expenses, net of reinsurance			$193,948

The following table includes the annual percentage payout of incurred claims by age, net of reinsurance, for property and casualty segment as supplementary information as of December 31, 2018:

	(unaudited)	(unaudited)	(unaudited)	(unaudited)	(unaudited)	(unaudited)	(unaudited)	(unaudited)	(unaudited)	(unaudited)
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Average	43.2 %	20.6 %	11.7 %	7.4 %	4.3 %	2.1 %	1.3 %	0.7 %	0.7 %	0.2 %

(dollar amounts in thousands, except per share and share data)

The reconciliation of the net incurred and paid claims development tables, by segment, to the liability for claims and claim adjustment expenses in the consolidated balance sheets is as follows:

	As of December 31, 2018
Net outstanding liabilities	
Managed Care	$ 394,226
Property and Casualty	193,948
Other short-duration insurance lines	3,655
Liabilities for unpaid claims and claim adjustment expenses, net of reinsurance	591,829
Reinsurance recoverable on unpaid claims - Property and Casualty	302,928
Insurance lines other than short-duration	42,502
Intersegment elimination	(470)
Total gross liability for unpaid claims and claim adjustment expense	$ 936,789

Claim liabilities as of December 31, 2018 and 2017 include approximately $415,900 and $605,200, respectively, of gross losses related to the impact of Hurricanes Irma and Maria which made landfall in Puerto Rico in September 2017.

12. Federal Employees' Health Benefits (FEHBP) and Federal Employees' (FEP) Programs

FEHBP

In prior years, 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 USVI 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.

The Company also has funds available related to the FEHBP amounting to $60,959 and $68,425 as of December 31, 2018 and 2017, respectively, and are included within cash and cash equivalents in the accompanying consolidated balance sheets. Such funds are 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, 2018 and 2017 was $62,911 and $32,928, respectively. The Company received $27 and $6,687, of payments made from the contingency reserve fund of OPM during 2017 and 2016, respectively. The Company did not receive contingency reserve payments during 2018. During the year ended December 31, 2018 the Company returned excess reserves of $23,030 to the contingency reserve fund.

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 consolidated financial statements. The claim payments and operating expenses reimbursed in connection with the FEHBP have been audited through 2011 by OPM.

FEP

In prior years, TSS entered into a contract with the BCBSA as per Contract No. C.S. 1039 with OPM to provide health benefits under one Government-wide Service Benefit Plan as contemplated in Title 5, Chapter 89, United States Code. The FEP covers employees and annuitants residing in the Commonwealth of Puerto Rico and the USVI as well as eligible dependents. The FEP is financed through a negotiated contribution made by the federal government and employees' payroll deductions. The accounting methodology and operations of the FEP are similar to those of the FEHBP as described before.

The claims payments and operating expenses charged to the FEP are subject to audit by the BCBSA. Management is of the opinion that the adjustments, if any, resulting from such audits will not have a significant effect in the accompanying consolidated financial statements. Operating expenses reimbursed in connection with the FEP have been audited through 2013 by BCBSA.

(dollar amounts in thousands, except per share and share data)

13. Long-Term Borrowings

A summary of the borrowings entered by the Company as of December 31 is as follows:

	2018	2017
Secured loan payable of $11,187, payable in monthly installments of $137 through October 1, 2023, plus interest at a rate reset periodically of 100 basis points over selected LIBOR maturity (which was 3.35% at December 31, 2018).	$7,907	$9,547
Secured loan payable of $20,150, payable in monthly installments of $84 through January 1, 2024, plus interest at a rate reset periodically of 275 basis points over selected LIBOR maturity (which was 5.15% at December 31, 2018).	18,218	19,226
Secured loan payable of $4,116, payable in monthly installments of $49 through January 1, 2024, plus interest at a rate reset periodically of 325 basis points over selected LIBOR maturity (which was 5.65% at December 31, 2018).	2,989	3,577
Total borrowings	29,114	32,350
Less: unamortized debt issuance costs	231	277
	$28,883	$32,073

