eHealth, Inc.
Form 10-Q
May 09, 2016
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549
FORM 10-Q

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

For the quarterly period ended March 31, 2016

OR

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

For the transition period from to
001-33071
(Commission File Number)

EHEALTH, INC.
(Exact name of registrant as specified in its charter)

Delaware	56-2357876
(State or other jurisdiction of incorporation or organization)	(I.R.S Employer Identification No)

440 EAST MIDDLEFIELD ROAD
MOUNTAIN VIEW, CALIFORNIA 94043
(Address of principal executive offices)

(650) 584-2700
(Registrant's telephone number, including area code)

Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

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 Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulations S-T (§232.405 of this chapter) 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 whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):
Large accelerated filer Accelerated filer

Non-accelerated filer Smaller reporting company
Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES NO

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of May 1, 2016 was 18,208,307 shares.

Table of Contents

EHEALTH, INC. FORM 10-Q
TABLE OF CONTENTS

	PART I FINANCIAL INFORMATION	PAGE
Item 1.	Financial Statements (unaudited)	1
	Condensed Consolidated Balance Sheets at December 31, 2015 and March 31, 2016	1
	Condensed Consolidated Statements of Comprehensive Income (Loss) for the three months ended March 31, 2015 and 2016	2
	Condensed Consolidated Statements of Cash Flows for the three months ended March 31, 2015 and 2016	3
	Notes to Condensed Consolidated Financial Statements	4
Item 2.	Management's Discussion and Analysis of Financial Condition and Results of Operations	12
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	31
Item 4.	Controls and Procedures	32
	PART II OTHER INFORMATION	
Item 1.	Legal Proceedings	33
Item 1A.	Risk Factors	34
Item 5.	Other Item	66
Item 6.	Exhibits	66
	Signatures	67

Table of Contents

PART I
FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands)

	December 31, 2015	March 31, 2016
Assets	(Note 1)	(unaudited)
Current assets:		
Cash and cash equivalents	$ 62,710	$ 66,689
Accounts receivable	9,647	19,625
Prepaid expenses and other current assets	5,185	4,947
Total current assets	77,542	91,261
Property and equipment, net	7,364	6,733
Other assets	4,697	3,624
Intangible assets, net	9,620	9,360
Goodwill	14,096	14,096
Total assets	$ 113,319	$ 125,074
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 3,012	$ 2,057
Accrued compensation and benefits	14,386	8,551
Accrued marketing expenses	10,698	2,966
Deferred revenue	392	332
Accrued restructuring charges	223	176
Other current liabilities	3,225	10,104
Total current liabilities	31,936	24,186
Non-current liabilities	4,962	4,888
Stockholders' equity:		
Common stock	29	29
Additional paid-in capital	266,699	268,255
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	9,498	27,532
Accumulated other comprehensive income	193	182
Total stockholders' equity	76,421	96,000
Total liabilities and stockholders' equity	$ 113,319	$ 125,074

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

Table of Contents

EHEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(In thousands, except per share amounts, unaudited)

	Three Months Ended March 31,	
	2015	2016
Revenue		
Commission	$57,819	$69,387
Other	3,469	4,457
Total revenue	61,288	73,844
Operating costs and expenses:		
Cost of revenue	2,414	2,184
Marketing and advertising	25,451	20,882
Customer care and enrollment	11,861	10,199
Technology and content	10,773	8,507
General and administrative	7,973	8,129
Restructuring charges	4,483	—
Amortization of intangible assets	345	260
Total operating costs and expenses	63,300	50,161
Income (loss) from operations	(2,012)	23,683
Other expense, net	(14)	(11)
Income (loss) before provision for income taxes	(2,026)	23,672
Provision for income taxes	56	5,638
Net income (loss)	$(2,082)	$18,034
Net income (loss) per share:		
Basic	$(0.12)	$0.99
Diluted	$(0.12)	$0.99
Weighted-average number of shares used in per share amounts:		
Basic	17,844	18,153
Diluted	17,844	18,217
Comprehensive income:		
Net income (loss)	$(2,082)	$18,034
Foreign currency translation adjustment	1	(14)
Comprehensive income (loss)	$(2,081)	$18,020

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

Table of Contents

EHEALTH, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands, unaudited)

	Three Months Ended March 31,	
	2015	2016
Operating activities		
Net income (loss)	$(2,082)	$18,034
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:		
Deferred income taxes	—	—
Depreciation and amortization	1,058	1,005
Amortization of internally-developed software	158	214
Amortization of book-of-business consideration	1,962	1,597
Amortization of intangible assets	345	260
Stock-based compensation expense	2,031	1,832
Deferred rent and other	27	(31)
Changes in operating assets and liabilities:		
Accounts receivable	(6,400)	(9,978)
Prepaid expenses and other assets	(894)	(153)
Accounts payable	(3,658)	(1,265)
Accrued compensation and benefits	16	(5,835)
Accrued marketing expenses	(7,156)	(7,732)
Deferred revenue	(152)	(60)
Accrued restructuring charges	1,771	(70)
Other liabilities	1,802	6,879
Net cash provided by (used in) operating activities	(11,172)	4,697
Investing activities		
Purchases of property and equipment and other assets	(384)	(411)
Net cash used in investing activities	(384)	(411)
Financing activities		
Cash used to net-share settle equity awards	(480)	(276)
Principal payments in connection with capital leases	(19)	(20)
Net cash used in financing activities	(499)	(296)
Effect of exchange rate changes on cash and cash equivalents	5	(11)
Net (decrease) increase in cash and cash equivalents	(12,050)	3,979
Cash and cash equivalents at beginning of period	51,415	62,710
Cash and cash equivalents at end of period	$39,365	$66,689

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

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 1 - Summary of Business and Significant Accounting Policies

Description of Business—eHealth, Inc. (the "Company," "eHealth," "we" or "us") is the leading private online source of health insurance for individuals, families and small businesses in the United States. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for and purchase Medicare-related, individual and family, small business and ancillary health insurance plans. We actively market the availability of Medicare-related insurance plans and offer Medicare plan comparison tools and educational materials for Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. We are licensed to market and sell health insurance in all 50 states and the District of Columbia.

Basis of Presentation—The accompanying condensed consolidated balance sheet as of March 31, 2016, the condensed consolidated statements of comprehensive income (loss) for the three months ended March 31, 2015 and 2016 and the condensed consolidated statements of cash flows for the three months ended March 31, 2015 and 2016, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2015 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2015, which was filed with the Securities and Exchange Commission on March 14, 2016. The accompanying statements should be read in conjunction with the audited consolidated financial statements and related notes contained in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles, or U.S. GAAP, for interim financial information. Accordingly, they do not include all of the financial information and footnotes required by U.S. GAAP for complete financial statements. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2015, and include all adjustments necessary for the fair presentation of eHealth's financial position as of March 31, 2016, its results of operations for the three months ended March 31, 2015 and 2016 and its cash flows for the three months ended March 31, 2015 and 2016. All adjustments are of a normal recurring nature. The results for the three months ended March 31, 2016 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2016.

Seasonality—The majority of our Medicare-related health insurance plans are sold in our fourth quarter, which includes the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. Additionally, substantially all Medicare Advantage and Medicare Part D prescription drug policies renew on January 1 of each year, resulting in our recognizing substantially all renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in our first quarter. Accordingly, Medicare plan-related commission revenue is highest in our first quarter, with Medicare plan-related commission revenue being higher in our fourth quarter compared to our second and third quarters.

The majority of our individual and family health insurance plans are sold in the annual open enrollment period as defined under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and

Education Reconciliation Act. Individuals and families generally will not be able to purchase individual and family health insurance outside of these open enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance.

Recent Accounting Pronouncements—In August 2015, the Financial Accounting Standard Board (“FASB”) issued Accounting Standards Update (“ASU”) No. 2015-14 (ASU 2015-14) "Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date." ASU 2015-14 defers the effective date by one year of ASU No. 2014-09, “Revenue from Contracts with Customers.” ASU 2014-09 supersedes the revenue recognition requirements in “Revenue Recognition (Topic 605)” and requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. In accordance with the deferral, the new standard is effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period and can be adopted using either a full retrospective or modified retrospective approach. Early adoption is permitted for annual reporting periods beginning after December 15, 2016, including interim

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

periods within that reporting period. We are currently in the process of evaluating the impact of the adoption of ASU 2014-09 on our consolidated financial statements.

In February 2016, the FASB issued ASU No. 2016-02 (ASU 2016-02) "Leases (Topic 842)." ASU 2016-02 requires lessees to put leases on their balance sheets but recognize expenses on their income statements; for lessors, the guidance modifies the classification criteria and the accounting for sales-type and direct finance leases. The guidance also eliminates existing real estate-specific provisions for all entities. The new standard is effective for annual reporting periods beginning after December 15, 2018, including interim periods within that reporting period. Early adoption is permitted. We are currently in the process of evaluating the impact of the adoption of ASU 2016-02 on our consolidated financial statements.

In March 2016, the FASB issued ASU No. 2016-08 (ASU 2016-08) "Revenue from Contracts with Customers (Topic 606)." ASU 2016-8 requires an entity to determine whether it is a principal or an agent in a transaction in which another party is involved in providing goods or services to a customer by evaluating the nature of its promise to the customer. The new standard is effective for annual reporting periods beginning after December, 15 2017, including interim periods within that reporting period. Early adoption is permitted for annual reporting periods beginning after December 15, 2016, including interim periods within that reporting period. We are currently in the process of evaluating the impact of the adoption of ASU 2016-08 on our consolidated financial statements.

In April 2016, the FASB issued ASU No. 2016-10 (ASU 2016-10), Identifying Performance Obligations and Licensing. ASU 2016-10 provides guidance in identifying performance obligations and determining the appropriate accounting for licensing arrangements. The effective date and transition requirements for the amendments in this Update are the same as the effective date and transition requirements in Topic 606 (and any other Topic amended by Update 2014-09). We are currently in the process of evaluating the impact of the adoption of ASU 2016-10 on our consolidated financial statements.

Recently Adopted Accounting Standards-In April 2015, the FASB issued ASU No. 2015-05 (ASU 2015-05), "Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40): Customer’s Accounting for Fees Paid in a Cloud Computing Arrangement." ASU 2015-05 provides guidance to clarify the customer’s accounting for fees paid in a cloud computing arrangement. It is effective for annual periods, and interim periods within those annual periods, beginning after December 15, 2015. Early adoption is permitted, including adoption in an interim period. We adopted this standard prospectively in the first quarter of 2016. Prior periods were not adjusted. The adoption of this standard did not have a material effect on our consolidated financial statements.

In March 2016, the FASB issued Accounting Standards Update (“ASU”) No. 2016-09 (ASU 2016-09), "Improvements to Employee Share-Based Payment Accounting (Topic 718)." ASU 2016-09 simplifies various aspects related to how share-based payments are accounted for and presented in the consolidated financial statements. The amendments include income tax consequences, the accounting for forfeitures, the classification of awards as either equity or liabilities and the classification on the statement of cash flows. It is effective for the first interim period beginning after December 15, 2016 and early adoption is permitted. We adopted this standard in the first quarter of 2016. Under ASU 2016-09, eHealth classifies the excess income tax benefits from stock-based compensation arrangements as a discrete item within income tax expense, rather than recognizing such excess income tax benefits in additional paid-in capital. As required by ASU 2016-09, this guidance was applied using a modified retrospective transition method and is effective as of January 1, 2016. The adoption of this guidance did not have a material effect to retained earnings, or other components of equity or net assets at the beginning of the period of adoption. Under ASU 2016-09, excess

income tax benefits from stock-based compensation arrangements are classified as cash flow from operations, rather than as cash flow from financing activities. We have elected to apply the cash flow classification guidance of ASU 2016-09 prospectively for the period ended March 31, 2016. Prior periods were not adjusted. Under ASU 2016-09, when shares are withheld from an employee's exercise of stock awards to fund our payment of the employee's taxes, the payment is classified as a financing activity. The adoption of this provision did not have a material effect on the cash flow statements from prior periods. In addition, we have elected to continue to estimate the number of stock-based awards expected to vest, as permitted by ASU 2016-09, rather than electing to account for forfeitures as they occur.

Note 2 – Balance Sheet Accounts

Cash and Cash Equivalents—As of December 31, 2015 and March 31, 2016, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. At December 31, 2015 and March 31, 2016, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three months ended March 31, 2015 and 2016.

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

As of December 31, 2015 and March 31, 2016, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2015	March 31, 2016
Cash	$ 8,086	$ 7,055
Money market funds	54,624	59,634
Total cash and cash equivalents	$ 62,710	$ 66,689

Our money market funds reflect unadjusted quoted prices in active markets for identical assets and are classified as Level 1 as of December 31, 2015 and March 31, 2016.

Accounts Receivable—As of December 31, 2015 and March 31, 2016, our accounts receivable consisted of the following (in thousands):

	December 31, 2015	March 31, 2016
Commissions receivable	6,136	416
Accounts receivable - for other revenues	3,511	1,742
Commissions receivable - for Medicare renewals	—	17,467
Total accounts receivable	$ 9,647	$ 19,625

Note 3 – Stockholders' Equity

Stock Plans—The following table summarizes activity under our 2014 Equity Incentive Plan, 2006 Equity Incentive Plan, 1998 Stock Plan and 2005 Stock Plan (collectively, the "Stock Plans") (in thousands):

	Shares Available for Grant
Shares available for grant December 31, 2015	3,542
Restricted stock units granted	—
Options granted	—
Restricted stock units cancelled (1)	6
Options cancelled (2)	—
Shares available for grant March 31, 2016	3,548

(1) Restricted stock units cancelled does not include restricted stock units cancelled under the 2006 Equity Incentive Plan, as our 2006 Equity Incentive Plan has been terminated with respect to the grant of additional awards.

(2) Options cancelled does not include stock options cancelled under the 2006 Equity Incentive Plan, as our 2006 Equity Incentive Plan has been terminated with respect to the grant of additional awards.

We maintain our 2006 Equity Incentive Plan, 2005 Stock Plan and 1998 Stock Plan, under which we previously granted options to purchase shares of our common stock and restricted stock units. The 2006 Equity Incentive Plan was terminated with respect to the grant of additional awards on June 12, 2014, upon adoption of our 2014 Equity Incentive Plan. The 2005 Stock Plan and 1998 Stock Plan were terminated with respect to the grant of additional awards upon the effectiveness of the 2006 Equity Incentive Plan. We will continue to issue new shares of common

stock upon vesting of restricted stock units and the exercise of stock options previously granted under the 2006 Equity Incentive Plan, 2005 Stock Plan and 1998 Stock Plan.

The following table summarizes stock option activity under the Stock Plans (in thousands, except per share amounts and weighted average remaining contractual life data):

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

	Number of Stock Options (1)	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (2)
Balance outstanding at December 31, 2015	1,275	$ 18.79	2.79	$ —
Granted	—	$ —		
Exercised	—	$ —		
Cancelled	(18)	$ 19.77		
Balance outstanding at March 31, 2016	1,257	$ 18.77	2.57	$ —
Vested and expected to vest at March 31, 2016	1,248	$ 18.77	2.55	$ —
Exercisable at March 31, 2016	1,085	$ 18.48	2.31	$ —

(1) There were no options granted during the three months ended March 31, 2016.
(2) The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2015 and March 31, 2016 and the exercise price of in-the-money options as of those dates.

The following table summarizes restricted stock unit activity, including performance-based and market-based restricted stock unit activity, under the Stock Plans (in thousands, except per share amounts and weighted average remaining contractual life data):

	Number of Restricted Stock Units (1)	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (2)
Balance outstanding as of December 31, 2015	966	$ 15.62	2.83	$ 9,636
Granted	—	$ —		
Vested	(92)	$ 17.15		
Cancelled	(7)	$ 17.59		
Balance outstanding as of March 31, 2016	867	$ 15.44	2.74	$ 8,146

(1) Includes certain restricted stock units with both service and performance-based or market-based vesting criteria granted to our executive officers. There were no restricted stock units granted during the three months ended March 31, 2016.

(2) The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31, 2015 and March 31, 2016 multiplied by the number of restricted stock units outstanding as of December 31, 2015 and March 31, 2016, respectively.

Stock Repurchase Programs—We had no stock repurchase activity during the three months ended March 31, 2016. In addition to the shares repurchased under our past repurchase programs as of March 31, 2016, we have in treasury 390,365 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2015 and March 31, 2016, we had a total of 11,025,933 shares and 11,054,253 shares, respectively, held in treasury.

Stock-Based Compensation—The following table summarizes stock-based compensation expense recorded during the three months ended March 31, 2015 and 2016 (in thousands):

	Three Months Ended March 31,	
	2015	2016
Stock options	$462	$326
Restricted stock units	1,569	1,506
Total stock-based compensation expense	$2,031	$1,832

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

The following table summarizes stock-based compensation expense by operating function for the three months ended March 31, 2015 and 2016 (in thousands):

	Three Months Ended March 31,	
	2015	2016
Marketing and advertising	$591	$555
Customer care and enrollment	117	123
Technology and content	435	435
General and administrative	775	719
Restructuring charges	113	—
Total stock-based compensation expense	$2,031	$1,832

Note 4 – Income Taxes

The following table summarizes our provision (benefit) for income taxes and our effective tax rates for the three months ended March 31, 2015 and 2016 (in thousands, except effective tax rate):

	Three Months Ended March 31,	
	2015	2016
Income (loss) before provision for income taxes	$(2,026)	$23,672
Provision for income taxes	$56	$5,638
Effective tax rate	(2.8)%	23.8 %

In the three months ended March 31, 2015 and 2016, we recorded a provision for income taxes of $0.1 million and $5.6 million, respectively. Our provision for income taxes in the three months ended March 31, 2015 primarily consisted of foreign income taxes and certain discrete items. The provision for income taxes in the three months ended March 31, 2016, primarily consisted of Federal and state alternative minimum income taxes, foreign income taxes and certain discrete items. We recorded a valuation allowance against the US deferred tax assets at the end of fiscal year 2014 and continue to maintain that full valuation allowance as of March 31, 2016 as we believe it is not more likely that not that the net deferred tax assets will be fully realized.

Note 5 – Net Income (Loss) Per Share

Basic net income (loss) per share is computed by dividing net income (loss) by the weighted-average number of common shares outstanding for the period. Diluted net income (loss) per share is computed by dividing the net income (loss) for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net income (loss) per share is computed giving effect to all potential dilutive common stock equivalent shares, including options and restricted stock units. The dilutive effect of outstanding awards is reflected in diluted net income (loss) per share by application of the treasury stock method.

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

The following table sets forth the computation of basic and diluted net income (loss) per share (in thousands, except per share amounts):

	Three Months Ended March 31,	
	2015	2016
Basic:		
Numerator:		
Net income (loss) allocated to common stock	$(2,082)	$18,034
Denominator:		
Weighted average number of common stock shares outstanding	17,844	18,153
Net income (loss) per share—basic:	$(0.12)	$0.99
Diluted:		
Numerator:		
Net income (loss) allocated to common stock	$(2,082)	$18,034
Denominator:		
Weighted average number of common stock shares outstanding	17,844	18,153
Weighted average number of options	—	—
Weighted average number of restricted stock units	—	64
Total common stock shares used in diluted per share calculation (1)	17,844	18,217
Net income (loss) per share—diluted:	$(0.12)	$0.99

(1) Total common stock shares used in the diluted per share calculation excludes market-based stock unit awards for which the related contingency had not been met as of March 31, 2016.

For each of the three-month periods ended March 31, 2015 and 2016, we had securities outstanding that could potentially dilute net income (loss) per share, but the shares from the assumed exercise of these securities were excluded in the computation of diluted net income (loss) per share as their effect would have been anti-dilutive for the periods presented. The number of outstanding weighted average anti-dilutive shares that were excluded from the computation of diluted net income (loss) per share consisted of the following (in thousands):

	Three Months Ended March 31,	
	2015	2016
Common stock options	1,702	1,263
Restricted stock units	618	713
Total	2,320	1,976

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 6 – Geographic Information and Significant Customers

Geographic Information—As of December 31, 2015 and March 31, 2016, our long-lived assets consisted primarily of property and equipment, internal-use software, goodwill and other indefinite-lived intangible assets and finite-lived intangible assets. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area were as follows (in thousands):

	As of December 31, 2015	As of March 31, 2016
United States	$ 35,341	$ 33,396
China	436	417
Total	$ 35,777	$ 33,813

Significant Customers—Substantially all revenue for the three months ended March 31, 2015 and 2016 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three months ended March 31, 2015 and 2016 are presented in the table below:

	Three Months Ended March 31,	
	2015	2016
Humana	34%	33%
UnitedHealthcare (1)	9 %	10%
Aetna (2)	9 %	11%

(1)UnitedHealthcare also includes other carriers owned by UnitedHealthcare.
(2)Aetna also includes other carriers owned by Aetna.

Commission revenue attributable to Medicare-related health insurance plans was approximately 51% and 62% of our commission revenue in the three months ended March 31, 2015 and 2016, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 38% and 29% of our commission revenue in the three months ended March 31, 2015 and 2016, respectively. We define our individual and family plan offerings as major medical individual and family health insurance plans, which do not include small business, Medicare-related health insurance plan offerings and other ancillary products such as short-term, stand-alone dental, life, vision, and accident insurance plan offerings.

As of December 31, 2015, three customers represented 24%, 18% and 15%, respectively, of our $9.6 million outstanding accounts receivable balance. As of March 31, 2016, two customers represented 60% and 11% of our $19.6 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2015 and March 31, 2016. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2016. Accordingly, our estimate for uncollectible amounts at December 31, 2015 and March 31, 2016 were not material.

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 7 – Restructuring Charges

In March 2015, we implemented an organizational restructuring and cost reduction plan designed to rebalance our resources and help reduce our cost structure as a result of lower than expected individual and family health insurance plan membership and revenue. As part of the plan, we eliminated approximately 160 full-time positions in the United States, representing approximately 15% of our workforce, primarily in our technology and content and customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. We incurred pre-tax restructuring charges of approximately $3.9 million for employee termination benefits and related costs, as well as $0.6 million in other pre-tax restructuring charges, primarily consisting of facility exit costs. The majority of the restructuring charges were recorded in the first quarter of 2015, when the activities comprising the plan were approved and substantially completed. In March 2015, as part of our restructuring activities, we also eliminated certain positions in our China operation.