Aggregate maturities of the Company's borrowings as of December 31, 2018 are summarized as follows:

Year ending December 31	
2019	$3,236
2020	3,236
2021	3,236
2022	3,236
2023	2,942
Thereafter	13,228
	$29,114

On December 28, 2016, TSM entered into a $35,500 credit agreement with a commercial bank in Puerto Rico. The agreement consists of three term loans: (i) Term Loan A in the principal amount of $11,187, (ii) Term Loan B in the principal amount of $20,150 and (iii) Term Loan C in the principal amount of $4,116. Term Loan A matures in October 2023 while the Term Loans B and C mature in January 2024. Term Loan A was used to refinance a previous $41,000 secured loan payable with the same commercial bank. Proceeds from Term Loans B and C were received on January 11, 2017 and were used to prepay the outstanding principal amount plus accrued interest of the 6.6% Senior Unsecured Notes due December 2020 ($24,000) and fund a portion of a debt service reserve for the loan (approximately $200). Interest payable commenced on January 1, 2017, in the case of Term Loan A, and on February 1, 2017, in the case of Term Loan B and Term Loan C. The Credit Agreement includes certain financial and non-financial covenants, including negative covenants imposing certain restrictions on the Corporation's business. The Company was in compliance with all these covenants as of December 31, 2018.

(dollar amounts in thousands, except per share and share data)

This credit agreement is guaranteed by a first mortgage held by the bank on the Company's land, building, and substantially all leasehold improvements, as collateral for the term of the loan under a continuing general security agreement.

The Company may, at its option, upon notice, as specified in the credit agreement, redeem and prepay prior to maturity, all or any part of the loan and from time to time upon the payment of a penalty fee of 3% during the first year, 2% during the second year and 1% during the third year, and thereafter, at par, as specified in the credit agreement, together with accrued and unpaid interest, if any, to the date of redemption specified by the Company.

Interest expense on the above borrowings amounted to $1,375, $1,196, and $1,763, for the years ended December 31, 2018, 2017, and 2016, respectively.

On April 18, 2017, TSA entered into a $10,000 revolving loan agreement with a commercial bank in Puerto Rico. This line of credit has an interest rate of 30-day LIBOR plus 25 basis points and contains certain financial and non-financial covenants that are customary for this type of facility. This line of credit had an original maturity date of April 17, 2018 and was renewed for an additional year, maturing on April 30, 2019.

14. Reinsurance Activity

The effect of reinsurance on premiums earned and claims incurred is as follows:

	Premiums Earned			Claims Incurred[1]		
	2018	2017	2016	2018	2017	2016
Gross	$3,009,830	$2,893,765	$2,945,017	$2,657,639	$3,010,728	$2,454,758
Ceded	(73,591)	(71,295)	(59,032)	(163,898)	(687,520)	(15,008)
Assumed	2,352	4,462	4,656	3,089	4,099	3,689
Net	$2,938,591	$2,826,932	$2,890,641	$2,496,830	$2,327,307	$2,443,439

(1) The claims incurred disclosed in this table exclude the portion of the change in the liability for future policy benefits amounting to $30,783, $25,794, and $28,752 that is included within the consolidated claims incurred during the years ended December 31, 2018, 2017 and 2016, respectively.

TSS, TSA, 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 2018, 2017, and 2016 TSP placed 16.45%, 14.88%, and 13.16% of its reinsurance business with one reinsurance company.

TSS has 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 at each renewal date. Premiums ceded under these contracts amounted to $1,524, $2,168, and $3,148 in 2018, 2017 and 2016, respectively. Claims ceded amounted to $320, $463, and $1,700, in 2018, 2017 and 2016, respectively. Principal reinsurance agreements include an organ transplant excess of loss treaty, which covers:

- For group policies, 80% of the claims up to a maximum of $800 (80% of $1,000), per person, per life. For other group policies with other options, the agreement covers 80% of the claims up to a maximum of $400 (80% of $500), per person, per life, or 80% of the claims up to a maximum of $200 (80% of $250), per person, per life.

- For policies provided to the active and retired employees of the Commonwealth of Puerto Rico and its instrumentalities, the treaty covers 100% of the claims up to a maximum of $1,000 per person, per life with major medical coverage, only if the covered person uses providers that are members of TSS network.

- For policies provided to the municipalities of Puerto Rico, the treaty covers 100% of the claims up to a maximum of $250, per person, per life, with plans with lifetime limits and all other plans 100% of the claims up to a maximum of $1,000, per person, per life.

TSA has an excess of loss reinsurance treaty whereby it cedes a portion of its premiums to a third party. This reinsurance contract is for a period of one year and is subject to modifications and negotiations in each renewal date. Premiums ceded under this contract amounted to $2,300 and $1,224, in 2018 and 2017, respectively. Claims ceded amounted to $1,804 and $1,360, in 2018 and 2017, respectively. This reinsurance agreement includes an excess of loss reinsurance coverage for certain hospital inpatient, hospital outpatient, ambulance, and physician services as well as pharmaceutical drugs. This agreement covers a maximum of $2,000 per person, per agreement term.

TSP utilized facultative reinsurance, pro rata, and excess of loss reinsurance treaties to manage its exposure to losses, including those from catastrophe events. TSP has geographic exposure to catastrophe losses from hurricanes and earthquakes. The incidence and severity of catastrophes are inherently unpredictable. Under these treaties, TSP ceded premiums written were $60,354, $62,268, and $45,957, in 2018, 2017, and 2016, respectively. In 2018 and 2017, TSP ceded claims incurred amounting to $152,704 and $678,624, respectively, related to losses caused by Hurricanes Irma and Maria.

During 2018, as part of the catastrophe program, TSP signed a multiyear reinsurance contract providing for retroactive and prospective reinsurance coverage. The retroactive coverage resulted in a deferred gain on retroactive reinsurance of $25,000 as of December 31, 2018, which is presented within the accounts payable and accruals in the accompanying consolidated balance sheets. The deferred gain on the retroactive reinsurance will be amortized using the recovery method. The recovery method provides for the amortization in proportion to the estimated recoveries made as of the reporting date as a percentage of total estimated recoveries.

Ceded unearned reinsurance premiums arising from TSP reinsurance transactions amounted to $11,760 and $12,393 as of December 31, 2018 and 2017, respectively, and are reported as other assets in the accompanying consolidated balance sheets.

Most principal reinsurance contracts are for a period of one year and are subject to modifications and negotiations in each renewal. Current property and catastrophe reinsurance program was renewed effective April 1, 2018 for the twelve-month period ending March 31, 2019. Other contracts were renewed as expiring on January 1, 2019.

Principal reinsurance agreements are as follows:

- Casualty excess of loss treaty provides reinsurance for losses up to $12,000, subject to a retention of $225.

- Medical malpractice excess of loss treaty provides reinsurance for losses up to $3,000, subject to a retention of $150.

- Property reinsurance treaty includes proportional cessions and a per risk excess of loss contract limiting losses to $325 in $30,000 risks.

- Catastrophe protection is purchased limiting losses to $10,000 per event with losses up to approximately $915,000.

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 $8,780, $8,826, and $8,838, in 2018, 2017, and 2016, 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.

- Several reinsurance agreements, mostly on an excess of loss basis up to a maximum retention of $200.

- Excess of loss agreement for the major medical business in Costa Rica reinsuring 100% of all claims over $35.

TSV participates in various retrocession reinsurance agreements. The retrocessions are based on group life and health reinsurance business pools for which TSV has participations ranging from 6.7% to 10% of the total reinsurance facility. TSV share of the reinsurer’s gross liability is limited to a maximum that ranges depending on the agreement from $50 to $500 per covered life. The agreements cover new and renewal business for a period of twelve months and may be cancelled subject to ninety days written notice at any anniversary date.