The following table summarizes the total cash and non-cash restructuring charges recorded during the three months ended March 31, 2015 and 2016, respectively (in thousands):

	Three Months Ended March 31,	
	2015	2016
Employee termination costs	$3,734	$ —
Non-cash employee termination costs - stock-based compensation	113	—
Facility and other termination costs	636	—
Total restructuring charges	$4,483	$ —

The following table summarizes the cash-based restructuring charges liability activity during the three months ended March 31, 2016 (in thousands):

	Three Months Ended March 31, 2016			
	Beginning balance	Charges	Payments	Ending balance
Employee termination costs	$12	$ —	$ (12)	$ —
Facility and other termination costs	421	—	(58)	363
Total restructuring liability	$433	$ —	$ (70)	$ 363
Less: restructuring charges associated with facilities - non-current				(187)
Restructuring charges liability - current				$ 176

Note 8 - Commitments and Contingencies

Legal Proceedings— On January 26 and March 10, 2015, two purported class action lawsuits were filed against us, our chairman and chief executive officer, Gary L. Lauer (“Mr. Lauer”), and our senior vice president and chief financial

officer, Stuart M. Huizinga (“Mr. Huizinga”), in the United States District Court for the Northern District of California. On May 6, 2015, the court consolidated the two cases. On June 10, 2015, a consolidated complaint was filed. The consolidated complaint alleges that the defendants made false and misleading statements regarding the Company’s financial performance, guidance and operations during an alleged class period of May 1, 2014 to January 14, 2015. The consolidated complaint alleges that we and Messrs. Lauer and Huizinga violated Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 and Rule 10b-5 promulgated thereunder. The consolidated complaint seeks compensatory damages, attorneys’ fees and costs, rescission or a rescissory measure of damages, equitable/injunctive relief and such other relief as the court deems proper. On July 15, 2015, defendants moved to dismiss the consolidated complaint. On March 14, 2016, the court entered an order granting the defendants' motion to dismiss the consolidated complaint with leave to file an amended consolidated complaint within 30 days, which was later extended to April 27, 2016. On April 27, 2016, plaintiff did not file an amended complaint but filed a notice of submission to the court's order dismissing the consolidated complaint. We believe the lawsuit to be without merit and intend to vigorously defend ourselves against it.

Table of Contents
EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

In May 2015 an individual plaintiff filed a lawsuit against a health insurance carrier and us in state court in the state of Texas. The complaint alleged that we and the health insurance carrier engaged in certain false, misleading and deceptive acts and/or omissions in violation of the Texas Deceptive Trade Practice - Consumer Protection Act in connection with the plaintiff's purchase of the health insurance carrier's health insurance product. The complaint sought economic and actual damages for alleged harm caused to the plaintiff as well as multiple damages, exemplary damages and attorney's fees and costs. In June 2015, we and the health insurance carrier removed the case to the United States District Court for the Eastern District of Texas, and the court ordered the plaintiff to file an amended complaint. The plaintiff filed the amended complaint in July 2015. The amended complaint purports to be a class action lawsuit on behalf of the purchasers of a certain health insurance product offered by the health insurance carrier. The amended complaint alleges that we and the health insurance carrier engaged in certain false, misleading and deceptive acts and/or omissions in violation of the Texas Deceptive Trade Practice - Consumer Protection Act, or DTPA, and the Texas Insurance Code in connection with the sale of the health insurance carrier's health insurance product. The amended complaint alleges certain other causes of action against the health insurance carrier. The amended complaint seeks economic and actual damages, multiple damages, exemplary damages, interest, attorney's fees and costs, and specific performance. We filed a cross-claim against the health insurance carrier under the DTPA alleging that the health insurance carrier is required to indemnify us or contribute to any damages we are required to pay the plaintiff and for attorney's fees. In August 2015, we and the health insurance carrier moved to dismiss the claims in the amended complaint. In January 2016, our motion to dismiss the amended complaint was denied. In April 2016, we entered into a settlement agreement with the plaintiff, pursuant to which the plaintiff released his individual claims against us for an immaterial amount. In May 2016, the court entered an order dismissing with prejudice all of the individual plaintiff's claims against us.

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations in any of the states, we could be subject to various fines and penalties, including revocation of our license to sell insurance in those states, and our business and financial results would be harmed. We would also be harmed to the extent that related publicity damages our reputation as a trusted source of objective information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome. At December 31, 2015 and March 31, 2016, we had no material liabilities included in our consolidated balance sheet for outstanding legal claims.

ITEM 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to submitted applications and our membership; our expectations relating to revenue (including commission revenue, advertising revenue and other revenue), sources of revenue, cost of revenue, the collectability of our accounts receivable, operating expenses, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses, general and administrative expenses and profitability; expectations regarding the potential costs and impact of our cost reduction measures and reduction in headcount; our expectations regarding the impact of healthcare reform on our business; our ability to enroll and plans relating to the enrollment of individuals and families into qualified

health plans through government health insurance exchanges; our ability to enter into agreements with and meet requirements to offer qualified health plans through state and federal health insurance exchanges; our expectations relating to the commission rates that health insurance carriers will pay; our expectations relating to the seasonality of our business; our expectations relating to the renewal of Medicare-related health insurance plans and the timing of our generation of renewal commission revenue on those plans; the timing of our receipt of commission payments; our expectations relating to seasonal trends in our business relating to the sale of Medicare-related health insurance; estimations of our membership and related assumptions that we make in our membership estimations; our expectations relating to membership attrition and retention rates; the shift between marketing partner and direct marketing channels as sources of submitted individual and family plan applications during 2016; our critical accounting policies and related estimates; our expectation that we will experience an increase in submitted applications during open enrollment periods; our belief that cash generated from operations and our current cash and cash equivalents will be sufficient to fund operations for the next twelve months; our beliefs relating to the potential for collection of our accounts receivable; expected competition from government-run health insurance exchanges and other sources; our ability to adjust headcount to respond to changes in demand due to annual open enrollment periods; our ability to convert subsidy-eligible individuals and families into members; the timing of open enrollment periods including restrictions on changes outside of such periods and our readiness therefore; the timing and source of our Medicare-related revenue; the impact of the healthcare reform laws on the healthcare industry in future periods; the potential impact of lawsuits challenging certain aspects of the Affordable Care Act;

Table of Contents

the merits of any lawsuits filed against us; future capital requirements; our need for additional regulatory licenses and approvals; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those risks associated with the impact of healthcare reform and court decisions relating to healthcare reform; our ability to retain existing members and enroll a large number of individuals and families during the annual healthcare reform open enrollment period; our ability to align our expenses with our revenue; the impact of annual enrollment period for the purchase of individual and family health insurance and its timing on our recognition of revenue; our ability to sell qualified health insurance plans to subsidy-eligible individuals and to enroll subsidy eligible individuals through government-run health insurance exchanges; competition, including competition from government-run health insurance exchanges; political, legislative and legal challenges to the Affordable Care Act; seasonality of our business and the fluctuation of our operating results; our ability to retain existing members and limit member turnover; changes in consumer behaviors and their selection of individual and family health insurance products, including the selection of products for which we receive lower commissions; product offerings among carriers and the resulting impact on our commission revenue; the impact of healthcare reform on the cost of health insurance; the cost of health insurance in the upcoming open enrollment period;
the impact of increased health insurance costs on demand; our ability to timely receive and accurately predict the amount of commission payments from health insurance carriers; variability in timing of commission payments from health insurance carriers; medical loss ratio requirements; delays in our receipt of items required to recognize Medicare revenue; changes in member conversion rates; our ability to accurately estimate membership; the evolving nature of Affordable Care Act implementation; our relationships with health insurance carriers; our success in marketing and selling health insurance plans and our unit cost of acquisition; our ability to hire, train and retain licensed health insurance agents and other employees; the need for health insurance carrier and regulatory approvals in connection with the marketing of Medicare-related insurance products; our ability to successfully market and sell Medicare-related health insurance plans; the operations of our customer care center; costs of acquiring new members; scalability of the Medicare business; lack of membership growth and retention rates; consumers' satisfaction with our service; changes in the competitive landscape; our ability to attract new members and to convert online visitors into paying members; changes in products offered on our ecommerce platforms; changes in commission rates; maintaining and enhancing our brand identity; our ability to derive desired benefits from investments in our business, including membership growth initiatives; system failures, capacity constraints, data loss or online commerce security risks; dependence on acceptance of the Internet as a marketplace for the purchase and sale of health insurance; our ability to develop an effective process for purchasing of health insurance over the Internet on smartphones, tablets and devices other than desktop or laptop computers; dependence upon Internet search engines; reliance on marketing partners; timing of receipt and accuracy of commission reports; payment practices of health insurance carriers; general economic factors; dependence on our operations in China; dependence on our carrier partners for timely information about membership changes; success of our sponsorship and advertising business; protection of our intellectual property and defense against intellectual property rights claims; legal liability and regulatory penalties; changes in our management and key employees; maintenance of relationships with business development partners; difficulties, delays, unexpected costs and an inability to achieve anticipated cost savings from the organizational restructuring and cost reduction program we implemented in March 2015; potential acquisitions; potential consolidation in the health insurance industry; maintenance of proper and effective internal controls; potential changes to accounting standards and interpretations; impact of provisions for income taxes; changes in laws and regulations, including in connection with health care reform and/or with respect to the marketing and sale of Medicare-related plans; compliance with insurance and other laws and regulations; exposure to security risks; and the performance, reliability and availability of our ecommerce platforms and underlying network infrastructure. Other risks include the risks discussed under the heading “Risk Factors” of this report and those discussed in our other Securities and Exchange Commission filings. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2016, and the audited consolidated financial statements and related notes

contained therein. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements.

Overview

We are the leading private online source of health insurance for individuals, families and small businesses. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, apply for and purchase Medicare-related, individual and family, small business and ancillary health insurance plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process.

We have invested heavily in technology and content related to our ecommerce platforms. We have also invested significant time and resources in obtaining licenses to sell health insurance in all 50 states and the District of Columbia,

Table of Contents

developing member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with leading health insurance carriers, enabling us to offer thousands of health insurance plans online. Our ecommerce platforms can be accessed directly through our websites as well as through our network of marketing partners.

Sources of Revenue

Commission Revenue

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platforms. Commission revenue represented 94% of total revenue in both the three months ended March 31, 2015 and 2016.

We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In addition, health insurance carriers often have the ability to terminate or amend our agreements unilaterally on short notice, including provisions in our agreements relating to our commission rates. The amendment or termination of an agreement we have with a health insurance carrier may adversely impact the commissions we are paid on health insurance plans that we have already sold through the carrier. See Critical Accounting Policies and Estimates of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of commission revenue.

We actively market the availability of Medicare-related health insurance plans through our Medicare ecommerce platforms (www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com). Our Medicare ecommerce platforms and telephonic enrollment capabilities enable consumers to research, compare and purchase Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, either online or telephonically, we generate revenue from commissions we receive from health insurance carriers. Medicare Advantage and Medicare Part D prescription drug plan pricing is set by health insurance carriers and approved by the Centers for Medicare and Medicaid Services, or CMS, an agency of the United States Department of Health and Human Services, and is not subject to negotiation or discounting by health insurance carriers or our competitors. Similarly, Medicare Supplement plan pricing is set by the health insurance carrier and approved by state regulators and is not subject to negotiation or discounting by health insurance carriers or our competitors.

We sell a greater number of Medicare plans in the fourth quarter of the year during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year, compared to the number of Medicare plans we sell during the first, second or third quarters of each year. For example, during 2015, 56% of our Medicare plan-related applications were submitted during the fourth quarter. During the fourth quarter, we generate the majority of commission revenues related to new Medicare plan-related enrollments. During the first quarter, we recognized substantially all of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue as substantially all Medicare Advantage and Medicare Part D policies renew on January 1 of each year.

In addition to Medicare plans, we also actively market the availability of individual and family, small business and ancillary health insurance plans through our ecommerce platforms (www.eHealth.com and www.eHealthInsurance.com), and generate revenue from commissions we receive from health insurance carriers whose plans are purchased through us, as well as commission override payments we receive for achieving sales volume thresholds or other objectives. We sell ancillary health insurance plans, which primarily consist of short-term,

dental, life, vision, and accident insurance plans, alongside individual and family health insurance plans and also as standalone products.

In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that changed and will continue to change the health insurance industry in substantial ways. We have described various aspects of health care reform in Part II, Item 1A. Risk Factors - Risks Related to Our Business. Various aspects of health care reform may impact our business positively. For instance, the mandate that individuals and families have qualified health insurance or face a tax penalty and the government providing individuals and families' subsidies in the form of premium tax credits and cost sharing reductions are provisions to the law that could benefit our business. Notwithstanding these aspects of health care reform, the implementation of health care reform has significantly reduced our individual and family health insurance membership and individual and family health insurance commission revenue and could in the future have a material adverse effect on our

Table of Contents

business and results of operations. Health care reform established annual open enrollment periods for the purchase of individual and family health insurance. For coverage effective in 2015, the open enrollment period ran from November 15, 2014 through February 15, 2015, and for coverage effective in 2016, the annual open enrollment period ran from November 1, 2015 through January 31, 2016. Individuals and families generally are not able to purchase individual and family health insurance outside of the annual enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for health insurance. The open enrollment period has changed the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. It also presents challenges to our ability to enroll a significant number of individuals and families into health insurance over a limited period of time and significantly reduces our ability to obtain new health insurance members outside of the open enrollment period. In addition, CMS tightened the requirements for individuals to qualify for a special enrollment period starting in 2016. We do not expect to enroll a significant number of individuals in individual and family health insurance outside of the annual enrollment period in 2016.

A substantial number of individuals and families are eligible for subsidies under health care reform. Health care reform's establishment of government-run health insurance exchanges through which individuals and families must purchase qualified health plans to receive government subsidies has increased our competition as individual and families may purchase qualified health plans directly from government exchanges. While they are not required to do so, government-run exchanges are permitted to allow agents and brokers to enroll individuals and families into qualified health plans through government-run exchanges. We have entered into an agreement with, and enrolled individuals and families into qualified health plans through, the Federally Facilitated Marketplace, or FFM, run by CMS. The FFM operated the health insurance exchange in 37 states during the last health care reform open enrollment period. Our ability to act as a health insurance agent for subsidy-eligible individuals purchasing qualified health plans through the FFM depends upon the FFM developing and maintaining an efficient, scalable and online enrollment process, and our ability to successfully enter into and maintain our agreement and integrate with the FFM. CMS has broad authority over the requirements that we must meet in order to be able to enroll individuals into qualified health plans through the FFM, and in addition to issuing new requirements, has the authority to interpret existing requirements. Among these requirements, and in order to enroll individuals in subsidy-eligible plans over the Internet through the FFM, we need to meet a number of requirements relating to display of information on our websites as well as new and comprehensive privacy and security requirements. These requirements are evolving. For example, we are required to translate significant portions of our website into Spanish for the next open enrollment period in certain jurisdictions in order to be able to offer qualified health plans to individuals in states where greater than 10% of the state's population is Spanish speaking (currently California and Texas), and we may not be able to meet this requirement and be able to offer qualified health plans in those states. Our ability to maintain compliance with the various requirements to enroll individuals through the FFM has presented, and could in the future present, significant challenges for us. In addition, CMS directed us and other web-based entities to make changes after the end of the last open enrollment period to the process we developed for enrolling individuals into qualified health plans through the FFM. As a result of the changes that we made to our online process in response to CMS' requirements, which require that we use a different and more cumbersome pathway through which individuals are enrolled in qualified health plans, we experienced a reduction in the rate at which individuals and families starting the application process for qualified health plans and subsidies became members. The FFM may not improve the process to a significant degree for the upcoming open enrollment period, and if it does not do so, this conversion rate reduction would adversely impact our ability to generate members and would harm our business, operating results and financial condition. We may have difficulty enrolling, and may not be able to enroll, individuals in qualified health plans in an efficient and scalable manner both during and outside of the annual open enrollment period in the future and the number of individuals and families we are able to enroll in qualified health plans could decline significantly, which would cause a significant reduction in our membership and revenue.

The future impact of health care reform on health insurance carriers that pay us our commission revenue is also unclear. Health insurance carriers have the ability to unilaterally change their relationship with us, including the commission rates we receive for acting as a health insurance agent, and may reduce the amount they pay us, alter the manner and geographic areas in which they permit us to sell their products and change our relationship with them in any number of ways. As a result of higher medical utilization rates than carriers projected and for other reasons, several health insurance carriers with which we have a relationship, including large national health insurance carriers, recently reduced or eliminated our commissions for individual and family health insurance enrollments outside of the open enrollment period. While certain health insurance carriers have indicated that they intend to increase commission rates for individuals and family health insurance we sell during the upcoming open enrollment period, they are not obligated to do so, and if they do not do so, our business, operating results and financial conditions could be harmed. In addition, at least one major health insurance carrier has indicated that it does not plan to sell qualified health plans to subsidy-eligible individuals on the FFM in several states. If significant numbers of health insurance carriers decline to sell individual and family health insurance, the number of plans offered on our website will be reduced, which could decrease demand for the individual and family health insurance that we sell.

Our commission revenue is influenced by a number of factors including:

Table of Contents

- the number of applications for Medicare-related, individual and family, small business and ancillary health insurance we submit to health insurance carriers;
- the number of members on submitted applications;
- the rate at which the individuals on those applications turn into paying members;
- the commission rates we receive for the health insurance plans that we sell; and
- our membership retention.

Submitted Applications. Historically, we have experienced a significant increase in the number of Medicare-related submitted applications during the Medicare annual enrollment period, which occurs during the fourth quarter of each year. During 2015, we experienced an increase in the number of Medicare-related applications submitted during the first, second and third quarters compared to the fourth quarter. Medicare Advantage applications submitted during the first, second and third quarters accounted for 45% of total Medicare submitted applications in 2015, compared to 34% in 2014. Total Medicare product applications submitted outside of the annual enrollment period accounted for 55% of total Medicare submitted applications in 2015, while 45% were submitted during the annual enrollment period in 2015. The number of individual and family health insurance applications submitted through us is historically highest during the health care reform open enrollment period, which has historically begun in the fourth quarter and run into the first quarter of the following year. Individual and family applications submitted through us during the first quarter of 2016 were lower than the number of applications submitted through us during the fourth quarter of 2015, and 47% below the number of applications submitted through us during the first quarter of 2015. During the second and third quarters, which are outside the health care reform open enrollment periods, the number of individual and family health insurance submitted applications has historically decreased significantly. We expect this trend to continue in 2016. We also expect our individual and family submitted applications will increase significantly during the fourth quarter of 2016, relative to the second and third quarters of 2016, as a result of the open enrollment period.

Members per Submitted Application. For Medicare-related health insurance, there is only one member per submitted application. However, for individual and family and certain ancillary health insurance plans, there may be more than one member per submitted application. We experienced a decline in the average number of members on individual and family health insurance applications submitted in the first quarter of 2015 compared to the second through fourth quarters of 2014, but consistent with the first quarter of 2014. The average improved in the second through fourth quarters of 2015 compared to the first quarter of 2015, but did not return to the same levels as the second through fourth quarters of 2014, and did not return to historical pre-healthcare reform rates. In the first quarter of 2016, we experienced a decline in the average number of members on individual and family health insurance applications submitted through us compared to the first quarter of 2015.

Approval Rates and Initial Payment Rates. The approval rates for Medicare-related health insurance remained relatively consistent in 2014 and 2015. As a result of the health care reform prohibition on using pre-existing health conditions as a reason to deny health insurance applications, we have experienced higher approval rates on individual and family plan applications submitted during the open enrollment periods compared to periods before health care reform implementation. Approval rates have historically been lower outside of the open enrollment period than for applications submitted during the open enrollment period. In addition, during the first and second quarters of 2015, our individual and family plan commission revenue benefited from carriers paying us earlier on policies approved during the open enrollment period that ended in 2015 compared to the prior open enrollment period. We believe that the more timely payment of commissions resulted from carriers being better prepared to handle large application volumes, and we also took steps to work with our carrier partners to ensure that their processes resulted in more timely commission payments to us in 2015 and thus far in 2016.

Commission Rates. The average commission dollars per-member-per-month that we receive for new health insurance plan members varies based upon a number of factors, including the ratio of policies that we sold for which we receive

per member-per-month commissions compared to percentage-of-premium commissions, the premiums on the policies we sold, the mix of our members by health insurance carrier and the commission rates we receive from each carrier. Additionally, commission rates may vary by carrier, by geography and by the type of plan purchased by a member.

In the first plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application but during the effective year of the plan, we are paid a fixed commission that is prorated for the number of months remaining in the calendar year. Additionally, if the plan is the first Medicare Advantage or Medicare Part D prescription drug plan issued to the member, we may receive a higher commission rate that covers a full twelve-month period, regardless of the month the plan was effective. Beginning with and subsequent to the second plan year, we typically receive fixed, monthly commissions for Medicare Advantage plans and fixed, annual commissions for Medicare Part D prescription drug plans. We earn commission revenue for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically until either the policy is cancelled or we otherwise do not remain the agent on the policy. Commission payments we receive for Medicare Supplement policies sold by us are typically a percentage of the premium on

Table of Contents

the policy and paid to us until the policy is cancelled or we otherwise do not remain the agent on the policy. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of Medicare plan commission revenue.

Historically, the commission payments we receive for individual and family, small business and ancillary health insurance plans we sold were a percentage of the premium our customers pay for those plans. Effective January 1, 2014, many carriers began paying our individual and family health insurance commissions at a flat amount per member per month. Commission payments are typically made to us on a monthly basis until either the policy is cancelled or we otherwise do not remain the agent on the policy.

As a result of our commission structure, much of our revenue for a given financial reporting period relates to health insurance plans that we sold prior to the beginning of the period and is recurring in nature. However, the increased volume of health insurance applications submitted during the annual open enrollment periods compared to applications submitted outside of the annual open enrollment period has caused us to experience shifts in the concentration of our membership by health insurance carrier and type of plan purchased and corresponding fluctuations in our average commission rate. For example, we have observed higher commissions on many of the individual and family health insurance plans that we sold during the 2015 open enrollment period for coverage effective in 2016 compared to policies that we sold during the 2014 open enrollment period for coverage effective in 2015. Recently, several health insurance carriers have reduced or eliminated commission for individual and family health insurance sold outside of the health care reform open enrollment period. While these carriers have indicated that they plan to increase commission rates for individual and family health insurance sold in the upcoming open enrollment period, they are not obligated to do so.

Retention Rates. Our commission revenue is also influenced by our member retention rates. Retention rates are typically lower in the first policy year and improves each subsequent year. Additionally, the member retention rates on our individual and family membership were negatively impacted by health care reform throughout 2014 and 2015. As a result, the number of new individual and family health insurance members added during the second, third and fourth quarters of 2015 and the first quarter of 2016 was not enough to offset the loss of existing members, resulting in an annual decline in individual and family health insurance estimated membership during those periods.

Other Revenue

Online Sponsorship and Advertising. We generate revenue from our online sponsorship and advertising program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website and allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us. In return, we are typically paid a flat fee or, with respect to individual and family health insurance plans, a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications. Health insurance carriers commit to sponsorship and advertising on a quarterly basis, if at all, and generally determine prior to the quarter whether to purchase sponsorship and advertising from us and how much they are willing to spend. As a result, our sponsorship and advertising revenue is difficult to predict. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of online sponsorship and advertising revenue.

Technology Licensing. We generate revenue from licensing the use of our health insurance ecommerce technology. Our technology platform enables health insurance carriers and agents to market and distribute health insurance plans online. Health insurance carriers or agents that license our technology typically pay us implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of technology licensing revenue.