15. Income Taxes

The Company and its subsidiaries are subject to Puerto Rico income taxes. Under Puerto Rico income tax law, the Company is not allowed to file consolidated tax returns with its subsidiaries. The Company's insurance subsidiaries are also subject to U.S. federal income taxes for foreign source dividend income. The Company is potentially subject to income tax audits in the Commonwealth of Puerto Rico for the taxable year 2015 and after, until the applicable statute of limitations expires. Tax audits by their nature are often complex and can require several years to complete.

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. The corporations are also 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 up to a limit of 25% of the excess.

The Company, through one of its Managed Care corporations, has a branch in the USVI 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 USVI, which has implemented a mirror tax law based on the U.S. Internal Revenue Code. The branch operations in the USVI had certain net operating losses for USVI tax purposes for which a valuation allowance has been recorded.

Companies within our Life Insurance segment operate as qualified domestic life insurance companies and are subject to the alternative minimum tax and taxes on its capital gains.

On December 22, 2017, U.S Government enacted PL 115-97, better known as the Tax Cut and Jobs Act (TCJA). The TCJA incorporates a series of changes in tax rates at the federal level applicable for taxable years beginning after December 31, 2017 and before January 1, 2026. The U.S. federal maximum corporate income tax rate is reduced from 35% to a 21% flat rate, this change did not have a significant impact for the Company and its insurance subsidiaries are only taxed in that jurisdiction for passive income earned on investments, which continue to be subject to withholding at source at its gross level. In addition, the TCJA incorporates restrictions on insurance business exception to passive foreign investment company (PFIC) rules, that were taxed under the PFIC's earnings, subject to an exception for certain income derived in the active conduct of an insurance business. At the moment, no significant impact for the Company has been identified. We annually test our compliance with the new guidelines for Section 1297 PFIC test, at the insurance subsidiary level.

On December 10, 2018, the Puerto Rico Government signed in to Law by, P C 1544, better known as the Puerto Rico Tax Reform, now Act 257 of 2018. With this Law, additional amendments are incorporated to the Puerto Rico Internal Revenue Code. Approved changes include: (i) a decrease in the maximum corporate tax rate from 39% to 37.5%; (ii) an increase from 80% to a 90% in the amount of net operating loss carryover deduction available to be claimed against current year net income for regular tax purposes; (iii) an increase in the withholding at source for services rendered from 7% to 10% ; (iv) a limitation in the amounts of net operating losses generated by a corporate shareholder allowed to be netted against net income distributed from a flow-through investment, not permitted for taxable years beginning after December 31, 2018; and (v) a revised large taxpayer definition to include flow-through entities and extend the determination of audited financial statement requirements at the group level. The Puerto Rico

Tax Reform also adds requirements for the deductibility of certain expenses as well as disclosure requirements related to any uncertain tax position (UTP) recorded following GAAP. All of these changes are effective for taxable years beginning January 1, 2019. During the year ended December 31, 2018, the Company recorded an additional deferred tax expense of $3,165 million related to the impact that the lower corporate tax rate had in our net deferred tax assets.

(dollar amounts in thousands, except per share and share data)

Federal income taxes recognized by the Company's insurance subsidiaries amounted to approximately $1,147, $985, and $733, in 2018, 2017, and 2016, respectively.

All other corporations within the group are subject to Puerto Rico income taxes as regular corporations, as defined in the P.R. Internal Revenue Code, as amended.