Lead Referrals. We generate revenue from referral fees paid to us based on Medicare-related and individual and family health insurance leads generated by our ecommerce platforms that are delivered and sold to third parties. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of lead referral revenue.

Table of Contents

Member Acquisition

Marketing initiatives are an important component of our strategy to increase revenue by growing our member base. Our marketing initiatives are focused on three primary member acquisition channels: direct, marketing partners and online advertising and are primarily designed to encourage consumers to complete an application for health insurance. For the periods ended March 31, 2015 and 2016, applications submitted through us for Medicare-related, individual and family, small business and ancillary health insurance from our three member acquisition channels as a percentage of all health insurance applications submitted on our websites were as follows:

	Three Months Ended March 31,	
	2015	2016
Source of total submitted applications (as a percentage of total submitted applications for the period):		
Direct	48 %	49 %
Marketing partners	41 %	33 %
Online advertising	11 %	18 %
Total	100%	100%

Direct. Our direct member acquisition channel consists of consumers who access our website addresses, (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com) either directly, through algorithmic natural search listings on Internet search engines and directories, or other forms of marketing, such as retargeting campaigns, television, direct mail and email marketing.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our websites through a network of affiliate partners and financial services and other companies. We compensate a significant number of our marketing partners by paying a fee each time a consumer referral from a partner results in a submitted health insurance application, regardless of whether the consumer's application is approved by the health insurance carrier. Some of our marketing partners have tiered arrangements in which the amount of the fee increases as the volume of submitted applications we receive from the marketing partner increases over a particular period. We recognize these expenditures in the period when a marketing partner's referral results in the submission of a health insurance application. Growth in our marketing partner channel depends upon our expanding marketing programs with existing partners and adding new partners to our network.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our websites through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, as well as various Internet marketing programs such as display advertising. We incur expenses associated with search advertising in the period in which the consumer clicks on the advertisement.

In addition to our marketing channels, we have acquired health insurance members through transactions with broker partners. We have entered into several agreements, whereby the partners have transferred certain of their existing health insurance members to us as the broker of record on the underlying policies. These transfers included primarily Medicare plan members. The first of these transferred books-of-business occurred in February 2009 and the most recent in June 2012.

Operating Costs and Expenses

Cost of Revenue

Included in cost of revenue are payments related to health insurance policies sold to members who were referred to our website by marketing partners with whom we have revenue-sharing arrangements. In order to enter into a revenue-sharing arrangement, marketing partners must be licensed to sell health insurance in the state where the policy is sold. Costs related to revenue-sharing arrangements are expensed as the related revenue is recognized.

Additionally, cost of revenue includes the amortization of consideration we paid to certain broker partners in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies. These transfers include primarily Medicare plan members. Consideration for all book-of-business transfers is being amortized to cost of revenue as we recognize commission revenue related to the transferred members.

Table of Contents

Marketing and Advertising

Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct, marketing partner and online advertising member acquisition channels, in addition to compensation and other expenses related to marketing, business development, partner management, public relations and carrier relations personnel who support our offerings.

Since a significant portion of our marketing and advertising expenses consists of expenses incurred as a result of payments owed to our marketing partners in connection with health insurance applications submitted on our ecommerce platforms and other forms of marketing, such as direct mail, email marketing, television, radio and retargeting campaigns, those expenses are influenced by seasonal submitted application patterns. As a result of the annual open enrollment periods for both Medicare-related and individual and family health insurance, marketing and advertising expenses increase during the fourth quarter of each year. Additionally, since the health care reform open enrollment periods for individual and family health insurance continues into the following year, marketing and advertising expenses increase during the first quarter of each year, but to a lesser extent than the fourth quarter. During the second and third quarters, marketing and advertising expenses decrease, consistent with the decrease in submitted applications compared to periods during the open enrollment periods. We expect these seasonal trends to continue in 2016.

Because the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of search engine advertising. Increases in submitted applications resulting from marketing partner referrals or visitors to our website from our online advertising channel has in the past and could in the future result in marketing and advertising expenses significantly higher than our expectations. This has in the past and could in the future negatively impact our profitability during such periods because the revenue (if any) derived from submitted applications that are approved by health insurance carriers is not recognized until future periods.

Historically, we have experienced decreases in submitted individual and family plan applications outside of the open enrollment period compared to inside the open enrollment period and the source of our submitted individual and family plan applications shifted so that a greater number of applications came from our direct member acquisition channel. During the open enrollment period, the source of our submitted individual and family plan applications shifted so that a greater number of applications came from our higher cost marketing partner member acquisition channel compared to outside of the open enrollment period. These seasonal trends are expected to continue in 2016.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits costs for personnel engaged in assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the enrollment process. In preparation for the Medicare annual enrollment period during 2014 and 2015, and to a lesser extent the open enrollment period for individual and family health insurance plans during 2014 and 2015, we began ramping up our customer care center staff during our third quarter to handle the anticipated increased volume of health insurance transactions. Additionally, in the first quarter of 2015, we retained some Medicare sales and enrollment personnel to handle the increased volume of individual and family plan applications during the annual open enrollment periods for individual and family health insurance that ended on February 15, 2015. We expect customer care and enrollment expenses to marginally increase in each sequential quarter of 2016 to handle the anticipated increase in volume of Medicare-related health insurance transactions during the Medicare annual enrollment period in the fourth quarter.

Technology and Content

Technology and content expenses consist primarily of compensation and benefits costs for personnel associated with developing and enhancing our website technology as well as maintaining our website. A majority of our technology and content group is located at our wholly-owned subsidiary in China, where technology development costs are generally lower than in the United States.

Table of Contents

General and Administrative

General and administrative expenses include compensation and benefits costs for staff working in our executive, finance, investor relations, government affairs, legal, human resources, internal audit, facilities and internal information technology departments. These expenses also include fees paid for outside professional services, including audit, tax, legal, government affairs and information technology fees.

Restructuring Charges

On March 10, 2015, we implemented an organizational restructuring and cost reduction plan. As part of the plan, we eliminated approximately 160 full-time positions, representing approximately 15% of our workforce primarily in our technology and content and customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. We incurred pre-tax restructuring charges of approximately $3.9 million for employee termination benefits and related costs as well as $0.6 million in other pre-tax restructuring charges, primarily consisting of facility exit costs. The majority of the restructuring charges were recorded in the first quarter of 2015, when the activities comprising the plan were substantially completed.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics for the three months ended March 31, 2015 and 2016 and as of March 31, 2015 and 2016:

	Three Months Ended March 31,		
	2015	2016	Percentage Change
Submitted applications:			
Medicare submitted applications (1)	20,200	30,900	53 %
IFP submitted applications (2)	140,000	74,300	(47)%
Other submitted applications (3)	101,100	97,400	(4)%
Total submitted applications (4)	261,300	202,600	(22)%
Medicare Advantage submitted applications (5)	15,100	23,126	53 %
Commission revenue (in thousands):			
Medicare commission revenue (6)	$29,219	$42,731	46 %
IFP commission revenue (7)	21,860	20,266	(7)%
Other commission revenue (8)	6,740	6,390	(5)%
Total commission revenue (9)	$57,819	$69,387	20 %

	As of March 31,		
	2015	2016	Percentage Change
Estimated membership:			
Medicare estimated membership (10)	155,600	220,300	42 %
IFP estimated membership (11)	584,900	523,000	(11)%
Other estimated membership (12)	421,700	409,600	(3)%
Total estimated membership (13)	1,162,200	1,152,900	(1)%

20

Table of Contents

Notes:

(1) Medicare-related health insurance applications submitted on our website or through our customer care center during the period, including Medicare Advantage, Medicare Part D Prescription drug and Medicare Supplement plans. Applications are counted as submitted when the applicant completes the application and either clicks the submit button on our website or provides verbal authorization to submit the application. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application.

(2) Major medical Individual and Family plan ("IFP") health insurance applications submitted on our website during the period. Applications are counted as submitted when the applicant completes the application, clicks the submit button on our website and submits the application to us. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information and providing an electronic signature. In addition, an applicant may submit more than one application. We define our “IFP” offerings as major medical individual and family health insurance plans, which does not include Medicare-related, small business or ancillary plans (primarily consisting of short-term, dental, life, vision, and accident insurance plans).

(3) Applications for health insurance plans other than Medicare and IFP submitted on our website during the period. Applications for ancillary plans are counted as submitted when the applicant completes the application, clicks the submit button on our website and submits the application to us. Applications for small business plans are counted as submitted when the applicant completes the application, the employees complete their applications, the applicant submits the application to us and we submit the application to the carrier. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application.

(4) Applications for all health insurance plans submitted on our website or through our customer care center during the period. See notes (1), (2) and (3) above for further information as to what constitutes a submitted application.

(5) Medicare Advantage plan health insurance applications submitted on our website or through our customer care center during the period. Applications are counted as submitted when the applicant completes the application and either clicks the submit button on our website or provides verbal authorization to submit the application. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application. Medicare Advantage submitted applications are included in Medicare submitted applications - See note (2) above.

(6) Commission revenue recognized on all Medicare-related health insurance during the period.

(7) Commission revenue recognized on all IFP health insurance plans during the period, including commission overrides.

(8) Commission revenue recognized on all insurance other than Medicare-related health insurance and IFP health insurance plans during the period.

(9) Total commission revenue recognized on all insurance plans during the period.

(10) Estimated number of members active on Medicare-related health insurance as of the date indicated. See the note below for additional information regarding our calculation of Medicare estimated membership.

(11) Estimated number of members active on IFP health insurance plans as of the date indicated. See the note below for additional information regarding our calculation of IFP estimated membership.

(12) Estimated number of members active on insurance plans other than Medicare-related health insurance and IFP health insurance plans as of the date indicated. See the note below for additional information regarding our calculation of other estimated membership.

(13) Estimated number of members active on all insurance plans as of the date indicated. See the note below for additional information regarding our calculation of total estimated membership.

Note:

Health insurance carriers bill and collect insurance premiums paid by our members. Health insurance carriers do not report to us the number of members that we have as of a given date. The majority of our non-Medicare members who terminate their policies do so by discontinuing their premium payments to the carrier and do not inform us of the cancellation. Also, some of our non-Medicare members pay their premiums less frequently than monthly. Given the number of months required to observe non-payment of commissions in order to confirm cancellations, we estimate the number of members who are active on insurance policies as of a specified date. We estimate the number of continuing members on all policies as of a specific date as follows:

- For Medicare-related health insurance plans, we take the number of members for whom we have received or applied a commission payment during the month of estimation.

- For IFP health insurance plans, we take the sum of (i) the number of IFP members for whom we have received or applied a commission payment for the month that is six months prior to the date of estimation after reducing that number using historical experience for assumed member cancellations over the six-month period; and (ii) the number of approved members over the six-month period prior to the date of estimation after reducing that number by the percentage of members who do not accept their approved policy from the same month of the previous year for each of the six months prior to the date of estimation and for estimated member cancellations through the date of the estimate.

- For ancillary health insurance plans (such as short-term, dental, vision, accident and student), we take the sum of (i) the number of members for whom we have received or applied a commission payment for the month that is one to three months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the one to three-

Table of Contents

month period); and (ii) the number of approved members over the one to three-month period prior to the date of estimation (after reducing that number using historical experience for an assumed number of members who do not accept their approved policy and for estimated member cancellations through the date of the estimate). The one to three-month period varies by insurance product and is largely dependent upon the timeliness of commission payment and related reporting from the related carriers. For small business health insurance plans, we estimate the number of members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier in the period it is reported. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us.

Health insurance carriers often do not communicate policy cancellation information to us. We often are made aware of policy cancellations at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

A member who purchases and is active on multiple standalone insurance plans will be counted as a member more than once. For example, a member who is active on both an individual and family health insurance plan and a standalone dental plan will be counted as two continuing members.

After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. For instance, we reconcile information carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated membership. Conversely, carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. We do not update our estimated membership numbers reported in previous periods. Instead, we reflect updated information regarding our historical membership in the membership estimate for the current period. As a result of the delay in our receipt of information from insurance carriers, actual trends in our membership are most discernible over periods longer than from one quarter to the next. In addition, and as a result of the delay we experience in receiving information about our membership, it is difficult for us to determine with any certainty the impact of current conditions such as health care reform implementation on our membership retention. Health care reform and other factors could cause the assumptions and estimates that we make in connection with estimating our membership to be inaccurate, which would cause our membership estimates to be inaccurate.

Critical Accounting Policies and Estimates

The preparation of financial statements and related disclosures in conformity with U.S. generally accepted accounting principles, or U.S. GAAP, requires us to make judgments, assumptions, and estimates that affect the amounts reported in the consolidated financial statements and the accompanying notes. These estimates and assumptions are based on current facts, historical experience, and various other factors that we believe are reasonable under the circumstances to determine reported amounts of assets, liabilities, revenue and expenses that are not readily apparent from other sources. To the extent there are material differences between our estimates and the actual results, our future consolidated results of operations may be affected.

An accounting policy is considered to be critical if the nature of the estimates or assumptions is material due to the levels of subjectivity and judgment necessary to account for highly uncertain matters or the susceptibility of such matters to change, and the effect of the estimates and assumptions on financial condition or operating performance. The accounting policies we believe to reflect our more significant estimates, judgments and assumptions and are most

critical to understanding and evaluating our reported financial results are as follows:

- Revenue Recognition;
- Stock-Based Compensation;
- Realizability of Long-Lived Assets; and
- Accounting for Income Taxes.

During the three months ended March 31, 2016, there were no significant changes to our critical accounting policies and estimates. Please refer to Management's Discussion and Analysis of Financial Condition and Results of Operations contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015, for a complete discussion of our critical accounting policies and estimates.

Table of Contents

Results of Operations

The following table sets forth our operating results and the related percentage of total revenues for the three months ended March 31, 2015 and 2016 (dollars in thousands):

	Three Months Ended March 31,					
	2015			2016		
Revenue:						
Commission	$57,819	94	%	$69,387	94	%
Other	3,469	6		4,457	6	
Total revenue	61,288	100		73,844	100	
Operating costs and expenses:						
Cost of revenue	2,414	4		2,184	3	
Marketing and advertising	25,451	42		20,882	28	
Customer care and enrollment	11,861	19		10,199	14	
Technology and content	10,773	18		8,507	12	
General and administrative	7,973	13		8,129	11	
Restructuring charges	4,483	7		—	—	
Amortization of intangible assets	345	1		260	—	
Total operating costs and expenses	63,300	103		50,161	68	
Income (loss) from operations	(2,012)	(3)		23,683	32	
Other expense, net	(14)	—		(11)	—	
Income (loss) before provision for income taxes	(2,026)	(3)		23,672	32	
Provision for income taxes	56	—		5,638	8	
Net income (loss)	$(2,082)	(3)	%	$18,034	24	%

Operating costs and expenses include the following amounts of stock-based compensation expense (in thousands):

	Three Months Ended March 31,	
	2015	2016
Marketing and advertising	$591	$555
Customer care and enrollment	117	123
Technology and content	435	435
General and administrative	775	719
Restructuring charges	113	—
Total stock-based compensation expense	$2,031	$1,832

Table of Contents

Three Months Ended March 31, 2015 and 2016

Revenue

The following table presents our commission, other revenue and total revenue for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Commission	$57,819	$69,387	$11,568	20%
Percentage of total revenue	94 %	94 %		
Other	$3,469	$4,457	$988	28%
Percentage of total revenue	6 %	6 %		
Total revenue	$61,288	$73,844	$12,556	20%

Three Months Ended March 31, 2015 and 2016—Commission revenue increased $11.6 million, or 20% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015, primarily due to a $13.5 million increase in Medicare-related commission revenue, partially offset by a $1.6 million decrease in individual and family health insurance commission revenue. The increase in Medicare related commission revenue is primarily due to increased Medicare membership for the period ended March 31, 2016 compared to the period ended March 31, 2015. Commission revenue from renewals of Medicare Advantage and Prescription Drug Plan products were approximately $29 million in the first quarter of 2016, representing approximately 52% annual growth compared to the first quarter of 2015. The decrease in individual and family plan related commission revenue is primarily due to decreased individual and family plan estimated membership for the period ended March 31, 2016 compared to the period ended March 31, 2015.

Other revenue increased $1.0 million, or 28%, in the three months ended March 31, 2016, compared to the three months ended March 31, 2015, due primarily to an increase of $0.4 million in online sponsorship and advertising revenue and an increase of $0.6 million in lead generation revenue.

We expect commission revenue to increase in absolute dollars in 2016 compared to 2015, primarily as a result of a continued increase in Medicare-related commission revenue, partially offset by decreases in individual and family health insurance related commission revenue and commission override revenue.

Operating Costs and Expenses

Cost of Revenue

The following table presents our cost of revenue for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Cost of revenue	$2,414	$2,184	$(230)	(10)%
Percentage of total revenue	4 %	3 %		

Three Months Ended March 31, 2015 and 2016—Cost of revenue decreased $0.2 million, or 10% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015, due primarily to a decrease in amortization expense associated with the consideration we paid to a broker partner in connection with the transfer of several Medicare plan books-of-business to us whereby we became the broker of record on the underlying policies.

We expect cost of revenue to decrease in absolute dollars in 2016 compared to 2015, primarily as a result of the decrease in amortization expense associated with the consideration we paid to a broker partner in connection with the transfer of several Medicare plan books-of-business to us whereby we became the broker of record on the underlying policies.

Table of Contents

Marketing and Advertising

The following table presents our marketing and advertising expenses for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Marketing and advertising	$25,451	$20,882	$(4,569)	(18)%
Percentage of total revenue	42 %	28 %		

Three Months Ended March 31, 2015 and 2016—Marketing and advertising expenses decreased $4.6 million, or 18%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015 due primarily to a $3.7 million decrease in variable advertising costs, and a decrease in compensation, benefits and other personnel costs of $0.8 million.

We expect our marketing and advertising expenses to increase in absolute dollars in 2016 compared to 2015 due primarily to an increase in variable advertising costs related to our Medicare-related health insurance business.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Customer care and enrollment	$11,861	$10,199	$(1,662)	(14)%
Percentage of total revenue	19 %	14 %		

Three Months Ended March 31, 2015 and 2016—Customer care and enrollment expenses decreased $1.7 million or 14% in the three months ended March 31, 2016 compared to the three months ended March 31, 2015, due primarily to a decrease in compensation, benefits and other personnel costs relating to the individual and family health insurance business.

We expect customer care and enrollment expenses to increase in absolute dollars in 2016 compared to 2015 as we hire additional customer care center personnel in connection with the Medicare annual enrollment period and the growth of our Medicare-related health insurance business.

Technology and Content

The following table presents our technology and content expenses for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Technology and content	$10,773	$8,507	$(2,266)	(21)%
Percentage of total revenue	18 %	12 %		

Three Months Ended March 31, 2015 and 2015—Technology and content expenses decreased $2.3 million, or 21%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015, primarily due to a

decrease in compensation, benefits and other personnel costs.

Table of Contents

We expect technology and content expenses to decrease in absolute dollars in 2016 compared to 2015 as a result of a decrease in compensation and benefits due to the reduction-in-force announced in March 2015.

General and Administrative

The following table presents our general and administrative expenses for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
General and administrative	$7,973	$8,129	$156	2%
Percentage of total revenue	13 %	11 %		

Three Months Ended March 31, 2015 and 2016—General and administrative expenses increased $0.2 million, or 2%, in the three months ended March 31, 2016 compared to the three months ended March 31, 2015, due primarily to increases in corporate and consulting fees, offset by a decrease in compensation, benefits and other personnel costs.

Restructuring Charges

The following table presents our restructuring charges for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Restructuring charges	$4,483	$ —	$(4,483)	(100)%
Percentage of total revenue	7 %	—%		

Three Months Ended March 31, 2015 and 2016—The organizational restructuring and cost reduction plan implemented in March 2015 resulted in no additional restructuring expense in the three months ended March 31, 2016.

Amortization of Intangible Assets

The following table presents our amortization of intangible assets for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Amortization of intangible assets	$345	$260	$(85)	(25)%
Percentage of total revenue	1 %	— %		

Three Months Ended March 31, 2015 and 2016—Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber decreased slightly in the three months ended March 31, 2016 compared to the three months ended March 31, 2015 due to certain assets that have been fully amortized compared to the prior period.

Table of Contents

Other Expense, Net

The following table presents our other expense, net, for the three months ended March 31, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Other expense, net	$(14)	$(11)	$3	(21)%
Percentage of total revenue	— %	— %		

Three Months Ended March 31, 2015 and 2016—Administrative bank fees, foreign exchange losses, management fees and interest expense on our capital lease obligations were partially offset by interest earned on our invested cash and foreign exchange gains in the three months ended March 31, 2016.

Provision for Income Taxes

The following table presents our provision for income taxes for the three months ended March 31, 2015 and 2016 and the dollar changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2015	2016	$	%
Provision for income taxes	$56	$5,638	$5,582	9,968%
Percentage of total revenue	— %	8 %		

Three Months Ended March 31, 2015 and 2016—In the three months ended March 31, 2015 and 2016, we recorded a provision (benefit) for income taxes representing effective tax rates of (3)% and 24%, respectively. Our provision for income taxes in the three months ended March 31, 2015 primarily consisted of foreign income taxes and certain discrete items. The provision for income taxes in the three months ended March 31, 2016 primarily consisted of Federal and state alternative minimum income taxes, foreign income taxes and certain discrete items. The effective tax rate for the three months ended March 31, 2016 is higher than 2015 because we will be subject to federal and certain state alternative minimum income taxes in the current year. We expect the annual effective tax rate to remain consistent for the remaining period in fiscal 2016, excluding the impact of quarterly discrete items.

Liquidity and Capital Resources

At March 31, 2016, our cash and cash equivalents totaled $66.7 million. Cash equivalents, which are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, consist of money market funds. At December 31, 2015, our cash and cash equivalents totaled $62.7 million. The increase in cash and cash equivalents reflects $4.7 million provided by operating activities, offset by $0.4 million used to purchase property and equipment and other assets and $0.3 million to net-share settle equity awards.

As of March 31, 2016, we have in treasury 390,365 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2015 and March 31, 2016, we had a total of 11,025,933 shares and 11,054,253 shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the three months ended March 31, 2015 and 2016 (in thousands):

27

Table of Contents

	Three Months Ended March 31,	
	2015	2016
Net cash provided (used in) by operating activities	$(11,172)	$4,697
Net cash used in investing activities	$(384)	$(411)
Net cash used in financing activities	$(499)	$(296)

Operating Activities

Cash provided by (used in) operating activities primarily consists of net income (loss), adjusted for certain non-cash items including deferred income taxes, depreciation and amortization, including amortization of intangible assets, stock-based compensation expense and the effect of changes in working capital and other activities.

The timing of the recognition of our commission revenue depends upon the timing of our receipt of commission reports and associated commission payments from health insurance carriers. If we were to experience a delay in receiving a commission payment from a health insurance carrier at the end of a quarter, our operating cash flows for that quarter could be adversely impacted. Additionally, commission override payments are reported to us in a more irregular pattern than premium commissions. For example, a carrier may make a commission override payment to us on an annual basis, which would positively impact our cash flows in the quarter the payment is received.

A significant portion of our marketing and advertising expenses is driven by the number of health insurance applications submitted on our ecommerce platforms. Since our marketing and advertising costs are expensed and generally paid as incurred and the revenue and cash earned from approved applications is recognized and paid as commissions are subsequently reported to us, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter. During open enrollment periods for individual and family health insurance plans, we experience an increase in the number of submitted individual and family plan health insurance applications and marketing and advertising expenses compared to outside of open enrollment periods. During the Medicare annual enrollment period, we experience an increase in the number of submitted Medicare-related health insurance applications and marketing and advertising expenses compared to outside of Medicare annual enrollment periods. The timing of open enrollment periods for individual and family health insurance and the Medicare annual enrollment period for Medicare-related health insurance may have positive or negative impacts to our cash flows during each quarter. Consistent with prior years, we expect marketing and advertising costs to decline during the second and third quarters compared to the first quarter and increase during the fourth quarter of 2016 compared to the third quarter of 2016 due to an increase in submitted applications for individual and family health insurance during the open enrollment period and due to an increase in submitted applications for Medicare plans during the annual enrollment period, which will have a negative impact on our cash flows in the quarter.

All Medicare Advantage and Medicare Part D prescription drug policies are renewed on January 1, resulting in our recording substantially all Medicare Advantage and Medicare Part D prescription drug plan renewal commission revenue in the first quarters of 2015 and 2016. As a result, we did not recognize significant renewal commission revenue in the second through fourth quarters of 2015 and do not expect significant renewal commission revenue in the second through fourth quarters of 2016. Renewal commissions for Medicare Advantage products are paid monthly; therefore the majority of renewal commissions for that product will be collected in quarters subsequent to the first quarter.

Three Months Ended March 31, 2016— Our operating activities provided cash of $4.7 million during the three months ended March 31, 2016 and consisted of net income of $18.0 million, increased by non-cash items of $4.9 million and offset by cash used by operating assets and liabilities and other activities of $18.2 million. Adjustments for non-cash items primarily consisted of $3.1 million of depreciation and amortization, including amortization of internally-developed software,
book-of-business consideration and intangible assets and $1.8 million of stock-based compensation expense. Cash used by operating assets and liabilities and other activities primarily consisted of an increase of $10.0 million in accounts receivable, a decrease of $0.2 million in prepaid expenses and other assets, a decrease of $1.3 million in accounts payable, a decrease of $7.7 million in accrued marketing expenses, a decrease of $5.8 million in accrued compensation and benefits, and an increase of $6.9 million in other liabilities primarily due to an increase in tax liabilities. Accounts receivable increased due to recognition of Medicare renewal commissions in the first quarter of 2016, while the Medicare Advantage portion of renewal commissions are collected monthly throughout the year.

Table of Contents

Three Months Ended March 31, 2015—Our operating activities used cash of $11.2 million during the three months ended March 31, 2015 and consisted of net loss of $2.1 million, increased by non-cash items of $5.6 million and offset by cash used by operating assets and liabilities and other activities of $14.7 million. Adjustments for non-cash items primarily consisted of $3.5 million of depreciation and amortization, including amortization of internally-developed software, book-of-business consideration and intangible assets, and $2.0 million of stock-based compensation expense. Cash used by operating assets and liabilities and other activities primarily consisted of an increase of $6.4 million in accounts receivable, an increase of $0.9 million in prepaid expenses and other assets, a decrease of $3.7 million in accounts payable, a decrease of $7.2 million in accrued marketing expenses, an increase in accrued restructuring charges of $1.8 million and an increase in other liabilities of $1.8 million. Accounts receivable increased due to recognition of Medicare renewal commissions in the first quarter of 2015, while the Medicare Advantage portion of renewal commissions are collected monthly throughout the year. Accrued marketing expenses decreased due to payment of the majority of outstanding balances at March 31, 2015.

Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software (including capitalized internally-developed software) to enhance our website and to support our growth.

Three Months Ended March 31, 2016—Net cash used in investing activities of $0.4 million during the three months ended March 31, 2016 was due to the purchase of property and equipment and other assets.

Three Months Ended March 31, 2015—Net cash used in investing activities of $0.4 million during the three months ended March 31, 2015 was due to $0.4 million used to purchase property and equipment and other assets.

Financing Activities

Our financing activities primarily consist of net proceeds from the exercise of common stock options, and cash used to net-share settle equity awards. Additionally, in periods in which we have an active stock repurchase program in effect, our financing activities include repurchases of common stock.

Three Months Ended March 31, 2016—Net cash used in financing activities of $0.3 million during the three months ended March 31, 2016 was primarily due to $0.3 million used to net-share settle the tax obligation related to vesting equity awards.

Three Months Ended March 31, 2015—Net cash used in financing activities of $0.5 million during the three months ended March 31, 2015 was primarily due to $0.5 million used to net-share settle the tax obligation related to vesting equity awards.

Future Needs

We believe that cash generated from operations and our current cash and cash equivalents will be sufficient to fund our operations for at least the next twelve months. Our future capital requirements will depend on many factors, including our level of investment in technology and advertising initiatives. We currently do not have any bank debt, line of credit facilities or other borrowing arrangements. To the extent that available funds are insufficient to fund our future activities, we may need to raise additional capital through public or private equity or debt financing to the extent such funding sources are available.

Contractual Obligations and Commitments

Operating Lease Obligations

We lease our operating facilities and certain of our equipment and furniture and fixtures under various operating leases, the latest of which expires in July 2023. Certain of these leases have free or escalating rent payment provisions. We recognize rent expense on our operating leases on a straight-line basis over the terms of the leases, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

In connection with the Mountain View, California lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced in increments of 25% of the original amount thereof on the first, second and third anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease. The standby letter of credit has since been reduced to $0.3 million.

Table of Contents

Service and Licensing Obligations

We have entered into service and licensing agreements with third-party vendors to provide various services, including network access, equipment maintenance and software licensing. The terms of these services and licensing agreements are generally up to three years. We record the related service and licensing expenses on a straight-line basis, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and certain contractual service and licensing obligations as of March 31, 2016 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2016 (nine months)	$ 3,557	$ 1,678	$ 5,235
2017	4,414	2,051	6,465
2018	3,217	646	3,863
2019	1,046	—	1,046
2020	1,075	—	1,075
Thereafter	2,445	—	2,445
Total	$ 15,754	$ 4,375	$ 20,129

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements, investments in special purpose entities or undisclosed borrowings or debt. Additionally, we are not a party to any derivative contracts or synthetic leases.

Table of Contents

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash and cash equivalents and accounts receivable. As of December 31, 2015 and March 31, 2016, our cash and cash equivalents were invested as follows (in thousands):

	December 31, 2015	March 31, 2016
Cash (1)	$ 8,086	$ 7,055
Money market funds (2)	54,624	59,634
Total cash and cash equivalents	$ 62,710	$ 66,689

(1) We deposit our cash and cash equivalents in accounts with major banks and financial institutions and such deposits are in excess of federally insured limits. We also have deposits with major banks in China that are denominated in both U.S. dollars and Chinese Yuan Renminbi and are not insured by the U.S. federal government.

(2) At December 31, 2015 and March 31, 2016 money market funds consisted of U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

We do not require collateral or other security for our accounts receivable. As of December 31, 2015, three health insurance carriers represented 24%, 18% and 15%, respectively, for a combined total of 57% of our $9.6 million outstanding accounts receivable balance. As of March 31, 2016, two health insurance carrier represented 60% and 11%, respectively, for a combined total of 71% of our $19.6 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2015 and March 31, 2016. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2016. Accordingly, our estimate for uncollectible amounts at March 31, 2016 was not material.

Significant Customers

Substantially all revenue for the three months ended March 31, 2015 and 2016 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three months ended March 31, 2015 and 2016 are presented in the table below:

	Three Months Ended March 31,	
	2015	2016
Humana	34%	33%
UnitedHealthcare (1)	9 %	10%
Aetna (2)	9 %	11%

(1) UnitedHealthcare includes other carriers owned by UnitedHealthcare.
(2) Aetna also includes other carriers owned by Aetna.

Foreign Currency Exchange Risk

To date, substantially all of our revenue has been derived from transactions denominated in United States Dollars. We have exposure to adverse changes in exchange rates associated with operating expenses of our foreign operations, which are denominated in Chinese Yuan Renminbi. Foreign currency fluctuations have not had a material impact

historically on our results of operations; however, there can be no assurance that future fluctuations will not have material adverse effects on our results of operations. We have not engaged in any foreign currency hedging or other derivative transactions to date.

Table of Contents

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures pursuant to Rules 13a-15(b) and 15d-15(b) under the Securities Exchange Act of 1934, as amended, as of the end of the period covered by this Quarterly Report on Form 10-Q.

Based on management's evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit 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 our management, including our chief executive officer and chief financial officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the three months ended March 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our chief executive officer and chief financial officer, believes that our disclosure controls and our internal control over financial reporting are designed to provide reasonable assurance of achieving their objectives and are effective at the reasonable assurance level. However, our management does not expect that our disclosure controls or our internal control over financial reporting will prevent all errors and all fraud. 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. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of a simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls. 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; over time, controls may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

Table of Contents

PART II
OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We also have become, and may in the future become, involved in litigation in the ordinary course of our business.

On January 26 and March 10, 2015, two purported class action lawsuits were filed against us, our chairman and chief executive officer, Gary L. Lauer (“Mr. Lauer”), and our senior vice president and chief financial officer, Stuart M. Huizinga (“Mr. Huizinga”), in the United States District Court for the Northern District of California. On May 6, 2015, the court consolidated the two cases. On June 10, 2015, a consolidated complaint was filed. The consolidated complaint alleges that the defendants made false and misleading statements regarding the Company’s financial performance, guidance and operations during an alleged class period of May 1, 2014 to January 14, 2015. The consolidated complaint alleges that we and Messrs. Lauer and Huizinga violated Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 and Rule 10b-5 promulgated thereunder. The consolidated complaint seeks compensatory damages, attorneys’ fees and costs, rescission or a rescissory measure of damages, equitable/injunctive relief and such other relief as the court deems proper. On July 15, 2015, defendants moved to dismiss the consolidated complaint. On March 14, 2016, the court entered an order granting the defendants' motion to dismiss the consolidated complaint with leave to file an amended consolidated complaint within 30 days, which was later extended to April 27, 2016. On April 27, 2016, plaintiff did not file an amended complaint but filed a notice of submission to the court's order dismissing the consolidated complaint. We believe the lawsuit to be without merit and intend to vigorously defend ourselves against it.

In May 2015 an individual plaintiff filed a lawsuit against a health insurance carrier and us in state court in the state of Texas. The complaint alleged that we and the health insurance carrier engaged in certain false, misleading and deceptive acts and/or omissions in violation of the Texas Deceptive Trade Practice - Consumer Protection Act in connection with the plaintiff’s purchase of the health insurance carrier’s health insurance product. The complaint sought economic and actual damages for alleged harm caused to the plaintiff as well as multiple damages, exemplary damages and attorney’s fees and costs. In June 2015, we and the health insurance carrier removed the case to the United States District Court for the Eastern District of Texas, and the court ordered the plaintiff to file an amended complaint. The plaintiff filed the amended complaint in July 2015. The amended complaint purports to be a class action lawsuit on behalf of the purchasers of a certain health insurance product offered by the health insurance carrier. The amended complaint alleges that we and the health insurance carrier engaged in certain false, misleading and deceptive acts and/or omissions in violation of the Texas Deceptive Trade Practice - Consumer Protection Act, or DTPA, and the Texas Insurance Code in connection with the sale of the health insurance carrier’s health insurance product. The amended complaint alleges certain other causes of action against the health insurance carrier. The amended complaint seeks economic and actual damages, multiple damages, exemplary damages, interest, attorney’s fees and costs, and specific performance. We filed a cross-claim against the health insurance carrier under the DTPA alleging that the health insurance carrier is required to indemnify us or contribute to any damages we are required to pay the plaintiff and for attorney’s fees. In August 2015, we and the health insurance carrier moved to dismiss the claims in the amended complaint. In January 2016, our motion to dismiss the amended complaint was denied. In April 2016, we entered into a settlement agreement with the plaintiff, pursuant to which the plaintiff released his individual claims against us for an immaterial amount. In May 2016, the court entered an order dismissing with prejudice all of the individual plaintiff’s claims against us.

Table of Contents

ITEM 1A. RISK FACTORS

In addition to other information in this Quarterly Report on Form 10-Q and in other filings we make with the Securities and Exchange Commission, the following risk factors should be carefully considered in evaluating our business as they may have a significant impact on our business, operating results and financial condition. If any of the following risks actually occurs, our business, financial condition, results of operations and future prospects could be materially and adversely affected. Because of the following factors, as well as other variables affecting our operating results, past financial performance should not be considered as a reliable indicator of future performance and investors should not use historical trends to anticipate results or trends in future periods.

Risks Related to Our Business

Changes and developments in the health insurance industry or in the health insurance system in the United States as a result of health care reform could harm our business.

Our business depends upon the private sector of the United States health insurance system, its relative role in financing health care delivery and health insurance carriers' use of, and payment of commissions to, agents and brokers to market health insurance plans. In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the industry in which we operate in substantial ways. Among several other provisions, health care reform includes a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer their employees group health insurance coverage or face tax penalties; requirements relating to employer contribution to employee health coverage; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; prohibitions on rescission of health insurance; prohibitions on lifetime coverage limits; requirements for guaranteed renewability of health insurance plans; health insurance premium setting guidelines; limitations on deductibles and cost-sharing; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality and, if they do not, to provide rebates to policyholders; minimum benefit levels for health insurance plans, including actuarial value standards and limitations on annual coverage limits; taxes and assessments on health insurance carriers; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for the purchase of individual and family health insurance; assistance for member run health insurance issuers; creation of multi-state health insurance plans to be offered on the exchanges and with oversight from the Office of Personnel Management; requirements for uniform disclosure relating to the costs and benefits of health insurance; government subsidized high risk pools; an expansion of Medicaid so that more individuals will be insured under state Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels. Many of the significant aspects of health care reform went into effect in 2014, although certain provisions were effective prior to 2014, such as medical loss ratio requirements for individual and family and small business health insurance and a requirement that persons 26 years of age and younger be able to stay on a parent's health insurance plan. Health care reform legislation required various departments of the executive branch to adopt regulations implementing its provisions. In addition, state governments have adopted, and will continue to adopt, changes to their existing laws and regulations in light of federal health care reform legislation and regulations. The implementation of health care reform has increased and could further increase our competition and could reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals, families or small businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause a substantial reduction in our membership and revenue; cause us to incur increased expense across our business and cause health insurance carriers to further reduce our commissions and other amounts they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. In addition, various aspects of

health care reform have caused and could continue to cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to reduce or eliminate the commissions we receive from them on the sale of health insurance plans, to exit the business of selling insurance plans in a particular jurisdiction, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower or no commissions, any of which could materially harm our business, operating results and financial condition.

Beginning in 2014, health insurance carriers offering coverage in the individual or small business health insurance market must ensure that such coverage meets certain actuarial value standards, includes certain minimum health benefits and is not subject to lifetime or, for most health insurance benefits, annual dollar amount coverage limits. Moreover, health insurance carriers cannot deny individuals health insurance for health reasons. Individuals also are required to hold plans providing minimum essential coverage to meet the mandate for health insurance and avoid a tax penalty. The cost of health insurance has generally increased and several health insurance carriers have indicated that they are suffering financial losses in their

Table of Contents

individual and family health insurance businesses, particularly with respect to their sale of qualified health plans offered through government-run health insurance exchanges. As a result, certain health insurance carriers have announced plans to and could exit the business of selling individual and family health insurance in certain markets or altogether. Moreover, in the jurisdictions where they continue to sell individual and family health insurance, we anticipate that premiums for individual and family health insurance will generally increase, perhaps substantially. If the cost of health insurance increases or if carriers exit the business of selling qualified health plans or individual and family health insurance in general, we could experience a reduction in demand for the individual and family health insurance that we sell, which could cause us to suffer a substantial reduction in our membership, and materially harm our business, operating results and financial condition. Moreover, compared to the increased cost of individual and family health insurance plans, government subsidies to purchase health insurance and the health care reform tax penalty may not be sufficient enough to drive a substantial number of new entrants into the individual and family health insurance market or incentivize our existing members to maintain their individual and family health insurance plans, which could contribute to a decline in our membership and materially harm our business, operating results and financial condition.

If we are not successful in retaining our existing members and enrolling a large number of individuals and families into individual and family health insurance plans during the health care reform open enrollment period, our business will be harmed.

As a result of health care reform, individual and family health insurance is required to be purchased during an open enrollment period. The most recent open enrollment period for individual and family health insurance began on November 1, 2015 and ended on January 31, 2016 for coverage effective in 2016. Outside of the open enrollment period, individuals and families can only purchase new or change their existing individual and family health insurance if they qualify for a special enrollment period, which requires certain qualifying events such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance. Our revenue depends in large part on the number of paying individual and family health insurance members we are successful in retaining and the number of individual and family health insurance members we acquire during the health care reform open enrollment period. We may not be successful in retaining or acquiring individual and family health insurance plan members for a number of reasons. If we are unsuccessful, our business, operating results and financial condition would be harmed. For example, we have experienced increased member attrition rates since the implementation of health care reform. We also experienced lower than expected individual and family health insurance application volumes during the last two open enrollment periods. These circumstances have resulted in lower individual and family health insurance plan membership. Open enrollment periods of limited duration in the individual and family health insurance markets have resulted, and may in the future result in a reduction in our membership and revenue; an increase in our expenses, particularly during the open enrollment periods; and otherwise may harm our business, operating results and financial condition, particularly given that the open enrollment period for individual and family health insurance overlaps with the annual enrollment period for the Medicare plans that we sell.

It may be difficult for the health insurance agents we employ and our systems and processes to handle as a business the increased volume of health insurance transactions that occur in a short period of time during the health care annual open enrollment period and/or the Medicare annual enrollment period. We hire a significant number of additional employees on a temporary or seasonal basis in a limited period of time to address the expected increase in the volume of health insurance transactions during the Medicare annual enrollment period. We must ensure that these employees are timely licensed, trained and certified and have the appropriate authority to sell health insurance in a number of states. We depend upon state departments of insurance, government exchanges and health insurance carriers for the licensing, certification and appointment of our health insurance agent employees. If our ability to market and sell individual and family health insurance or Medicare-related health insurance is constrained during an enrollment period for any reason, such as technology failures, reduced allocation of resources, any inability to timely license,

train, certify and authorize our employees to sell health insurance, interruptions in the operation of our website or systems, or issues with government-run health insurance exchanges, we could suffer a reduction in our membership and our business, operating results and financial condition could be harmed. In addition, we have reduced our employee and other resources as a part of expense reduction measures. Our expense reductions measures have negatively impacted the resources that we dedicate to the sale of individual and family health insurance, have caused us to sell less individual and family health insurance, and could harm our business, operating results and financial condition in the future.

If investments we make in enrollment periods do not result in a significant number of paying members, our business, operating results and financial condition would be harmed.

In an attempt to attract and enroll a large number of individuals during the Medicare annual enrollment period and the health care reform open enrollment period, we may invest in areas of our business, including technology and content, customer care and enrollment, and marketing. During 2014, our technology and content expense increased as a result of our investment

Table of Contents

in our technology platform. We also increased staffing in our customer care center in anticipation of higher demand and application volume during the open enrollment period for coverage effective 2015. Despite our investment in these and other areas, our individual and family health insurance membership declined. While we may not determine to invest heavily in the health care reform open enrollment period, any investment we make in either the Medicare annual enrollment period or the health care reform open enrollment period may not result in a significant number of paying members. If it does not, our future profitability will be negatively impacted and our business, operating results and financial condition would be harmed.

Our business may be harmed if we are not successful in enrolling subsidy-eligible individuals through government-run health insurance exchanges.

As a part of health care reform, each state is required to implement a health insurance exchange where individuals and small businesses can purchase health insurance. For states that do not implement a health insurance exchange, the federal government has implemented and is operating the exchange for that state. The Federally-Facilitated Marketplace, or FFM, operated some part of the health insurance exchange in 37 states for the open enrollment period that began November 1, 2015 and ended on January 31, 2016. It may operate the health insurance exchange for a fewer or greater number of states in the future. Beginning in 2014, individuals and families whose incomes are between 133% and 400% of the federal poverty level are generally entitled to subsidies in connection with their purchase of health insurance. A federal regulation promulgated under the Patient Protection and Affordable Care Act clarifies that states may, but are not required to, allow agents and brokers such as us to market the qualified health plans offered on government-run health insurance exchanges and that are the plans that subsidy-eligible individuals must purchase in order to receive their subsidies. In order to offer qualified health plans, agents and brokers must meet certain conditions, such as receiving permission to do so from the health insurance exchange, entering into an agreement with the health insurance exchange, ensuring that the enrollment and subsidy application is completed through the state's health insurance exchange (or the FFM in states that did not establish their own exchange) and complying with privacy, security and other standards, some of which have been recently issued and contain requirements that are new to us. In the event Internet-based agents and brokers such as us use the Internet for completion of qualified health plan selection purposes, their websites are required to meet certain additional conditions, such as compliance with standards for display of health plan and related information; providing consumers the ability to view all health plans offered on the government-run exchange; displaying certain health plan and other data available on the exchange; and providing a mechanism for consumers to withdraw from the application process on the agent or broker's website. A large segment of the population is eligible for subsidies in connection with the purchase of health insurance, and a substantial number of our existing members may be eligible for subsidies. We have determined to focus on enrolling individuals in qualified health plans through FFM as opposed to states operating their own health insurance exchanges. As a result, we may lose existing members who reside in states not supported by FFM and may not gain new subsidy-eligible members in those states, which could harm our business, operating results and financial condition. In addition, we may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members and in enrolling them through the FFM and other government-run health insurance exchanges should we determine to offer qualified health plans through those other exchanges. If we are not able to satisfy these conditions and requirements, or if we are not able to successfully adopt and maintain solutions that allow us to enroll large numbers of individuals and families in qualified plans over the Internet both during and outside of open enrollment periods, we will lose existing members and new members, and may incur additional expense, which would harm our business, operating results and financial condition.