The components of income tax expense (benefit) consisted of the following:

	2018	2017	2016
Current income tax expense	$2,212	$34,412	$1,981
Deferred income tax benefit	(32,078)	(9,916)	(8,326)
Total income tax (benefit) expense	$(29,866)	$24,496	$(6,345)

(dollar amounts in thousands, except per share and share data)

The income tax (benefit) 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:

	2018	2017	2016
(Loss) income before taxes	$(93,172)	$78,977	$11,086
Statutory tax rate	39.00 %	39.00 %	39.00 %
Income tax (benefit) expense at statutory rate	(36,337)	30,801	4,324
(Decrease) increase in taxes resulting from			
Exempt income, net	(2,330)	(3,853)	(5,158)
Effect of taxing life insurance operations as a qualified domestic life insurance company instead of as a regular corporation	(3,445)	(4,871)	(5,033)
Effect of taxing capital gains at a preferential rate	4,819	(2,116)	(3,799)
Adjustment to deferred tax assets and liabilities for changes in effective tax rates	9,217	(120)	1,669
Other adjustments to deferred tax assets and liabilities	(43)	836	2,852
Effect of extraordinary dividend distribution from the JUA Association - reported net of taxes in other income	-	(922)	(151)
Charges against the catastrophe loss reserve	-	1,567	-
Allowance for doubtful receivables recapture	-	2,688	-
Tax credit benefit	(306)	(555)	(709)
Tax returns to provision true up	(798)	363	(181)
Subtotal	7,114	(6,983)	(10,510)
Other permanent disallowances, net:			
Disallowance of expenses related to exempt interest income	-	-	58
Disallowed interest expense	-	-	8
Other	(229)	50	-
Total other permanent differences	(229)	50	66
Other adjustments	(414)	628	(225)
Total income tax (benefit) expense	$(29,866)	$24,496	$(6,345)

(dollar amounts in thousands, except per share and 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, 2018 and 2017 of the Company and its subsidiaries is composed of the following:

	2018	2017
Deferred tax assets		
Allowance for doubtful receivables	$14,092	$11,787
Liability for pension benefits	12,846	13,826
Postretirement benefits	527	662
Deferred compensation	2,202	2,168
Accumulated depreciation	979	1,296
Impairment loss on investments	765	950
Contingency reserves	75	1,950
Share-based compensation	5,587	6,795
Alternative minimum income tax credit	2,627	1,874
Purchased tax credits	1,229	2,767
Net operating loss	60,731	38,839
Reinsurance agreement	9,375	-
Accrued liabilities	4,292	3,271
Difference in tax basis of investments portfolio	320	-
Other	188	873
Gross deferred tax assets	115,835	87,058
Less: valuation allowance	(9,867)	(8,283)
Deferred tax assets	105,968	78,775
Deferred tax liabilities		
Deferred policy acquisition costs	(6,382)	(7,323)
Catastrophe loss reserve	(12,385)	(6,371)
Unrealized gain on securities available for sale	(6,781)	(19,440)
Unrealized gain on equity investments	(2,773)	-
Difference in tax basis of investments portfolio	-	(220)
Unamortized debt issue costs	(87)	(108)
Intangible asset	(909)	(1,546)
Employee benefits plan	(886)	(535)
Gross deferred tax liabilities	(30,203)	(35,543)
Net deferred tax asset	$75,765	$43,232

The net deferred tax asset shown in the table above at December 31, 2018 and 2017 is reflected in the consolidated balance sheets as $79,010 and $65,123, respectively, in deferred tax assets and $3,245 and $21,891, 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 valuation allowance is mostly related to the net operating losses generated by the Company's USVI operations and the health clinic's operations based on the available evidence are not considered to be realizable at the reporting dates.

At December 31, 2018, the Company and its subsidiaries have net operating loss carry-forwards for Puerto Rico income tax purposes of approximately $176,977, which are available to offset future taxable income for up to December 2027. The carryforwards generally expire in 2026 through 2027. Except for the valuation allowance described in the previous paragraph, the Company concluded that as of December 31, 2018, it is more likely than not that the entities that have these net operating loss carry-forwards will generate sufficient taxable income within the applicable net operating loss carry-forward periods to realize its deferred tax asset. This conclusion is based on the historical results of each entity, adjusted to exclude non-recurring conditions, and the forecast of future profitability. Management will continue to evaluate, on a quarterly basis, if there are any significant events that will affect the Company's ability to utilize these deferred tax assets.