In order to sell qualified health plans to subsidy eligible individuals during the open enrollment period, we must establish and maintain relationships with government-run health insurance exchanges, particularly the FFM, and given that at least a part of the qualified health insurance plan enrollment process must occur through the health insurance exchanges, we must maintain our technology platform to be able to enroll consumers in qualified health plans through

the FFM in a scalable manner. If we are not able to adopt and maintain solutions to integrate with government-run health insurance exchanges or if the health insurance exchange websites and other processes are not consumer friendly, efficient and compatible with the process we have developed for enrolling individuals and families into qualified health plans through the exchanges, we would not be successful in retaining and acquiring members, and our business, operating results and financial condition would be harmed. CMS has broad authority of the requirements that we must meet in order to enroll individuals into qualified health plans through the FFM, and in addition to issuing new requirements, has the authority to interpret existing requirements. For example, CMS directed us to alter our method of enrolling subsidy eligible individuals into qualified health insurance plans beginning in February 2016. The change required us to cease using the online process we developed for enrolling individuals into qualified health plans through the FFM and use a prescribed FFM process. As a result of the changes that we made to our online process in response to CMS requirements, we experienced a reduction in the rate at which individuals and families starting the application process for qualified health plan and subsidies became members. The FFM may not improve the process to a significant degree for the upcoming open enrollment period, and if it does not do so, we may have difficulty enrolling, and may not be able to enroll, individuals in qualified health plans in an efficient and scalable manner both during and outside of the annual open enrollment period and our number of qualified health plan enrollments could decline, which

Table of Contents

would result in our loss of existing members and new potential members, a reduction in our individual and family health insurance plan membership and harm our business, operating results and financial condition. While CMS has indicated that it is investigating whether it will make changes to the prescribed FFM process, any adopted changes may not be effective and CMS may be unwilling or unable to make changes in time for the upcoming open enrollment period or at all, which would harm our ability to enroll individuals in qualified health plans and our business, operating results and financial condition. We may also be required to incur additional expense in enrolling subsidy eligible individuals in qualified health plans which would increase our cost of acquisition. In addition, health insurance exchange websites, systems and infrastructure must be operational and not suffer significant outages or technical problems as a result of the number of individuals attempting to enroll in qualified health plans or for other reasons. If exchanges experience these problems, particularly the FFM, we would not be successful in retaining and acquiring new individual and family health insurance plan members, and our business, operating results and financial condition would be harmed.

We have entered into agreements with CMS relating to our ability to enroll individuals in qualified health plans through the FFM. The agreements contain comprehensive privacy and security and other requirements. In order to be able to enroll individuals into qualified health plans, we also must satisfy several other regulatory requirements and comply with additional laws and regulations. There are risks and uncertainties relating to our ability to enroll individuals into qualified health plans online through the FFM. Among other things, we must maintain our agreements with the FFM which need to be renewed every year; satisfy the requirements contained in the relevant agreements as well as applicable laws and regulations; maintain a compliant Internet platform incorporating those requirements; maintain qualified health plan information from health insurance carriers and CMS and incorporate it into our web platform; maintain a privacy and security program to conform to the privacy and security requirements of our agreement with CMS as well as applicable laws and regulations; and adopt and maintain solutions to integrate with the FFM so that information may be passed to and from us relating to enrollment in qualified health plans and subsidy eligibility. These requirements are evolving. For example, we are required to translate significant portions of our website into Spanish for the next open enrollment period in certain jurisdictions in order to be able to offer qualified health plans to individuals in states where greater than 10% of the state's population is Spanish speaking (currently California and Texas), and we may not be able to meet this requirement and be able to offer qualified health plans in those states. Our ability to maintain compliance with the various requirements to enroll individuals through the FFM has presented, and could in the future present, significant challenges for us. If we are not successful in these regards, we will not be successful in enrolling individuals and families into qualified health plans, which would harm our business, operating results and financial condition. We also depend upon the Federal government for a number of things relating to our ability to enroll individuals online into qualified health plans through the FFM, including certain qualified health plan information that is required under the applicable regulations to be displayed on our website. In addition, the FFM may at any time cease allowing us to enroll individuals in qualified health plans or change the requirements for doing so and must allocate resources to ensuring, and otherwise ensure, that its technology platform functions properly to enroll individuals online with an adequate customer experience and that results in our receiving credit for enrollments so that we may be paid a commission. We also depend on the FFM to maintain and permit us to use certain access points to the FFM in order for us to be able to assist individuals in applying for subsidies and enrolling in qualified health plans online. If the FFM does not maintain or permit us to use these access points, if the FFM changes them so that the technology we developed to integrate with the FFM does not work or results in errors, if CMS requests further changes to our online process for enrolling individuals into qualified health plans, or if our technology and website or the FFM's technology or website do not function or work together properly to allow us to assist with subsidy applications and enroll large numbers of individuals into qualified health plans in a short period of time, our business, operating results and financial condition would be harmed, particularly if we were not able to scalably and efficiently enroll individuals into qualified health plans online during the open enrollment period for individual and family health insurance. In addition, instability or changes to either the FFM website, particularly the portions used by consumers who are referred by agents and brokers, or other FFM operations relating to agent and broker assisted enrollment in qualified health plans, could negatively impact our ability to retain existing members and

add new members. A negative impact to our ability to retain existing members and add new members would harm our business, operating results and financial condition.

While the FFM has developed a platform that we can use to assist individuals and families in applying for subsidies and enrolling in qualified health plans online, none of the states that operate their own health insurance exchanges have developed this capability. As a result, while we have assisted subsidy eligible individuals in applying for qualified health insurance plans in non-FFM states, we are not able to do so entirely online. If these state exchanges do not adopt processes and technology that allow us to assist subsidy-eligible individuals in enrolling through these exchanges over the Internet and without use of health insurance agents in our customer care centers, we will not be able to effectively enroll subsidy eligible individuals in these states, and our business, operating results and financial condition will be harmed.

In part to attempt to satisfy the conditions necessary for us to use our Internet technology platform to enroll individuals into qualified health plans as a health insurance agent, and assist individuals in applying for subsidies through government-run health insurance exchanges, we have incurred significant operating expenses. The operating expenses that we

Table of Contents

incur may not result in increased revenue for a number of reasons both within and outside of our control. If our revenue does not offset our costs and operating expenses, our financial condition and results of operations could be negatively affected. For instance, we incurred significant technology and content expense in part to develop the capability to enroll individuals into qualified health insurance plans through exchanges. Despite our investment in this regard, our individual and family health insurance plan membership has declined. Furthermore, CMS has recently directed us to make changes to that process. If we are not successful in leveraging our technology to enroll subsidy-eligible individuals through the FFM in a scalable and efficient manner, do not successfully adopt solutions that enable online enrollment through government-run health insurance exchanges in an ecommerce friendly experience, or either we or the government-run exchanges experience technical or other problems in connection with the enrollment of individuals in qualified health plans, we will lose existing members and new members or may not receive commissions for the plans that we sell through the government-run exchanges. We have also reduced headcount and other expenses across our business. We anticipate this reduction, implemented in March 2015, will make it more difficult for us to enroll individuals through health insurance exchanges and otherwise, which could result in a reduction in our membership and our commission revenue.

We depend upon health insurance carriers and government-run health insurance exchanges to adopt and maintain systems and processes that can handle sales of individual and family health insurance outside of the open enrollment period to those who qualify for special enrollment periods, which may include systems and processes that verify whether individuals and families are permitted to purchase individual and family health insurance outside of the open enrollment period. The failure of health insurance exchanges to develop these systems and processes has negatively impacted our ability to sell qualified health plans using our technology platform outside of the open enrollment period. If these systems and processes are not developed, are not maintained or are not compatible with our platform and processes for selling individual and family health insurance, our ability to sell individual and family health insurance outside of the open enrollment period will be negatively impacted, which could harm our business, operating results and financial condition, particularly given that we have reduced headcount relating to our ability to sell individual and family health insurance and will need to rely more on our technology to do so. In addition, CMS recently announced that it was eliminating certain exceptions that would allow individuals and families to enroll in health insurance during a special enrollment period and that individuals and families will be subject to increased verification of the grounds for any special enrollment period that they claim, which could reduce the number of individuals and families that are able to purchase health insurance in special enrollment periods and harm our business, operating results and financial condition.

If we do not successfully compete with government-run health insurance exchanges, our business may be harmed.

We compete with government-run health insurance exchanges, among others. Among other things, the exchanges may elect whether or not we are able to enroll subsidy-eligible individuals in qualified health plans through them and determine the manner in which we may do so. The exchanges have websites where individuals and small businesses can shop for and purchase health insurance, and they also have offline customer support and enrollment capabilities. Individuals who are eligible for government subsidies in the form of premium tax credits and cost sharing reductions must apply for their subsidy and purchase qualified health plans through a government exchange to receive their subsidy. In the aggregate, government exchanges have greater resources, larger marketing budgets and greater public outreach capability than we do. They may also impact the process we use to enroll individuals and families through them in a manner that results in a reduction of the individuals and families that we are able to enroll through exchanges. Government exchanges may invest heavily in paid search advertising to a degree that increases paid search advertising cost for health insurance related Internet search terms. In addition, individuals that utilize our platform and services to apply for subsidies and health insurance through government exchanges receive marketing and communications from the government exchanges after they do so. In the event our existing members purchase health insurance directly through health insurance exchanges without using us as their health insurance agent, as a result of their being eligible for a subsidy or otherwise, we will no longer receive commission revenue as a result of our sale of

health insurance to them. The exchanges also compete with us for new members, and under regulations adopted as a part of health care reform, government-run health insurance exchanges are required to automatically re-enroll individuals and families into a qualified health insurance plan purchased through the exchange if the individuals or families do not take affirmative action, which may inhibit our ability to grow our membership. Competitive pressure from government-run health insurance exchanges has resulted, and may in the future result, in our experiencing increased marketing costs, decreased traffic to our website, a reduction in our individual and family health insurance membership and revenue and may otherwise harm our business, operating results and financial condition.

Our revenue will be adversely impacted if commission rates decline or if consumers choose health insurance products for which we receive lower or no commissions.

Table of Contents

Our revenue will be adversely impacted if our commission rates decline. The commission rates we receive are impacted by a variety of factors, including the particular health insurance plans chosen by our members, the carriers offering those plans, our members' states of residence, the laws and regulations in those jurisdictions, the average premiums of plans purchased through us and health care reform. Our commission revenue per member has in the past decreased, and could in the future decrease, as a result of either reductions in contractual commission rates, unfavorable changes in health insurance carrier override commission programs, or the mix of carriers whose products we sell during a given period, all of which are beyond our control and may occur on short notice. To the extent these and other factors cause our commission revenue per member to decline, our revenue may decline and our business, operating results and financial condition would be harmed.

Our revenue will be adversely impacted if consumers enroll in Medicare or individual and family health insurance plans that reduce our average commission revenue per member. Due in part to health care reform, some health insurance carriers have exited or reduced individual and family health insurance selling efforts in certain markets, leading to changes in the health insurance carrier composition of our commission revenue. Since our commission rates vary by carrier, a shift in the mix of products selected by our new members will have an impact on our average commission revenue per member. Some health insurance carriers, including large national health insurance carriers, have recently reduced or eliminated our commission rates for individual and family health insurance products because they no longer want us to sell them. As a result, we may elect not to offer those carriers' individual and family health insurance products for sale on our website. Any reduction in the supply of the individual and family health insurance offered on our website may adversely impact demand for the individual and family health insurance we sell, and if individuals and families do not purchase health insurance through us as a result of these circumstances, our business, operating results and financial condition would be harmed. While health insurance carriers that have reduced or eliminated individual and family health insurance commissions have generally informed us that they anticipate paying us commissions for individual and family health insurance that we sell during the upcoming open enrollment period, if they do not do so or if they do not increase our commission rates to pre-reduction levels, our business, operating results and financial condition would be harmed. In addition, we are required to display or provide access to all qualified health insurance plans available through the FFM in our individual and family health insurance shopping process regardless of whether we receive commissions for the sale of those plans. If consumers choose health insurance products for which we receive lower or no commissions, our commission revenue per member could decline and our business, operating results and financial condition would be harmed.

Given that Medicare related and individual and family health insurance purchasing is concentrated during the annual open enrollment periods, a reduction in our average commission revenue per member could occur over a short period of time and could adversely impact our revenue in future periods, which would harm our business, operating results and financial condition.

Our business may be harmed if we lose our relationship with health insurance carriers or our relationship with health insurance carriers is modified.

We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers also may amend the terms of our agreements unilaterally on short notice. Carriers may be unwilling to allow us to sell their existing or new health insurance plans, or desire to amend our agreements with them, for a variety of reasons, including for competitive or regulatory reasons, dissatisfaction with the economics of the members that we place with them or because they do not want to be associated with our brand. We may also terminate our relationship with health insurance carriers. In addition, many aspects of health care reform have caused, and may in the future cause, carriers to modify their relationship with us given the substantial changes in the industry in which we operate. For instance, in addition to the medical loss ratio requirements, health care reform contains taxes and assessments on health insurance carriers that may make their businesses less profitable. Carriers may choose to exclude us from their most profitable or

popular plans or may determine not to distribute health insurance plans in the Medicare, individual and family and small business markets in certain geographies or altogether. A small number of health insurance plans have limited our relationship with them so that we are able to only sell their qualified health plans through government-run health insurance exchanges and do not permit us to sell their individual and family health insurance plans outside of those exchanges. In the event we are not successful in gaining or maintaining the ability to sell Medicare, individual and family and qualified health insurance plans, if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans or if health insurance carriers change our relationship with them in other ways, we could lose a substantial number of existing and potential members and commission revenue, which would materially harm our business, operating results and financial condition. The termination of our relationship with a health insurance carrier by us or the health insurance carrier or the amendment of or change in our relationship with a carrier could reduce the variety of health insurance plans we offer or have other adverse impacts, which could harm our business, operating results and financial condition. It also could adversely impact, or cause the termination of, commissions for past and future sales, which would materially harm our business, operating results and financial condition. Our business could also be harmed if in the future we

Table of Contents

fail to develop new carrier relationships and are unable to offer consumers a variety of health insurance plans in each jurisdiction.

Several health insurance carriers have recently publicly indicated that they are suffering losses in their individual and family health insurance businesses as a result of the impact of health care reform and have recently reduced or eliminated our individual and family health insurance commissions for new sales of individual and family health insurance products. While certain health insurance carriers have indicated that they plan to increase commission rates for individual and family health insurance sold in the open enrollment period, they are not obligated to do so and may determine not to increase commission rates or may pay no commissions for the sale of individual and family health insurance during the open enrollment period. If they do not increase commission rates to levels that existed prior to the reductions, our business, operating results and financial condition could be materially harmed. In addition, the reduction in contractual commission rates and these carriers' desire to not sell individual and family health insurance outside of the open enrollment period will reduce the plans that we are able to offer on our websites, which could result in less consumer demand for the individual and family health insurance that we sell, a reduction in our membership and harm our business operating results and financial condition. Additionally, in the future and as a result of health care reform or for other reasons, an increasing number of health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels, including in-house agents and carrier websites, to sell their own plans, determine not sell individual and family health insurance or otherwise limit or prohibit us from selling their plans on their ecommerce platforms. In addition to reducing commission rates, health insurance carriers have ceased and may in the future cease selling qualified health plans or individual and family health insurance in certain markets or altogether. They may also determine to exit the individual and family health insurance business in certain states or increase premiums to a significant degree, which could cause our members' health insurance to be terminated or our members to purchase new health insurance. If we lose these members, our business, operating results and financial condition could be harmed. In addition, a reduction in the individual and family health insurance products that we are able to offer as a result of carriers exiting the market in certain geographies or altogether, could adversely impact demand for our services and a reduction in our membership, which would harm our, business, operating results and financial results.

Significant consolidation in the health insurance industry could alter our relationships with carriers and harm our business and financial results

The health insurance industry in the United States has experienced a substantial amount of consolidation, resulting in a decrease in the number of health insurance carriers. Significant additional consolidation may occur given the proposed acquisition of Humana by Aetna and the proposed acquisition of Cigna by Anthem. Consolidation in the health insurance industry could cause a loss of or changes in our relationship with carriers and reduction in our commission or other revenue, which could harm our business, operating results and financial condition. In the future, we may be forced to offer health insurance from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. Revenue derived from Humana represented approximately 34% and 33% of our total revenue in the three months ended March 31, 2015 and 2016, respectively. Revenue derived from carriers owned by UnitedHealthcare represented approximately 9% and 10% of our total revenue in the three months ended March 31, 2015 and 2016, respectively. Revenue derived from carriers owned by Aetna represented approximately 9% and 11% of our total revenue in the three months ended March 31, 2015 and 2016, respectively. We have several agreements that govern our sale of health insurance plans with these health insurance carriers. They may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact or cause the termination of the commission payments that we receive from these health insurance carriers, including commissions on plans that we have already sold, which could materially harm our business, operating results and financial condition. Our revenue could be adversely impacted if we are unable to maintain currently-existing levels of business with any of our significant health insurance carriers if we are unable to offset any loss of business with alternative health insurance

carriers. We expect that a small number of health insurance carriers will account for a significant portion of our revenue for the foreseeable future and any impairment of our relationship with, or the material financial impairment of, these health insurance carriers could adversely affect our business.

Our business may be harmed if certain aspects of the Patient Protection and Affordable Care Act that are beneficial to our business are successfully challenged and held unenforceable by the courts or if the Patient Protection and Affordable Care Act is changed as a result of elections.

A number of lawsuits have been filed challenging various aspects of the Patient Protection and Affordable Care Act and related regulations. In the event these lawsuits are successful and result in the unenforceability of aspects of the law or regulations that are beneficial to our business or cause changes in the health insurance industry that are adverse to our business, our business, operating results and financial condition could be harmed. In addition, the efficacy of the Patient Protection and

Table of Contents

Affordable Care Act is the subject of much debate among members of Congress and the public. Efforts to date to amend or repeal the law have generally been unsuccessful as a result of the balance of power in Congress and the President's veto power. However, the upcoming Presidential election and future Congressional elections may result in the election of individuals that have different views with respect to health care reform compared to the current administration and Congress. If the Patient Protection and Affordable Care Act is amended or repealed as a result of any change in the balance of power in Congress or as a result of the election of a new President, such amendment or repeal could harm our business, operating results and financial condition. In addition, even if the Patient Protection and Affordable Care Act is not amended or repealed, the President and the executive branch of the Federal government have a significant impact on the implementation of the provisions of the law, and the new President's administration could make changes impacting the implementation of the Patient Protection and Affordable Care Act, which could harm our business, operating results and financial condition.

Our future operating results are likely to fluctuate and could fall short of expectations.

Our operating results are likely to fluctuate as a result of a variety of factors, including the factors described elsewhere in this Risk Factors section, many of which are outside of our control. As a result, comparing our operating results on a period-to-period basis may not be meaningful and you should not rely on our past results as an indication of our future performance, particularly in light of the fact that our business and industry are undergoing substantial change as a result of health care reform. If our revenue or operating results differ from our guidance or fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially. In the past, when our revenue and operating results differed from our guidance and the expectations of investors or securities analysts, the price of our common stock was impacted.

Our business model is characterized primarily by revenue based on commissions we receive from insurance carriers whose policies are purchased by our members. For both Medicare Advantage and Medicare Part D prescription drug plans, we record commission revenue on an annual basis but may receive commission payments from insurance carriers on either a monthly or annual basis typically for a period of at least six years, depending on the carrier arrangement, provided that the policy remains active with us and we remain the agent on the policy. We receive commissions and record related revenue for an individual and family, small business, ancillary or Medicare Supplement health insurance policy, typically on a monthly basis, until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. A significant component of our marketing and advertising expenses consists of expenses incurred in search engine advertising at the time a consumer clicks on an advertisement and payments owed to our marketing partners in connection with applications submitted on our ecommerce platforms by potential members referred to us by our marketing partners. As a result of any timing difference between expense and associated revenue recognition, our operating results and cash flows may be adversely affected in periods where we experience a significant increase in new applicants. For example, the Medicare annual enrollment period and the implementation of health care reform open enrollment periods for individual and family health insurance have in the past caused a substantial number of health insurance applications to be submitted through us in a short period of time and a substantial increase in marketing and advertising expenses. Because commission revenue related to any submitted applications that result in paying members is not recognized until future periods, the marketing and advertising expense associated with the submitted applications has a negative impact on operating results and cash flows in the period in which the submitted applications were received. In addition, if we incur other unanticipated or one-time expenses in a particular quarter, lose a significant amount of our member base for any reason or our commission rates are reduced, through a change in the health insurance products chosen by our members, carrier reduction in our commission rates or otherwise, the impact of our incurring increased marketing and advertising expenses would be especially pronounced and we would likely be unable to offset these expenses by increasing sales within that quarter or to replace lost revenue in the quarter with revenue from new members and our business, operating results and financial condition would be harmed.

41

Table of Contents

Seasonality may cause fluctuations in our financial results.

The seasonality of our business is outside of our control. For example, the health care reform open enrollment period has changed the seasonality of our individual and family health insurance business. Since the fourth quarter of 2013, we have experienced a greater number of individual and family health insurance submitted applications in the fourth quarter and first quarter and a lower number of submitted applications in the second and third quarter of the year compared to periods prior to the introduction of open enrollment periods. The seasonality in our business could change in the future for a number of reasons, including as a result of changes in timing of the Medicare or individual and family health plan annual open enrollment periods and changes in, and the enforceability of, the laws and regulations that govern the sale of health insurance. We may not be able to timely adjust to changes in the seasonality of our business. For example, if the timing of the open enrollment periods for Medicare-related health insurance or individual and family health insurance change, we may not be able to timely adapt to changes in customer demand. If we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed. Additional information regarding the seasonality in our business is included in Part I, Item 1 Business and Item 7 Management's Discussion and Analysis of Financial Condition and Results of Operations and elsewhere in the Annual Report on Form 10-K.

Our revenue will be adversely impacted if our membership does not grow or if we are unable to retain our existing members.

Our estimated individual and family health insurance plan membership has declined substantially since the implementation of health care reform. Our revenue has been, and will continue to be, adversely impacted if our membership does not grow. We receive revenue from commissions health insurance carriers pay to us for health insurance policies sold through our ecommerce platform. When one of these policies is canceled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission revenue. Our members may choose to discontinue their health insurance policies for a variety of reasons. For example, our members may replace a health insurance policy purchased through us with a health insurance policy provided by a new or existing employer or may determine that they can no longer afford health insurance. They may also determine that they do not like the benefits and physician network covered under the plan. In addition, our members may choose to purchase new policies through other sources or use a different agent, if, for example, they are not satisfied with our customer service or the health insurance plans that we offer. Our expense reduction measures have impacted the number of our employees dedicated to customer service in our individual and family health insurance business, which could cause a greater number of individuals to be dissatisfied with our customer service. Consumers may also purchase health insurance policies directly from government-run health insurance exchanges, including as a result of the requirement that subsidy-eligible individuals must purchase qualified health plans through government-run health insurance exchanges to be able to receive a subsidy under health care reform, and we would not remain the agent on the policy. Health insurance carriers have in the past and may in the future terminate health insurance plans purchased and held by our members. If we are not successful in transferring members covered under a terminated plan to another policy that we offer, we will lose these members and associated commission revenue. Our cost of acquiring a new member is substantially greater than the cost involved in maintaining our relationship with an existing member. If we are not able to successfully retain existing members and limit member turnover, our revenue and operating margins will be adversely impacted and our business, operating results and financial condition would be harmed. In addition, the Medicare-related commission rates that we receive may be higher in the first calendar year of a policy if the policy is the first Medicare-related policy issued to the member. The individual and family commission rates that we receive are typically higher in the first twelve months of a policy. After the first twelve months, they generally decline significantly. As a result, if we do not add a sufficient number of members on new policies, our revenue will be negatively impacted.

Our operating results fluctuate depending upon CMS regulations, health insurance carrier payment practices and the timing of our receipt of commission reports from health insurance carriers.

The timing of our revenue depends upon the timing of our receipt of commission reports and associated payments from health insurance carriers. There have been instances where the report of commissions and payment has been delayed, such as during holiday periods or as a result of the health care reform open enrollment period. We also have experienced, and may in the future experience, a delay in receiving commission payments and reports as a result of a CMS regulation issued in 2014 prohibiting carriers from paying commissions during the fourth quarter on Medicare Advantage and Medicare Part D prescription drug policies sold during the fourth quarter with an effective date in the following year. Any delay in our receipt of commission payments or reports could materially impact our financial results for a given quarter as we would not be able to recognize the related commission revenue in that quarter. In addition, much of our commission override revenue is not reported and paid to us in accordance with a scheduled pattern, and some is only reported and paid to us once per year. The timing of our revenue recognition could also result in a large amount of commission revenue from a carrier being recorded in a given quarter

Table of Contents

that is not indicative of the amount of revenue we may receive from that carrier in subsequent quarters, causing fluctuations in our operating results. We also could report revenue below the expectations of our investors or securities analysts in any particular period if a material report or payment from a health insurance carrier were delayed or not received within the time frame required for revenue recognition.

The Medicare annual enrollment period and the implementation of open enrollment periods under health care reform for the purchase of individual and family health insurance present a challenge as they require us to enroll a significant number of individuals into health insurance over a limited period of time. Significant increases in enrollment activity over a limited amount of time may also make it difficult for health insurance carriers to timely and accurately report commission information to us. To the extent health insurance carriers have difficulty in reporting timely and accurate commission information to us, we may be unable to recognize revenue in accordance with our revenue recognition policies, which could cause us to defer substantial revenue until such time our health insurance carriers are able to resume reporting timely and accurate commission information to us.

The medical loss ratio requirements that are a part of health care reform may harm our business.

The federal Patient Protection and Affordable Care Act enacted in March 2010 and related amendments in the Health Care and Education Reconciliation Act of 2010 contain provisions requiring health insurance carriers to maintain specified medical loss ratios. The medical loss ratio requirements for both individual and family and small business health insurance became effective in 2011 and, among other things, require health insurance companies to spend 80% of their premium revenue in each of their individual and small group health insurance businesses on reimbursement for clinical services and activities that improve health care quality. The medical loss ratio requirement for Medicare Advantage plans is 85% and went into effect in 2014. If a health insurance carrier fails to meet medical loss ratio requirements, the health insurance carrier is required to rebate a portion of its premium revenue to its members to make up for the difference.

Carrier reaction to the individual and family medical loss ratio requirements was to significantly reduce the commissions we receive in connection with the sale of individual and family health insurance. Health insurance carriers may determine to reduce or further reduce our Medicare Advantage plan, individual and family, or small group commissions as a result of the medical loss ratio requirements or other aspects of health care reform, including any increased expenses in complying with or dealing with the impact of health care reform, which would harm our business, operating results and financial condition. In addition, if health insurance companies fail to meet medical loss ratio requirements, we may be required to pay back commissions that are related to any premium amounts the carriers are required to rebate policyholders as a result, which would harm our business, operating results and financial condition. The medical loss ratio requirements also may cause certain health insurance carriers to limit the geographies in which they sell health insurance or exit certain markets altogether, place less reliance on agents to distribute their plans, or limit their health insurance offerings in any number of other ways, each of which would harm our business, operating results and financial condition. The implementation of medical loss ratio requirements has caused and could further cause health insurance carriers to reduce the amount they are willing to spend in connection with our sponsorship and advertising and technology licensing businesses, which also could harm our business, operating results and financial condition.

Our business may be harmed if we lose our relationship with health insurance carriers whose Medicare-related health insurance products we sell or if our relationship with those carriers changes.

In 2010 we began to actively market the availability of Medicare-related health insurance plans using our ecommerce platforms, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We refer to these plans as Medicare plans. We market Medicare plans to Medicare-eligible individuals, who are predominately senior citizens over the age of 65. The sale of Medicare Advantage and Medicare Part D prescription

drug plans are subject to an annual enrollment period during the fourth quarter of each year, when a substantial percentage of the annual sales of these plans occur. We sell Medicare plans as a health insurance agent using our websites and customer care centers.

Our Medicare plan-related revenue is concentrated in a small number of health insurance carriers. The success of our Medicare-related health insurance business depends upon our ability to enter into new and maintain existing relationships with health insurance carriers on favorable economic terms. The concentration of our Medicare plan sales in a limited number of health insurance carriers makes us vulnerable to changes in carrier commission rates and changes in the competitiveness of our carriers' Medicare products. If our Medicare carriers reduce our commission rates, reduce the amount they pay us for advertising services, or the competitiveness of their products declines compared to original Medicare or the products of Medicare carriers with which we do not have a relationship, our business, operating results and financial condition would be harmed.

Table of Contents

In addition, we may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carriers. For instance, a carrier may terminate our relationship. Moreover, CMS heavily regulates the sale of Medicare Advantage and Medicare Part D prescription drug plans and has and will continue to penalize health insurance carriers for certain regulatory violations by suspending or terminating the carrier's ability to market and sell Medicare plans for significant periods of time. Given the concentration of our Medicare plan sales in a small number of carriers, if we lose a relationship with a health insurance carrier to market their Medicare plans temporarily or permanently for these or any other reasons, our sales as a health insurance agent and Medicare plan related revenue could suffer significantly, and our business, operating results and financial condition would be harmed. The agreements that we have with health insurance carriers to sell Medicare plans may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact, or cause the termination of, the commission payments that we receive for selling their Medicare plans, including commissions on plans that we have already sold, which could materially harm our business operating results and financial condition.

Our business may be harmed if we do not market Medicare plans effectively or if our websites and marketing materials are not timely approved.

Health insurance carriers whose Medicare plans we sell must approve our websites, our marketing material and call center scripts for us to be able to generate Medicare plan demand and sell Medicare plans to Medicare-eligible individuals as a health insurance agent. These marketing materials also must be filed with CMS. In addition, we use Medicare plan cost and benefit data collected and made publicly available by CMS. In the event that CMS or a health insurance carrier disapproves, or delays approval, of our websites, our marketing material or call center scripts, or if CMS does not timely release Medicare plan cost and benefit data for the following year’s Medicare plans prior to the annual enrollment period, we could lose a significant source of Medicare plan demand and our ability to sell Medicare plans would be adversely impacted, each of which would harm our business, operating results and financial condition. CMS recently broadened its interpretation of rules and regulations relating to Medicare plan-related marketing material so that they apply to websites that we did not previously need to submit to health insurance carriers for approval and file with CMS. This broadened interpretation also applies the same approval and filing process to marketing material of our marketing partners. If we are not successful in timely submitting these marketing materials to health insurance carriers for approval, in gaining that approval and in filing the marketing material with CMS, our Medicare plan marketing could become less effective, which would harm our business, operating results and financial condition. Further, if a marketing partner of ours does not consent to having its website or other marketing material filed with the CMS, does not make changes required by carriers or CMS or does not comply with the CMS marketing guidelines or other Medicare program related laws, rules and regulations, we may lose the ability to receive referrals of individuals interested in purchasing Medicare plans from that marketing partner and our business, operating results and financial condition would be harmed.

In addition, each time we or our marketing partners substantively change our websites or call center scripts after they are filed with CMS, we need to resubmit them to our health insurance carriers and have them filed with CMS. We are not permitted to make CMS filings ourselves. Given the review cycles our scripts, websites and other marketing material undergo, it is very difficult to make changes to them, and our inability to timely make changes to these marketing materials, whether to comply with new rules and regulations or otherwise could adversely impact our ability to sell Medicare plans during the Medicare annual enrollment period or otherwise, which could impact our business, operating results and financial condition. In addition, if a change to scripts or websites is required by CMS or health insurance carriers, we may be prevented from selling Medicare plans during this period of review, which could harm our business, operating results, and financial condition, particularly if it occurred during the annual enrollment period.

Our Medicare plan-related revenue is dependent upon the number of paying Medicare plan insurance members we are successful in retaining and acquiring during the Medicare annual enrollment period. If we are not successful in

retaining and acquiring Medicare plan members during the annual enrollment period for any reason, our business, operating results and financial condition would be harmed.

Our ability to sell Medicare-related health insurance plans as a health insurance agent depends upon our ability to timely hire, train and retain licensed health insurance agents for our customer care center.

In addition to our websites, we rely upon our customer care centers to sell Medicare plans. The success of our customer care center operations is largely dependent on licensed health insurance agents and other employees. In order to sell Medicare-related health insurance plans, our health insurance agent employees must first be licensed by the states in which they are selling plans and certified and appointed with the health insurance carrier that offers the plans in each state that the Medicare-related health insurance product is being sold by the agent. Because a significant number of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we hire and train a significant number of additional employees on a temporary or seasonal basis in a limited period of time. It may be difficult for the health insurance

Table of Contents

agents we employ and our systems and processes to handle the increased volume of health insurance transactions that occur in a short period of time during the Medicare annual enrollment period. We must also ensure that our health insurance agent employees are timely licensed in a significant number of states and certified and appointed with the health insurance carriers whose products we sell. We depend upon state departments of insurance and health insurance carriers for the licensing, certification and appointment of our health insurance agent employees. We may not be successful in timely hiring a sufficient number of additional licensed agents or other employees for the Medicare annual enrollment period, and even if we are successful, these employees may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments with our health insurance carrier partners. If we and our health insurance agent employees are not successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the annual enrollment period, which would harm our business, operating results and financial condition.

Our ability to sell Medicare-related health insurance plans as a health insurance agents depends upon our maintenance of functioning information technology systems.

The success of our Medicare plan customer care center operations is dependent on information technology systems. The vast majority of our Medicare plan members utilize our customer care center in connection with their purchase of a Medicare plan. CMS rules require that our health insurance agent employees utilize CMS-approved scripts in connection with the sale of Medicare plans and that we record and maintain the recording of telephonic interactions relating to the sale of Medicare plans. We rely on telephone, call recording, customer relationship management and other systems and technology in our Medicare customer care center operations, and we are dependent upon third parties for some of them, including our telephone and call recording systems. The effectiveness and stability of our Medicare customer care center systems and technology are critical to our ability to sell Medicare plans, particularly during the Medicare annual enrollment period, and the failure or interruption of any of these systems and technology or any inability to handle increased volume during the annual enrollment period would harm our business, operating results and financial condition.

Our success in selling Medicare-related health insurance will depend upon a number of factors some of which our outside of our control.

We determined to enter into the Medicare plan market because we believe the number of individuals becoming eligible for Medicare is increasing and these individuals are increasingly using the Internet to shop for health insurance plans. We also believe that, on average, member retention rates and the commissions that health insurance carriers pay in connection with the sale of Medicare plans compare favorably to the member retention rates and commissions we receive in connection with our sale of individual and family health insurance. Should we prove to be wrong, or should these circumstances reverse, our success in marketing Medicare plans would be materially and adversely impacted, which could harm our business, operating results and financial condition. For instance, portions of health care reform impose significant changes to original Medicare and the Medicare Advantage program by, among other things, increasing benefits original Medicare provides, reducing payments to Medicare Advantage plans and imposing medical loss ratio requirements for Medicare Advantage plans. In addition, CMS has in the past determined to reduce the payments it makes to health insurance carriers in connection with the sale of Medicare Advantage plans and it may do so again in the future. These reductions have caused, and could in the future cause, the cost of Medicare Advantage plans to increase or the benefits under Medicare Advantage plans to decrease, either of which would impair our ability to sell Medicare Advantage plans and our business, operating results and financial condition could be harmed. They also may cause health insurance carriers to reduce our compensation, which would harm our business, operating results and financial condition.

The majority of our Medicare-related health insurance plan sales occur over the telephone. Telephone sales of Medicare related health insurance require a licensed health insurance agent to complete and are time consuming

compared to sales over the Internet. Given the resources required in connection with telephonic Medicare related health insurance sales, it may prove difficult for us to continue to grow our Medicare-related health insurance sales compared to prior periods. Even if we are able to grow those sales, it may be expensive to add the additional resources necessary for the growth. If we are not able to scalably grow our Medicare related health insurance sales over the Internet or in other ways that require fewer resources, our business, operating results and financial condition would be harmed.

Our success in the Medicare plan market as a health insurance agent will also depend upon a number of additional factors, including:

- our ability to continue to adapt our ecommerce platforms to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the effective modification of our user experience;

Table of Contents

- our success in marketing to Medicare-eligible individuals and in entering into marketing partner relationships to drive Medicare-eligible individuals to our ecommerce platforms;

- our effectiveness in entering into and maintaining relationships with marketing partners that refer Medicare-eligible individuals to us;

- our ability to hire and retain additional employees with experience in Medicare, including our ability to timely implement Medicare sales expertise into our customer care centers;

- our ability to implement and maintain an effective information technology infrastructure for the sale of Medicare plans, including the infrastructure and systems that support our websites, call centers and call recording;

- our ability to leverage technology in order to sell, and otherwise become more efficient at selling, Medicare-related plans over the telephone;

- our ability to comply with the numerous, complex and changing laws and regulations and CMS guidelines relating to the marketing and sale of Medicare plans, including continuing to conform our online and offline sales processes to those laws and regulations; and

- the effectiveness with which our competitors market the availability of Medicare plans from sources other than our ecommerce platforms.

As a result of these factors, we may prove unsuccessful in marketing Medicare plans and acting as a health insurance agent in connection with their sale, which would harm our business, operating results and financial condition. In addition, if our efforts to market Medicare plans during any annual enrollment period were impeded due to lack of health insurance carrier or CMS approval, or for other reasons, the impact on our business, operating results and financial condition would be significantly greater given the seasonality of our Medicare-related revenues, membership acquisition and expenses and the fact that much of the sales of Medicare plans occur during this period.

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws and regulations, and non-compliance or changes in laws and regulations could harm our business, operating results and financial condition.

The marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. The marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans are principally regulated by CMS. The marketing and sale of Medicare Supplement plans are principally regulated on a state-by-state basis by state departments of insurance. The laws and regulations applicable to the marketing and sale of Medicare plans are numerous, ambiguous and complex, and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently. As a result of these laws, regulations and guidelines, we have altered, and likely will have to continue to alter, our websites and sales process to comply with several requirements that are not applicable to our sale of non-Medicare-related health insurance plans. For instance, many aspects of our online platforms and our marketing material and processes, as well as changes to these platforms, materials and processes, including call center scripts, must be filed on a regular basis with CMS and reviewed and approved by health insurance carriers in light of CMS requirements. In addition, certain aspects of our Medicare plan marketing partner relationships have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. Changes to the laws, regulations and guidelines relating to Medicare plans, their interpretation or the manner in which they are enforced could be incompatible with these relationships, our platforms or our sale of Medicare plans. For instance, in February 2015 CMS issued guidance indicating that third

party websites and marketing material must be filed for approval with CMS. Health insurance carriers have interpreted this guidance to mean that websites and marketing material of our marketing partners must go through the process of CMS filing and review and approval by health insurance carriers. Our marketing partners may not consent to having their websites or other marketing material filed with CMS. In addition, we have a number of marketing partners who refer leads to us for Medicare-related health insurance products. Given the resources and review required of us and health insurance carriers prior to CMS filing, it is unlikely that we will be able to have all of our marketing partner websites and material filed and approved by CMS, which could harm our business, operating results and financial condition. In addition, even for our marketing partner websites and marketing material that are filed with CMS, they may not make it through the review process in time for the Medicare annual enrollment period. Moreover, under CMS guidance, websites and marketing material must be refiled with CMS if changed, which also will make it difficult to adapt and optimize marketing partner websites and marketing material in a short amount

Table of Contents

time. Given these circumstances, the CMS guidance relating to third party websites could harm our business, operating results and financial condition.

Due to changes in CMS guidance or enforcement or interpretation of existing guidance, or as a result of new laws, regulations and guidelines, CMS, state departments of insurance or health insurance carriers may determine to object to or not to approve aspects of our online platforms or marketing material and processes and may determine that certain existing aspects of our Medicare-related business are not in compliance. As a result, the progress of our Medicare operations could be slowed or we could be prevented from operating aspects of our Medicare revenue generating activities altogether, which would harm our business, operating results and financial condition, particularly if it occurred during the Medicare annual enrollment period. It could also result in the write-down of the value of goodwill and intangible assets acquired in connection with our PlanPrescriber acquisition and purchase of the Medicare.com domain name.

The impact that health care reform legislation will have on the market for Medicare plans is unclear, but it could change demand for Medicare plans, the way these plans are delivered, the commissions that carriers pay to health insurance agents in connection with their sale or could adversely impact us in other ways. In the event that laws and regulations adversely impact our ability to market the availability of any type of Medicare plan on our ecommerce platform, Medicare plan demand or the amounts that health insurance agents are paid for selling these plans, our business, operating results and financial condition would be harmed.

CMS has in the past proposed changing the rules relating to compensation of agents in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans to reduce our compensation as a health insurance agent in connection with the sale of these plans. In the event CMS adopts regulations that have the effect of reducing the compensation that we receive in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans, our business, operating results and financial conditions would be harmed. In addition, CMS adopted regulations that changed the definition of a plan year from being twelve months from the effective date of a policy to January 1 through December 31 of each year, causing all Medicare Advantage and Medicare Part D prescription drug policies to renew on January 1 of each year. As a result, we record all Medicare Advantage and Medicare Part D prescription drug plan renewal commission revenue in the first quarter of each year. This plan year change resulted in our recognition of minimal renewal commission revenue outside of the first quarter of 2015, and we expect similar results in the future. In addition, CMS also issued a regulation prohibiting carriers from paying commissions during the fourth quarter on Medicare Advantage and Medicare Part D prescription drug policies sold during the fourth quarter with an effective date in the following year, which negatively impacts our operating cash flows in the fourth quarter of the year. This regulation also makes it more difficult for us to recognize revenue relating to our sale of Medicare Advantage and Medicare Part D prescription drug plans in the fourth quarter of the year, given that our revenue recognition policy requires us to receive either a cash payment or commission statement in the period we recognize revenue, provided we receive the second corroborating communication shortly following the period of recognition. If health insurance carriers do not send at least one of these communications during the fourth quarter, our recognition of revenue relating to our sale of these policies in the fourth quarter will be delayed until we receive the first communication, which would adversely impact our financial results in the fourth quarter. In the event health care reform, the actions of the federal government or other circumstances decrease the demand for Medicare Advantage plans or other alternatives to original Medicare, or result in a reduction in the amount paid to us or impact the timing of our revenue recognition in connection with the sale of these plans, our business, operating results and financial condition could be harmed.

We may be unsuccessful in competing effectively against current and future competitors.

The market for selling health insurance plans is highly competitive. We compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our competitors

include local insurance agents across the United States who sell health insurance plans in their communities. There also are a number of companies that operate websites, provide an online shopping experience for consumers interested in purchasing health insurance and act as a health insurance agent in connection with that purchase. Some local agents also use “lead aggregator” services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to health insurance agents or carriers. Many health insurance carriers also directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. CMS also offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans. We compete with the FFM and state health insurance exchanges implemented as a result of health care reform. Health care reform also has resulted in health insurance plan cost and benefit data being more readily accessible, which could facilitate additional competition. To remain competitive against our current and future competitors, we will need to market our services effectively and continue to improve the online shopping experience and functionalities of our website and other platforms that our current and future customers

Table of Contents

may access to purchase health insurance products from us. If we cannot predict, develop and deliver the right shopping experience and functionality in a timely and cost-effective manner, or if we are not effective in driving a substantial number of consumers interested in purchasing health insurance to our website in a cost-effective manner, we may not be able to compete successfully against our current or future competitors and our business, operating results and financial condition may be adversely affected.

Some of our current and potential competitors have longer operating histories, larger customer bases, greater brand recognition and significantly greater financial, technical, marketing and other resources than we do. As compared to us, our current and future competitors may be able to:

- undertake more extensive marketing campaigns for their brands and services;
- devote more resources to website and systems development;
- negotiate more favorable commission rates and commission override payments; and
- make more attractive offers to potential employees, marketing partners and third-party service providers.

In addition, CMS has the ability to regulate our marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans, and government-run health insurance exchanges, including CMS with respect to the FFM, have the ability to regulate our marketing and sale of qualified health plans under health care reform. CMS and the exchanges could impact the commissions we receive in connection with the sale of these plans and impose other restrictions and limitations that make it difficult for us to sell them. Competitive pressures may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, or may otherwise harm our business, operating results and financial condition.

If we are not successful in cost-effectively converting visitors to our website and customer call centers into members for which we receive commissions, our business and operating results would be harmed.

Our growth depends in large part upon growth in our membership. The rate at which consumers visiting our ecommerce platforms and customer care centers seeking to purchase health insurance are converted into paying members is a significant factor in the growth of our membership. A number of factors have influenced, and could in the future influence, the conversion rate for any given period, some of which are outside of our control. These factors include:

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers' ability or willingness to pay for health insurance, availability of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business, including health care reform;
- the quality of and changes to the consumer experience on our ecommerce platforms or with our customer care center;
- regulatory requirements, including those requirements imposed by CMS, that make the experience on our online platforms cumbersome or difficult to navigate;
- the variety, competitiveness and affordability of the health insurance plans that we offer;
- system failures or interruptions in the operation of our ecommerce platforms or call center operations;
-

changes in the mix of consumers who are referred to us through our direct, marketing partner and online advertising member acquisition channels;

- changes in the mix of consumers who access our ecommerce platforms through mobile or tablet devices

- health insurance carriers offering the health insurance plans for which consumers have expressed interest, and the degree to which our technology is integrated with those carriers;

- health insurance carrier guidelines applicable to applications submitted by consumers, the amount of time a carrier takes to make a decision on that application and the percentage of submitted applications approved by health insurance carriers;

Table of Contents

- the percentage of our members who did not accept their approved policies and from whom we do not receive commission payments; and

- our ability to enroll subsidy-eligible individuals in qualified health plans through government-run health insurance exchanges.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels. For example, our conversion rates have historically been lower with respect to consumers referred to us by Internet lead aggregators and relatively higher with respect to consumers coming to us through our direct member acquisition channel. In addition, we have experienced an increase in the percentage of mobile phone and tablet visitors to our platforms, and the conversion rate for individuals who use our mobile and tablet platform to shop for and purchase health insurance has historically been lower than desktop and laptop users. We may make changes to our ecommerce platform in response to regulatory requirements or undertake other initiatives in an attempt to improve consumer experience or for other reasons. These changes have in the past, and may in the future, have the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platform or telephonically via our customer care centers and are converted into members could cause an increase in our cost of acquiring members on a per member basis. To the extent the rate at which we convert consumers visiting our ecommerce platforms or telephonically via our customer care centers into members suffers, or in the event the number of mobile and tablet visitors to our platforms continue to increase, our membership growth rate may decline, which would harm our business, operating results and financial condition.