16. Pension Plans

Non-contributory Defined Benefit Pension Plan

The Company sponsors a non-contributory defined-benefit pension plan for its employees and for the employees of certain 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 for the pension plan is December 31.

In December 2016, the Company announced that effective January 31, 2017, it would freeze the pay and service amounts used to calculate pension benefits for active employees who participated in the pension plan. Therefore, as of the effective date, active employees in the pension plan do not accrue additional benefits for future service and eligible compensation received.

(dollar amounts in thousands, except per share and share data)

The following table sets forth the plan's benefit obligations, fair value of plan assets, and funded status as of December 31, 2018 and 2017, accordingly:

	2018	2017
Change in benefit obligation		
Benefit obligation at beginning of year	$185,052	$163,877
Service cost	-	223
Interest cost	6,853	7,186
Benefit payments	(4,466)	(10,503)
Actuarial (gain) loss	(18,114)	24,269
Settlements	(9,848)	-
Benefit obligation at end of year	$159,477	$185,052
Accumulated benefit obligation at end of year	$159,477	$185,052
Change in fair value of plan assets		
Fair value of plan assets at beginning of year	$158,879	$140,398
Actual return on assets	(11,608)	24,984
Employer contributions	2,000	4,000
Settlements	(9,848)	-
Benefit payments	(4,466)	(10,503)
Fair value of plan assets at end of year	$134,957	$158,879
Funded status at end of year	$(24,520)	$(26,173)

The amounts recognized in the consolidated balance sheets as of December 31, 2018 and 2017 consist of the following:

	2018	2017
Pension liability	$24,520	$26,173
Net actuarial loss recognized in accumulated other comprehensive loss, net of a deferred tax of $10,469 and $10,176 in 2018 and 2017, respectively	23,691	24,540

The following assumptions were used on a weighted average basis to determine benefits obligations of the plan as of December 31, 2018 and 2017.

	2018	2017
Discount rate	4.50 %	3.75%
Expected return on plan assets	6.50 %	6.50%
Rate of compensation increase	N/A	N/A

(dollar amounts in thousands, except per share and share data)

The components of net periodic benefit cost and other amounts recognized in other comprehensive income for 2018, 2017, and 2016 were as follows:

	2018	2017	2016
Components of net periodic benefit cost			
Service cost	$-	$223	$3,640
Interest cost	6,853	7,186	8,749
Expected return on plan assets	(9,020)	(8,740)	(9,003)
Prior service benefit	-	-	(450)
Actuarial loss	961	369	4,028
Settlement loss	2,110	-	-
Net periodic benefit cost	$904	$(962)	$6,964

	2018	2017	2016
Other changes in plan assets and benefit obligations recognized in other comprehensive income			
Net actuarial (gain) loss	$2,515	$8,024	$(24,628)
Amortization of:			
Prior service credit	-	-	2,225
Actuarial loss	(3,071)	(369)	(4,028)
Total recognized in other comprehensive income	$(556)	$7,655	$(26,431)

Net periodic benefit cost includes settlement charges as a result of retirees selecting lump-sum distributions. Settlement charges may increase in the future if the number of eligible participants deciding to receive distributions and the amount of their benefits increases.

The Company recognized a pre-tax curtailment income of $1,773 during the year ended December 31, 2016 resulting from the freezing of the plan that was effective January 31, 2017.

The estimated net actuarial loss that will be amortized from accumulated other comprehensive loss into net periodic pension benefits cost during the next twelve months is $358.