Our conversion rates are also impacted by changes in both the percentage of submitted applications that are approved by carriers as well as changes in the percentage of our members who do not accept their approved policies. Any decline in the percentage of submitted applications that result in paying members will adversely impact our commission revenue as well as our membership, which could harm our business, operating results and financial condition. Given that individual and family health insurance purchasing is concentrated during the annual open enrollment period, we may experience a shift in the mix of individual and family health insurance products selected by our new members over a short period of time. Any reduction in our average commission revenue per member during the open enrollment period caused by such a shift or otherwise would also harm our business, operating results and financial condition.

We have adopted solutions so that we may sell qualified health insurance plans to health care reform subsidy-eligible individuals and families over the Internet in the states in which the FFM operates the state's health insurance exchange. Pursuant to health care reform laws and regulations, the purchase of qualified health plans must occur through a government-run health insurance exchange, which means that a part of the purchasing process will occur through its systems. We are dependent upon the FFM's systems for individuals to be able to complete the process of purchasing a qualified health plan and to convert into members for which we receive commission revenue. CMS has recently directed us and other web based entities to make changes to our process for enrolling individuals and families into qualified health plans through the FFM. The changes require that we use a different pathway through which individuals are enrolled in qualified health plans through the FFM. This new pathway has reduced our conversion rates for qualified health plans and could result in lower conversion rates in the upcoming open enrollment period, which could harm our business, operating results and financial condition. In addition, if the FFM portion of the pathway we are required to use does not work properly or we are not properly identified by FFM systems as the agent of record on health insurance plan sales, we could suffer a reduction in our membership and our commission revenue and loss of new members, and our business, operating results and financial condition will be harmed.

While we have assisted subsidy eligible individuals in applying for qualified health insurance plans in non-FFM states, we are not able to do so entirely online and do not intend to focus on enrolling individuals in qualified health

plans in non-FFM states as a result. If these state exchanges do not adopt processes and technology that allow us to assist subsidy-eligible individuals in enrolling through these exchanges over the Internet and without use of health insurance agents in our customer care centers, we will not be able to or may continue to not choose to enroll a significant number of subsidy eligible individuals in these states and our business, operating results and financial condition could be harmed.

Table of Contents

Changes in the quality and affordability of the health insurance plans that carriers offer on our ecommerce platforms could harm our business and operating results.

The demand for health insurance marketed through our ecommerce platforms is impacted by, among other things, the variety, quality and price of the health insurance plans we offer. Some health insurance carriers have exited certain state insurance markets where we have historically represented their insurance plans and we may determine not to work with other health insurance carriers. If our ability to sell a variety of high-quality, affordable health insurance plans in the Medicare, individual and family, small business and ancillary product markets is impaired, or our health insurance plan offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform or otherwise, our sales or average commission rate per member may decrease and our business, operating results and financial condition could be harmed. For example, the cost of health insurance has increased substantially in many states as a result of health care reform implementation and some health insurance carriers have exited the individual and family health insurance business in certain states. Moreover, as a result of several carriers not desiring to sell individual and family health insurance during the current special enrollment period and as a result of their reductions in our commissions for those sales, we are not able to sell individual and family health insurance plans that we have historically sold. This reduction in the supply we are able to offer consumers may adversely impact demand for the individual and family health insurance we sell, and if individuals and families do not purchase health insurance through us as a result of these circumstances, our business, operating results and financial condition would be harmed.

Health insurance carriers could determine to reduce the commissions paid to us, which could harm our business and operating results.

Our commission rates, and the commission override payments we receive from health insurance carriers for achieving sales volume thresholds or other objectives, are either set by each carrier or negotiated between us and each carrier. Carriers have altered, and may in the future alter, the contractual relationships we have with them on short notice, either by renegotiation or unilateral action. If these contractual changes result in reduced commissions, our business may suffer and our operating results and financial condition would be harmed. For example, several health insurance carriers have reduced or eliminated commission for individual and family health insurance sold outside of the health care reform open enrollment period. While these carriers have indicated that they plan to increase commission rates for individual and family health insurance old in the upcoming open enrollment period, they are not obligated to do so. If they do not, our business operating results and financial condition will be harmed.

If we are not able to maintain and enhance our brand, our business and operating results will be harmed.

We believe that maintaining and enhancing our brand identity is critical to our relationships with existing members, marketing partners and health insurance carriers and to our ability to attract new members, marketing partners and health insurance carriers. The promotion of our brand in these and other ways may require us to make substantial investments and we anticipate that, as our market becomes increasingly competitive, these branding initiatives may become increasingly difficult and expensive. Our brand promotion activities may not be successful or yield increased revenue, and to the extent that these activities yield increased revenue, the increased revenue may not offset the expenses we incur and our operating results could be harmed. If we do not successfully maintain and enhance our brand, our business may not grow and we could lose our relationships with health insurance carriers, marketing partners and/or members, which would harm our business, operating results and financial condition.

In addition, we have historically received media attention in connection with our public relations efforts. While we cannot be certain of the impact of media coverage on our business, if it were to be reduced or if we were to receive negative publicity, the number of consumers visiting our platform or customer call centers could decrease, and our cost of acquiring members could increase as a result of a reduction in the number of members coming from our direct member acquisition channel, both of which could harm our business, operating results and financial condition.

System failures or capacity constraints could harm our business and operating results.

The performance, reliability and availability of our ecommerce platforms and underlying network infrastructures are critical to our financial results, our brand and our relationship with members, marketing partners and health insurance carriers. Although we regularly attempt to enhance our ecommerce platforms and system infrastructure, system failures and interruptions may occur if we are unsuccessful in these efforts, if we are unable to accurately project the rate or timing of increases in our website traffic or for other reasons, some of which are completely outside our control. Although we have experienced only minor system failures and interruptions to date, we could experience significant failures and interruptions in the future, which would harm our business, operating results and financial condition. If these failures or interruptions occurred

Table of Contents

during the Medicare annual enrollment period or during the open enrollment period under health care reform, the negative impact on us would be particularly pronounced.

We rely in part upon third-party vendors, including data center and bandwidth providers, to operate our ecommerce platforms. We cannot predict whether additional network capacity will be available from these vendors as we need it, and our network or our suppliers' networks might be unable to achieve or maintain a sufficiently high capacity of data transmission to allow us to process health insurance applications in a timely manner or effectively download data, especially if our website traffic increases. Any system failure that causes an interruption in or decreases the responsiveness of our services would impair our revenue-generating capabilities and harm our business and operating results and damage our reputation. In addition, any loss of data could result in loss of customers and subject us to potential liability. Our database and systems are vulnerable to damage or interruption from human error, earthquakes, fire, floods, power loss, telecommunications failures, physical or electronic break-ins, computer viruses, acts of terrorism, other attempts to harm our systems and similar events. In addition, our operations are vulnerable to earthquakes in the San Francisco Bay Area and elsewhere in Northern California.

Consumers may access our customer care centers for assistance in connection with submitting health insurance applications. We depend upon third parties, including telephone service providers and third party software providers, to operate our customer care centers. Any failure of the systems that we rely upon in the operation of our customer care centers could negatively impact sales as well as our relationship with consumers and members, which could harm our business, operating results and financial condition.

If consumers or carriers opt for more traditional or alternative channels for the purchase and sale of health insurance, our business will be harmed.

Our success depends in part upon widespread consumer and health insurance carrier acceptance of the Internet as a marketplace for the purchase and sale of health insurance. Consumers and health insurance carriers may choose to depend more on traditional sources, such as individual agents, or alternative sources may develop, including as a result of health care reform legislation. For instance, an increasing percentage of individuals are using their phones or tablet computers to shop for health insurance over the Internet and may prefer to complete their purchases over these devices. Our future growth, if any, will depend in part upon:

- the growth of the Internet as a commerce medium generally, and as a market for consumer financial plans and services specifically;
- consumers' willingness to conduct their own health insurance research;
- our ability to make the process of purchasing health insurance online an attractive alternative to traditional and new means of purchasing health insurance;
- our ability to develop an effective process for purchasing health insurance over the Internet on smartphones, tablets and devices other than desktop or laptop computers;
- our ability to successfully and cost-effectively market our services as superior to traditional or alternative sources for health insurance to a sufficiently large number of consumers; and
- health insurance carriers' willingness to use us and the Internet as a distribution channel for health insurance plans.

If we are not successful in these regards, and if consumers and health insurance carriers determine that other sources for health insurance and health insurance applications are superior, our business will not grow and our operating

results and financial condition would be harmed.

We depend upon Internet search engines to attract a significant portion of the consumers who visit our website, and if we are unable to effectively advertise on search engines on a cost-effective basis, our business and operating results would be harmed.

We derive a significant portion of our website traffic from consumers who search for health insurance through Internet search engines, such as Google, Bing and Yahoo!. A critical factor in attracting consumers to our website is whether we are prominently displayed in response to an Internet search relating to health insurance. Search engines typically provide two types

Table of Contents

of search results, algorithmic listings and paid advertisements. We rely on both algorithmic listings and paid advertisements to attract consumers to our websites.

Algorithmic search result listings are determined and displayed in accordance with a set of formulas or algorithms developed by the particular Internet search engine. The algorithms determine the order of the listing of results in response to the consumer's Internet search. From time to time, search engines revise these algorithms. In some instances, these modifications have caused our website to be listed less prominently in algorithmic search results, which has resulted in decreased traffic to our website. We may also be listed less prominently as a result of new websites or changes to existing websites that result in these websites receiving higher algorithmic rankings with the search engine. For example, government health insurance exchange websites have recently begun to appear prominently in algorithmic search results. Our website may become listed less prominently in algorithmic search results for other reasons, such as search engine technical difficulties, search engine technical changes and changes we make to our website. In addition, search engines have deemed the practices of some companies to be inconsistent with search engine guidelines and decided not to list their website in search result listings at all. If we are listed less prominently in, or removed altogether from, search result listings for any reason, the traffic to our websites would decline and we may not be able to replace this traffic, which in turn would harm our business, operating results and financial condition. If we decide to attempt to replace this traffic, we may be required to increase our marketing expenditures, which would also increase our cost of member acquisition and harm our business, operating results and financial condition.

We purchase paid advertisements on search engines in order to attract consumers to our website. We typically pay a search engine for prominent placement of our name and website when particular health insurance-related terms are searched for on the search engine, regardless of the algorithmic search result listings. The prominence of the placement of our advertisement is determined by a combination of factors, including the amount we are willing to pay and algorithms designed to determine the relevance of our paid advertisement to a particular search term. As with algorithmic search result listings, search engines may revise the algorithms relevant to paid advertisements and websites other than our ecommerce platforms may become more optimized for the algorithms. These changes may result in our having to pay increased amounts to maintain our paid advertisement placement in response to a particular search term. We could also have to pay increased amounts should the market share of major search engines continue to become more concentrated with a single search engine. Additionally, we bid against our competitors and others for the display of these paid search engine advertisements. Many of our competitors, including many health insurance carriers and government-run health insurance exchanges, have greater resources with which to bid and better brand recognition than we do. We have experienced increased competition from health insurance carriers, government health insurance exchanges and some of our marketing partners for both algorithmic search result listings and for paid advertisements. This competition has increased the cost of paid internet search advertising and has increased our marketing and advertising expenses. This competition has in the past increased substantially during the open enrollment periods for individual and family health insurance and Medicare related health insurance and may increase further if these open enrollment periods occur over the same period of time. If paid search advertising costs increase or becomes cost prohibitive, whether as a results of competition, algorithm changes or otherwise our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which would harm our business, operating results and financial condition.

We rely significantly on marketing partners and our business and operating results would be harmed if we are unable to maintain effective relationships with our existing marketing partners or if we do not establish successful relationships with new marketing partners.

In addition to marketing through Internet search engines, we frequently enter into contractual marketing relationships with other online and offline businesses that promote us. These marketing partners include financial and online service companies, affiliate programs and online advertisers and content providers. We also have relationships with marketing

partners, including pharmacy chains that promote our Medicare platforms to their customers. We compensate many of our marketing partners for their referrals on a submitted health insurance application basis and, if they are licensed to sell health insurance, may share a percentage of the commission we earn from the health insurance carrier for each member referred by the marketing partner.

Many factors influence the success of our relationship with our marketing partners, including:

- the continued positive market presence, reputation and growth of the marketing partner;

- the effectiveness of the marketing partner in marketing our website and services, including whether the marketing partner is successful in maintaining the prominence of its website in algorithmic search result listings and paid Internet advertisements;

Table of Contents

- the compliance of our marketing partners, and of the manner marketing partners refer consumers to our platforms, with applicable laws, regulations and guidelines;

- the interest of the marketing partner's customers in the health insurance plans that we offer on our ecommerce platforms;

- the contractual terms we negotiate with the marketing partner, including the marketing fees we agree to pay a marketing partner;

- the percentage of the marketing partner's customers that submit applications or purchase health insurance policies through our ecommerce platforms;

- the ability of a marketing partner to maintain efficient and uninterrupted operation of its website; and

- our ability to work with the marketing partner to implement website changes, launch marketing campaigns and pursue other initiatives necessary to maintain positive consumer experiences and acceptable traffic volumes.

For instance, we partner with Internet lead aggregators who refer a significant number of consumers to our online platforms. Major search engines have in the past and may in the future determine not to list lead aggregator websites prominently in search result listings for various reasons, which would cause a significant reduction in the number of consumers referred to us through our marketing partner channel. While we have relationships with a large number of marketing partners, we depend upon referrals from a limited number of marketing partners for a significant portion of the submitted applications we receive from our marketing partner customer acquisition channel. Moreover, a significant portion of our referrals for the purchase of Medicare plans comes from a single marketing partner.

Given our reliance on our marketing partners, our business operating results and financial condition would be harmed if any of the following were to occur:

- if we are unable to maintain successful relationships with our existing marketing partners, particularly marketing partners responsible for a significant number of our submitted applications;

- if we fail to establish successful relationships with new marketing partners;

- if we experience competition in our receipt of referrals from our high volume marketing partners; and

- if we are required to pay increased amounts to our marketing partners.

To the extent that health care reform makes it less profitable or desirable for marketing partners to promote us to their customers, we may lose relationships with existing marketing partners or those marketing partners may refer fewer individuals to us. We may also have difficulty entering into relationships with new marketing partners. We may also need to reduce or eliminate the compensation that we pay to marketing partners to the extent that health care reform has the effect of reducing commissions for individual and family health insurance or causes our members to stay on their health insurance policies for a shorter period of time. For example, we have reduced compensation we pay to marketing partners for individual and family health insurance in light of the reduction in commission rates by several health insurance carriers. If we are not able to timely change the terms of our agreements with marketing partners, our business, operating results and financial condition could be harmed. Even if we are able to reduce the compensation that we pay to marketing partners, our relationships with existing marketing partners may be adversely affected, and given that our marketing partners are not obligated to send referrals to us, the reduction any reduction in marketing partner compensation could result in less demand for the health insurance that we sell. We may lose marketing partner

referrals if our competitors pay marketing partners more than we do or be forced to pay increased fees to our marketing partners, which could harm our business, operating results and financial condition. If we lose marketing partner referrals during the Medicare or individual and family health insurance annual open enrollment periods, the adverse impact on our business would be particularly pronounced. In addition, the promulgation of laws, regulations or guidelines, or the interpretation of existing laws, regulations and guidelines, by state departments of insurance or by CMS, could cause our relationships with our marketing partners to be in non-compliance with those laws, regulations and guidelines. For instance, CMS recently issued guidance that health insurance carriers have interpreted to mean that websites and marketing material of our Medicare-related marketing partners must be filed with CMS before use. Before filing with CMS, these websites and marketing materials will need to undergo a review by health insurance carriers for whom we market Medicare products. Our marketing partners may not consent to having their websites or other marketing material filed with CMS, and we and health insurance carriers may not be able to dedicate the resources necessary to have the websites and marketing material

Table of Contents

reviewed. If we or health insurance carriers are not able to timely do so, our business, operating results and financial condition could be harmed. In addition, as a result of our acquisition of PlanPrescriber, we have marketing partner relationships with pharmacy chains that utilize aspects of our platform and tools. Our relationships with these pharmacy chains result in the referral of a significant number of individuals to us who are interested in purchasing Medicare-related health insurance plans. If CMS or state departments of insurance were to change existing laws, regulations or guidelines, or interpret existing laws, regulations or guidelines, to prohibit these arrangements, or if pharmacy partners otherwise decided to no longer utilize aspects of our platform and tools, we could experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and customer care centers, which would harm our business, operating results and financial condition and could result in a write-down of the value of intangible assets acquired in our PlanPrescriber acquisition.

We rely on health insurance carriers to accurately and regularly prepare commission reports, and if these reports are inaccurate or not sent to us in a timely manner, our business and operating results could be harmed. We also may not recognize trends in our membership as a result of a lack of information from health insurance carriers.

For individual and family, small business, ancillary and Medicare Supplement health insurance plans, health insurance carriers pay us a flat amount per member per month or a percentage of the paid health insurance premium on a health insurance policy that we have sold during the period that a member maintains coverage under the policy. For both Medicare Advantage and Medicare Part D prescription drug policies, health insurance carriers typically pay us a fixed commission amount during the period the policy remains active, typically for at least six years, depending on the carrier. We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission revenue, prepare our financial reports, projections and budgets and direct our marketing and other operating efforts based on the reports we receive from health insurance carriers. There have been instances where we have determined that policy cancellation data reported to us by a health insurance carrier has not been accurate. Although we recognize commissions reported to us net of estimated cancellations, the extent to which health insurance carriers are inaccurate in their reporting of policy cancellations could cause us to change our cancellation estimates, which could adversely impact our revenues. We apply judgment and make estimates based on historical data and current trends to independently determine whether or not carriers are accurately reporting commissions due to us. To the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, we will not recognize revenue to which we are entitled, which would harm our business, operating results and financial condition.

We also depend on health insurance carriers and others for data related to our membership. For instance, with respect to health insurance plans other than small business health insurance, health insurance carriers do not directly report member cancellations to us, resulting in the need for us to determine cancellations using payment data that carriers provide. We infer cancellations from this payment data by analyzing whether payments from members have ceased for a period of time, and we may not learn of a cancellation for several months. With respect to our small business membership, many groups notify the carrier directly with respect to increases or decreases in group size and policy cancellations. Our insurance carrier partners often do not communicate this information to us, and it often takes a significant amount of time for us to learn about small business group cancellations and changes in our membership within the group itself. We often are not made aware of policy cancellations until the time of the group’s annual renewal.

A substantial number of our existing members may become eligible for health care reform subsidies in connection with their purchase of health insurance. In addition, the open enrollment periods applicable in connection with the sale of both individual and family health insurance and Medicare-related health insurance condenses purchasing activity over a limited period of time. The increased amount of health insurance purchasing activity and member movement as a result of health care reform over a limited period of time as well as any member turnover that we experience may make it difficult for health insurance carriers to accurately report commission information to us in a timely manner,

which would also make it difficult or impossible for us to accurately report and estimate our membership at any given point in time. Delays in accurate reporting of commissions may result in delays in recognition of commission revenue compared to historical patterns and our business, operating results and financial condition could be harmed. In addition, if we experience a disruption in our ability to accurately estimate our membership it could result in a decrease in our stock price as a result of uncertainty relating to our membership base.

After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. We also reconcile information health insurance carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated our membership. As a result of open enrollment periods, we may not receive information from our carriers on as timely a basis due to significant spikes in volume,

Table of Contents

which could impair the accuracy of our estimates of the number of members we have for a period of time. Additionally, health insurance carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be different from our estimates, perhaps materially. Total revenue per estimated member for the period would also change if our estimated membership changed. Our estimate regarding the average amount of time our members maintain their health insurance plans also could be inaccurate as it depends on the accuracy of our membership estimates.

Economic conditions and other factors beyond our control may negatively impact our business, operating results and financial condition.

Our revenue depends upon demand for health insurance in the individual and family and small business markets, which can be influenced by a variety of factors beyond our control. For instance, as a result of substantial health insurance premium inflation in recent years, we believe that many employers have sought to reduce the costs associated with providing health insurance to their employees, including offering fewer benefits to employees, reducing or eliminating dependent coverage, increasing employee health insurance premium contributions and eliminating health insurance benefits altogether. We have no control over the economic and other factors that influence these trends, and they may reverse, including as a result of health care reform legislation. If economic or other factors beyond our control negatively impact our business, our business, operating results and financial condition could be harmed.

We believe that demand for the health insurance and services we offer are impacted by prevailing economic conditions. We cannot be certain of the future impact that economic conditions will have on our business. A softening of demand for health insurance and services offered by us, whether caused by changes in customer preferences or a weak U.S. economy, including as a result of disruptions in the global financial markets or a decrease in general consumer confidence, could adversely impact our operating results. Consumers may attempt to reduce expenses by canceling existing health insurance purchased through us, determine not to purchase new health insurance through us, or purchase health insurance plans for which we receive lower commissions. To the extent the economy or other factors adversely impact our membership retention or the number or type of health insurance applications submitted through us and that are approved by health insurance carriers, our rate of growth will decline and our business and operating results will be harmed. A continuing negative economic environment could also adversely impact the health insurance carriers whose plans are offered on our ecommerce platforms, and they may determine to reduce their commission rates or take other actions that would negatively impact our sale of health insurance as well as our sponsorship and technology licensing businesses.

There are many risks associated with our operations in China.

A portion of our operations is conducted in China. Among other things, we use employees in China to maintain and update our ecommerce platforms. This and other information is delivered to us through secured communications over the Internet. Our business would be harmed if this connection temporarily failed and we were prevented from promptly updating our software or implementing other changes to our database and systems. Our operations in China also expose us to different and unfamiliar laws, rules and regulations, including different intellectual property laws, which are not as protective of our intellectual property as the laws in the United States, and different labor and tax laws. United States and Chinese trade laws may impose restrictions on the importation of programming or technology to or from the United States. Additionally, we have recently experienced greater competition for qualified personnel in China, which has raised market salaries and increased our compensation costs related to employees in that location. If competition for personnel increases further, our compensation expenses could rise considerably or, if we determine to

not increase compensation levels, our ability to attract and retain qualified personnel in China may be impaired, which could harm our business, operating results and financial condition. These risks could cause us to incur increased expenses and could harm our ability to effectively and successfully manage our operations in China, which in turn could cause our business, operating results and financial condition to suffer.

Our sponsorship and advertising business may not be successful.