The following assumptions were used on a weighted average basis in computing the periodic benefit cost for the years ended December 31, 2018, 2017, and 2016:

	2018	2017	2016
Discount rate	3.75%	4.50%	4.75%
Expected return on plan assets	6.50%	6.50%	7.00%
Rate of compensation increase	N/A	N/A	Graded; 3.50% to 8.00%

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(dollar amounts in thousands, except per share and share data)

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, 2018, the assumed target asset allocation for the program is: 45% to 55% in equity securities, 36% to 44% 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 5.8% to 7.2%. The Company selected a rate from within this range of 6.50% for 2018 and 6.50% for 2017, 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 0.15% 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 10.

The following table summarizes fair value measurements by level at December 31, 2018 and 2017 for assets measured at fair value on a recurring basis:

	2018 Level 1	Level 2	Level 3	Total	NAV
Government obligations	$-	$6,856	$ -	$6,856	$-
Non-agency backed securities	-	759	-	759	-
Corporate obligations	-	10,490	-	10,490	-
Limited Liability Corporations	-	-	-	-	97,660
Real estate	-	-	-	-	7,975
Registered investments	2,328	1,610	-	3,938	-
Common/Collective trusts	-	4,231	-	4,231	1,898
Common stocks	1,566	-	-	1,566	-
Preferred stocks	6	23	-	29	-
Forward foreign currency contracts		42	-	42	-
Interest-bearing cash	700	-	-	700	-
Derivatives	-	44	-	44	-
	$4,600	$24,055	$ -	$28,655	$107,533

(dollar amounts in thousands, except per share and share data)

	2017 Level 1	Level 2	Level 3	Total	NAV
Government obligations	$-	$7,131	$ -	$7,131	$-
Non-agency backed securities	-	641	-	641	-
Corporate obligations	-	8,560	-	8,560	-
Limited Liability Corporations	-	-	-	-	119,581
Real estate	-	-	-	-	7,568
Registered investments	3,388	659	-	4,047	-
Hedge funds	-	8,808	-	8,808	1,972
Common stocks	1,920	-	-	1,920	-
Preferred stocks	23	17	-	40	-
Interest-bearing cash	501	-	-	501	-
Derivatives	(1)	17	-	16	-
	$5,831	$25,833	$ -	$31,664	$129,121

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.

- 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.

(dollar amounts in thousands, except per share and share data)

- 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 assets with consideration of the liability characteristics in order to better align assets and liabilities.

- 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 $2,000 to its pension program in 2019.

The following benefit payments, which reflect expected future service, as appropriate, are expected to be paid:

Year ending December 31	
2019	$9,572
2020	9,145
2021	9,329
2022	9,214
2023	9,278
2024 – 2028	49,475

Non-contributory Supplemental Pension Plan
In addition, the Company sponsors a non-contributory 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, 2018 and 2017, the Company has recorded a pension liability of $6,754 and $7,499, respectively. The charge to accumulated other comprehensive loss related to the non-contributory pension plan at December 31, 2018 and 2017 amounted to $35 and $445, respectively, net of a deferred tax asset of $61 and $290, respectively.

17. 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.

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During the year ended December 31, 2018, TSP received the approval of the Commissioner of Insurance and withdrew $10,000 from the catastrophe fund following the payment for catastrophe losses related to the impact of Hurricanes Irma and Maria in September 2017.

The interest earning assets in this fund, which amounted to $38,978 and $48,363 as of December 31, 2018 and 2017, 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 2018 and 2017 since the level of the catastrophe reserve exceeds 8% of the catastrophe exposure.

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.

TSP retained earnings are restricted in the accompanying consolidated balance sheets by the total catastrophe loss reserve balance, which as of December 31, 2018 and 2017 amounted to $37,749 and $46,578, respectively.

18. Stockholders' Equity

a. Common Stock

On November 12, 2015, the Company converted 1,426,721 issued and outstanding Class A shares into Class B common stock purchased pursuant to the provisions of the Articles of incorporation approved by Class A shareholders at the time of the Company's Initial Public Offering.

b. Preferred Stock

Authorized capital stock includes 100,000,000 of preferred stock with a par value of $1.00 per share. As of December 31, 2018 and 2017, there are no issued and outstanding preferred shares.

c.