We sell advertising space to health insurance carriers on our website through our sponsorship and advertising program. Health insurance carriers have and may continue to determine to eliminate or reduce spending on our sponsorship and advertising program as a result of various aspects of health care reform, including the medical loss ratio requirements that became effective in 2011. As a result, our business, operating results and financial condition could be harmed. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for advertising on our ecommerce platforms, our sponsorship and advertising program will be adversely impacted. For example, the cost of health insurance has increased substantially in many states as a result of health care reform implementation and

Table of Contents

some health insurance carriers have exited the individual and family health insurance business in certain states. In addition, several health insurance carriers have reduced commissions that they pay for the sale of individual and family health insurance outside of the open enrollment period. The reduction in the number of health insurance carriers desiring to sell individual and family plan products or our decision not to offer individual and family health insurance from carriers who have reduced or eliminated commission could mean reduced demand in our sponsorship and advertising program as well as reduced demand for the individual and family health insurance products that we sell. Since much of our sponsorship revenue depends upon the number of applications we submit to health insurance carriers, these circumstances would reduce our sponsorship revenue and our business, operating results and financial condition could be harmed. The success of our sponsorship and advertising program depends on a number of other factors, including the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer and health insurance carrier adoption of the Internet and our ecommerce platforms as a medium for the purchase and sale of health insurance, our ability to attract consumers visiting our ecommerce platforms and convert those consumers into members, the existence of a relationship between us and a diverse group of carriers that offer a number of health insurance plans in the markets in which we attempt to sell advertising, the cost, benefit and brand recognition of the health insurance plan that is the subject of the advertising, the impact the advertising has on the sale of the health insurance plan that is the subject of the advertising and the effectiveness of the carrier's other means of advertising. In addition, while our practice of selling advertising is described on our ecommerce platforms, it could cause consumers to perceive us as not objective, which could harm our brand and result in a decline in our health insurance sales. It also could adversely impact our relationship with health insurance carriers that do not purchase our advertising. As a result, our business, operating results and financial condition could be harmed.

We also develop, host and maintain carrier dedicated Medicare plan websites through our advertising program. Our success in doing so is dependent upon the same factors that could impact our sponsorship program. In addition, since we maintain relationships with a limited number of health insurance carriers to sell their Medicare plans, our Medicare plan-related advertising revenue is concentrated in a small number of health insurance carriers and our ability to generate Medicare plan-related advertising revenue would be harmed by the termination or non-renewal of any of these relationships as well as by a reduction in the amount a health insurance carrier is willing to pay for these services. Historically, our Medicare advertising revenue is concentrated during the Medicare annual enrollment period in the fourth quarter and it is difficult for us to predict the amount of Medicare advertising revenue we would receive from health insurance carriers from year to year. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for our Medicare advertising service, our business, operating results and financial condition could be harmed. Moreover, in light of the regulations applicable to the marketing and sale of Medicare plans, and given that these regulations are often unclear, change frequently and are subject to changing interpretations, we may in the future not be permitted to sell Medicare plan-related advertising. If we are not successful in generating Medicare plan-related advertising revenue, our business operating results and financial condition could be harmed.

We may not be successful in licensing the use of our ecommerce technology to health insurance carriers and other third parties.

We license the use of our ecommerce technology to health insurance carriers and agents. Carriers use our platform to offer their own health insurance policies on their websites, and agents use it to power their quoting and online content. We are typically paid implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications. Health care reform could reduce health insurance carrier and agent demand for our technology licensing platform as a result of the reduction in the number of health insurance carriers selling individual and family plan products, the medical loss ratio requirements that became effective in 2011; a desire to not sell or reduce selling efforts or for other reasons. In addition, health insurance carriers who currently use the platform could determine to cease using it, reduce the number and type of plans offered on the platform or renegotiate the fees that

they pay, any of which would reduce the revenue we receive from our technology licensing business.

The business of licensing the use of our technology to others could facilitate carrier, health insurance agent and other third party competition with us in the sale of health insurance over the Internet and is subject to a number of additional risks and uncertainties, including consumer and health insurance carrier adoption of our ecommerce platforms as a medium for the purchase and sale of health insurance, our ability to establish relationships with new health insurance carriers, the reliability and performance of our ecommerce platforms and the relative cost of developing competing technology. If we are not able to offer health insurance carriers and other third parties a reliable platform to cost-efficiently offer their plans over the Internet, our technology licensing business will be unsuccessful.

We may not be able to adequately protect our intellectual property, which could harm our business and operating results.

Table of Contents

We believe that our intellectual property is an essential asset of our business and that our technology infrastructure currently gives us a competitive advantage in the distribution of individual and family and small business health insurance. We rely on a combination of copyright, trademark and trade secret laws as well as confidentiality procedures and contractual provisions to establish and protect our intellectual property rights in the United States. We have not filed for protection of our intellectual property in any foreign jurisdiction other than China. We have Chinese-registered computer software copyrights for an internally-developed software system and a project management tool and have certain trademarks in China. We have not filed any patent applications in China. The efforts we have taken to protect our intellectual property may not be sufficient or effective, and our trademarks, copyrights and patents if issued, may be held invalid or unenforceable. Moreover, the law relating to intellectual property is not as developed in China, and our intellectual property rights may not be as respected in China as they are in the United States. Any United States or other patents issued to us may not be sufficiently broad to protect our proprietary technologies, and given the costs of obtaining patent protection, we may choose not to seek patent protection for certain of our proprietary technologies. We may not be effective in policing unauthorized use of our intellectual property, trade secrets and other confidential information, and even if we do detect violations, litigation may be necessary to enforce our intellectual property rights. Any enforcement efforts we undertake, including litigation, could be time-consuming and expensive, could divert our management's attention and may result in a court determining that our intellectual property or other rights are unenforceable. If we are not successful in cost-effectively protecting our intellectual property rights, trade secrets and confidential information, our business, operating results and financial condition could be harmed.

We may in the future be subject to intellectual property rights claims, which are extremely costly to defend, could require us to pay significant damages and could limit our ability to use certain technologies in the future.

There are a large number of patents, copyrights, trademarks and trade secrets applicable to the internet and technology industries and entities frequently enter into litigation based on allegations of infringement or other violations of intellectual property rights. We have received, and may in the future receive, notices that claim we have misappropriated, infringed or misused other parties' intellectual property rights, and, to the extent we gain greater visibility, we face a higher risk of being the subject of intellectual property infringement claims. There may be third-party intellectual property rights, including issued or pending patents that cover significant aspects of our technologies or business methods or that cover third-party technology that we use as a part of our websites. Any intellectual property claim against us, with or without merit, could be time consuming, expensive to settle or litigate and could divert our management's attention and other resources. These claims also could subject us to significant liability for damages and could result in our having to stop using technology found to be in violation of a third party's rights. We might be required to seek a license for third-party intellectual property, which may not be available on reasonable terms or at all. Even if a license is available, we could be required to pay significant royalties, which would increase our operating expenses. We may also be required to develop alternative non-infringing technology, which could require significant effort and expense. If we cannot license or develop technology for any infringing aspect of our business, we would be forced to limit our services and may be unable to compete effectively. Any of these results would harm our business, operating results and financial condition.

Any legal liability, regulatory penalties, or negative publicity for the information on our website or that we otherwise distribute or provide could harm our business and operating results.

We provide information on our website, through our customer care centers and in other ways regarding health insurance in general and the health insurance plans we market and sell, including information relating to insurance premiums, coverage, benefits, provider networks, exclusions, limitations, availability, plan comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our website. Separately, from time to time, we use the information provided on our website and otherwise collected by us to publish reports designed to educate consumers, facilitate public

debate, and facilitate reform at the state and federal level relating to the accessibility and affordability of health insurance. If the information we provide on our website, through our customer care centers or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, health insurance carriers and others could attempt to hold us liable for damages, our relationships with health insurance carriers could be terminated and regulators could attempt to subject us to penalties, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which could result in our loss of our commission revenue. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints without significant financial cost, we cannot guarantee that we will be able to do so in the future. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

Table of Contents

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations, we could lose our relationship with health insurance carriers and be subject to various fines and penalties, including revocation of our licenses to sell insurance which would in turn potentially cause us to lose our commission revenue, and our business, operating results and financial condition would be materially harmed.

Changes in our management and key employees could affect our financial results, and a recent reduction in force may impede our ability to attract and retain highly skilled personnel.

Our success is dependent upon the performance of our senior management and key personnel. Our management and employees can terminate their employment at any time. The loss of the services of any of our executive officers or key employees could harm our business. For example, we appoint a single writing agent with each insurance carrier. If we lose the service of our appointed writing agent, the duties of writing agent will need to be transitioned to other company personnel. Due to our national reach and the large number of carrier partners whose policies are purchased by our members, this transition may be difficult and requires a significant period of time to complete. If the transition is not successful or takes too long to complete, our agency relationship with particular insurance carriers may be terminated, our commission payments could be discontinued or delayed and, as a result, our business, operating results and financial condition would be harmed.

Our success is also dependent upon our ability to attract and retain qualified personnel for all areas of our organization. In March 2015, we implemented a reduction in our workforce to align our employee base and cost structure with our current and anticipated revenues. These reductions have resulted in reallocations of duties, increased employee uncertainty and discontent and additional attrition. We may not be successful in attracting and retaining personnel on a timely basis, on competitive terms or at all, and the reductions in force could make it more difficult to do so. If we are unable to attract and retain the necessary personnel, our business would be harmed.

We may experience difficulties, delays or unexpected costs and not achieve anticipated cost savings from our recently implemented cost reduction plan.

In March 2015, we implemented an organizational restructuring and cost reduction plan. As part of the plan, we eliminated approximately 160 full-time positions in the United States, representing approximately 15% of our workforce primarily in our technology and content and customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. The majority of the restructuring activities comprising the plan were substantially completed in the first quarter of 2015, and we also eliminated certain positions in our China operation in that quarter.

For our cost reduction plan to be successful and build a framework for future growth, we must continue to execute and deliver on our core business initiatives with fewer human resources and losses of intellectual capital. For instance, as a part of the reduction-in-force, we have significantly reduced headcount in our customer care and enrollment and technology and content groups. These reductions could impair our ability to assist consumers seeking to purchase health insurance. They also constrain our ability to enhance our technology platforms as well as adapt our technology platforms and service to changes in the health insurance industry brought about by changes to the implementation of health care reform, regulatory or for other reasons. The reductions will also impact our ability to enter new business areas and develop and enhance our existing products and services. In the aggregate, the reduction-in-force could harm our business, operating results and financial condition.

In addition, we will need to manage complexities associated with a geographically diverse organization. We must also attract, retain and motivate key employees, including highly qualified management, product development,

engineering, sales, marketing, business development and general and administrative personnel who are critical to our business. We may not be able to attract, retain or motivate qualified employees in the future, and our inability to do so may adversely affect our business.

There may also be other risks associated with our cost reduction plan, and we cannot guarantee that we will be able to successfully manage these or other risks. If we fail to execute on our initiatives in these ways or others, such failure could result in a material adverse effect on our business and results of operations. We cannot ensure we will not undertake additional workforce reductions, that any of our restructuring efforts will be successful, or that we will be able to realize the cost savings and other anticipated benefits from any existing or future cost reduction plans.

Table of Contents

Acquisitions could disrupt our business and harm our financial condition and operating results.

We may decide to acquire businesses, products and technologies. Our ability as an organization to successfully make and integrate acquisitions is unproven. Acquisitions could require significant capital infusions and could involve many risks, including the following:

- an acquisition may negatively impact our results of operations because it will require us to incur transaction expenses, and after the transaction, may require us to incur charges and substantial debt or liabilities, may require the amortization, write down or impairment of amounts related to deferred compensation, goodwill and other intangible assets, or may cause adverse tax consequences, substantial depreciation or deferred compensation charges;

- an acquisition undertaken for strategic business purposes may negatively impact our results of operations;

- we may encounter difficulties in assimilating and integrating the business, technologies, products, personnel or operations of companies that we acquire, particularly if key personnel of the acquired company decide not to work for us;

- an acquisition may disrupt our ongoing business, divert resources, increase our expenses and distract our management;

- we may be required to implement or improve internal controls, procedures and policies appropriate for a public company at a business that prior to the acquisition lacked these controls, procedures and policies;

- the acquired businesses, products or technologies may not generate sufficient revenue to offset acquisition costs or to maintain our financial results;

- we may have to issue equity securities to complete an acquisition, which would dilute our stockholders' ownership and could adversely affect the market price of our common stock; and

- acquisitions may involve the entry into geographic or business markets in which we have little or no prior experience.

We cannot assure you that we will be able to identify or consummate any future acquisition on favorable terms, or at all. If we do pursue an acquisition, it is possible that we may not realize the anticipated benefits from the acquisition or that the financial markets or investors will negatively view the acquisition. Even if we successfully complete an acquisition, it could harm our business, operating results and financial condition.

If we fail to maintain proper and effective internal controls, our ability to produce accurate financial statements could be impaired, which could adversely affect our operating results, our ability to operate our business and our stock price.

We have a complex business organization. Ensuring that we have adequate internal financial and accounting controls and procedures in place to help ensure that we can produce accurate financial statements on a timely basis is a costly and time-consuming effort that needs to be re-evaluated frequently and is complicated by the expansion of our business operations. Our management, including our chief executive officer and chief financial officer, does not expect that our internal control over financial reporting will prevent all errors or all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time,

controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. As a result, we cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations, or result in material misstatements in our financial statements. Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002 and

Table of Contents

the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

Changes in our provision for income taxes or adverse outcomes resulting from examination of our income or other tax returns could adversely affect our results.

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections, changes in the valuation of our deferred tax assets and liabilities, expiration of or lapses in the research and development tax credit laws, tax effects of share-based compensation, outcomes as a result of tax examinations or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. For instance, given increased uncertainty regarding our future taxable income, we modified our assessment of the realizability of our domestic deferred tax assets and recorded a full valuation allowance against our domestic deferred tax assets in the amount of $11.5 million during the fourth quarter of 2014, resulting in expected minimum taxes recorded in the first three quarters of 2015. The related domestic deferred tax assets remain available for use in future periods and will reduce the Company’s tax provision if taxable income is generated. To the extent that our provision for income taxes is subject to volatility or adverse outcomes as a result of tax examinations, our operating results could be harmed.

Significant judgment is required to determine the recognition and measurement attribute prescribed in U.S. generally accepted accounting principles (“U.S. GAAP”) relating to accounting for income taxes. In addition, U.S. GAAP applies to all income tax positions, including the potential recovery of previously paid taxes, which if settled unfavorably could adversely impact our provision for income taxes or additional paid-in capital. In addition, we are subject to examinations of our income tax returns by the Internal Revenue Service and other tax authorities. We assess the likelihood of adverse outcomes resulting from these examinations to determine the adequacy of our provision for income taxes. There may be exposure that the outcomes from these examinations will have an adverse effect on our operating results and financial condition.

Risks Related to State Insurance Regulation

Regulation of the sale of health insurance is subject to change, and future regulations could harm our business and operating results.

The laws and regulations governing the offer, sale and purchase of health insurance are subject to change, and future changes may be adverse to our business. For example, a long standing provision in each state’s law that we believe is advantageous to our business is that once health insurance premiums are set by the carrier and approved by state regulators, they are fixed and not generally subject to negotiation or discounting by insurance companies or agents. Additionally, state regulations generally prohibit carriers, agents and brokers from providing financial incentives, such as rebates, to their members in connection with the sale of health insurance. As a result, we do not currently compete with carriers or other agents and brokers on the price of the health insurance plans offered on our website. If these regulations change, we could be forced to reduce prices or provide rebates or other incentives for the health insurance plans sold through our ecommerce platforms, which would harm our business, operating results and financial condition.

States have, and will continue, to adopt new laws and regulations in response to health care reform legislation. It is difficult to predict how these new laws and regulations will impact our business, but in some cases such laws and regulations could amplify the adverse impacts of health care reform, or states may adopt new requirements that

adversely impact our business, operating results and financial condition.

We are also subject to additional insurance regulatory risks, because we use the Internet as our distribution platform. In many cases, it is not clear how existing insurance laws and regulations apply to Internet-related health insurance advertisements and transactions. To the extent that new laws or regulations are adopted that conflict with the way we conduct our business, or to the extent that existing laws and regulations are interpreted adversely to us, our business, operating results and financial condition would be harmed.

If we fail to comply with the numerous state laws and regulations that are applicable to the sale of health insurance, our business and operating results could be harmed.

The sale of health insurance is heavily regulated by each state in the United States. For instance, in addition to the impact and changes in regulations resulting from health care reform, state regulators require us to maintain a valid license in

Table of Contents

each state in which we transact health insurance business and further require that we adhere to sales, documentation and administration practices specific to that state. In addition, each employee who transacts health insurance business on our behalf must maintain a valid license in one or more states. Because we do business in all 50 states and the District of Columbia, compliance with health insurance-related laws, rules and regulations is difficult and imposes significant costs on our business. Each jurisdiction's insurance department typically has the power, among other things, to:

- grant and revoke licenses to transact insurance business;
- conduct inquiries into the insurance-related activities and conduct of agents and agencies;
- require and regulate disclosure in connection with the sale and solicitation of health insurance;
- authorize how, by which personnel and under what circumstances insurance premiums can be quoted and published and an insurance policy sold;
- approve which entities can be paid commissions from carriers and the circumstances under which they may be paid;
- regulate the content of insurance-related advertisements, including web pages, and other marketing practices;
- approve policy forms, require specific benefits and benefit levels and regulate premium rates;
- impose fines and other penalties; and
- impose continuing education requirements.

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New insurance laws, regulations and guidelines also may not be compatible with the sale of health insurance over the Internet or with various aspects of our platform or manner of marketing or selling health insurance plans. Failure to comply with insurance laws, regulations and guidelines or other laws and regulations applicable to our business could result in significant liability, additional department of insurance licensing requirements, the revocation of licenses in a particular jurisdiction and/or our inability to sell health insurance plans, which could significantly increase our operating expenses, result in the loss of our commission revenue and otherwise harm our business, operating results and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand. Because some consumers, marketing partners and health insurance carriers may not be comfortable with the concept of purchasing health insurance using the Internet, any negative publicity may affect us more than it would others in the health insurance industry and would harm our business, operating results and financial condition. Changes in insurance laws, regulations and guidelines may also be incompatible with various aspects of our business and require that we make significant modifications to our existing technology or practices, which may be costly and time-consuming to implement and could also harm our business, operating results and financial condition.

In addition, we have received, and may in the future receive, inquiries from regulators regarding our marketing and business practices. We typically respond by explaining how we believe we are in compliance with relevant regulations or may modify our practices in connection with the inquiry. Any modification of our marketing or business practices

in response to future regulatory inquiries could harm our business, operating results or financial condition.

Risks Related to the Internet and Electronic Commerce

Our business is subject to security risks and, if we are unable to safeguard the security and privacy of confidential data, including personal health information, our business will be harmed.

Our services involve the collection and storage of confidential information of consumers and the transmission of this information to their chosen health insurance carriers and to government. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers. As a result, we are subject to various laws and regulations regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We cannot guarantee that our facilities and systems, and those of our third party service

Table of Contents

providers, will be free of security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with privacy and security laws, requirements and regulations may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by us or third party service providers, and enforcement actions. We may be required to expend significant amounts and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, techniques used to obtain unauthorized access or to sabotage systems change frequently. As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures. Additionally, our third party service providers may cause security breaches for which we are responsible.

Any compromise or perceived compromise of our security by us or by one of our vendors could damage our reputation, cause the termination of relationships with government-run health insurance exchanges and our members, marketing partners and health insurance carriers, reduce demand for our services and subject us to significant liability and expense as well as regulatory action and lawsuits, which would harm our business, operating results and financial condition. While we have contingency plans and insurance coverage for potential liabilities of this nature, these may not be sufficient to cover all claims or a significant amount of our liability. In addition, in the event that data security laws are implemented, or our health insurance carrier or other partners determine to impose requirements on us relating to data security, we may not be able to timely comply with such requirements or such requirements may not be compatible with our current processes. Changing our processes could be time consuming and expensive, and failure to timely implement required changes could result in our inability to sell health insurance plans in a particular jurisdiction or for a particular health insurance carrier or subject us to liability for non-compliance, any of which would damage our business, operating results and financial condition. For instance, health insurance carriers may require us to be compliant with Payment Card Industry, or PCI, security standards in order to accept credit card information from consumers. PCI compliance is generally assessed on an annual basis, and we may not always be compliant with new and evolving PCI standards. If we are not in compliance with PCI standards, we may not be able to accept credit card information from consumers and our relationship with health insurance carriers could be adversely impacted or terminated, which would harm our business, operating results and financial condition.

Government regulation of the Internet could adversely affect our business.

The laws governing general commerce on the Internet remain unsettled and it may take years to fully determine whether and how existing laws such as those governing intellectual property, privacy and taxation apply to the Internet. In addition, the growth and development of the market for electronic commerce may prompt calls for more stringent consumer protection laws that may impose additional burdens on companies conducting business over the Internet. Any new laws or regulations or new interpretations of existing laws or regulations relating to the Internet could harm our business and we could be forced to incur substantial costs in order to comply with them, which would harm our business, operating results and financial condition.

Our business could be harmed if we are unable to correspond with our consumers or market the availability of our ecommerce platforms by email.

We use email to market our services to potential members and as the primary means of communicating with our existing members. The laws and regulations governing the use of email for marketing purposes continue to evolve and the growth and development of the market for commerce over the Internet may lead to the adoption of additional legislation. If new laws or regulations are adopted, or existing laws and regulations are interpreted, to impose additional restrictions on our ability to send email to our members or potential members, we may not be able to communicate with them in a cost-effective manner. In addition to legal restrictions on the use of email, Internet service providers, e-mail service providers and others attempt to block the transmission of unsolicited email, commonly known as “spam.” Many Internet and e-mail service providers have relationships with organizations whose

purpose it is to detect and notify the Internet and e-mail service providers of entities that the organization believes is sending unsolicited e-mail. If an Internet or e-mail service provider identifies email from us as "spam" as a result of reports from these organizations or otherwise, we can be placed on a restricted list that will block our email to members or potential members. If we are unable to communicate by email with our members and potential members as a result of legislation, blockage or otherwise, our business, operating results and financial condition would be harmed.

Table of Contents

Consumers depend upon third-party service providers to access our website, and our business and operating results could be harmed as a result of technical difficulties experienced by these service providers.

Consumers using our website depend upon Internet, online and other service providers for access to our website. Many of these service providers have experienced significant outages, delays and other difficulties in the past and could experience them in the future. Any significant interruption in access to our website or increase in our website's response time as a result of these difficulties could damage our relationship with insurance carriers, marketing partners and existing and potential members and could harm our business, operating results and financial condition.

Risks Related to the Ownership of Our Common Stock

The trading price of our common stock may be subject to significant fluctuations and volatility, and our stockholders may be unable to resell their shares at a profit.

The stock markets, in general, and the markets for high technology stocks in particular, have historically experienced high levels of volatility. The market for technology stocks has been extremely volatile and frequently reaches levels that bear no relationship to the past or present operating performance of those companies. These broad market fluctuations may adversely affect the trading price of our common stock. In addition, the trading price of our common stock has been subject to significant fluctuations and may continue to fluctuate or decline, particularly as a result of developments relating to health care reform legislation and the implementation of health care reform. Other factors that could cause fluctuations in the trading price of our common stock include, but are not limited to, the following:

- price and volume fluctuations in the overall stock market from time to time;
- significant volatility in the market price and trading volume of technology companies in general, and companies in our industry;
- actual or anticipated changes in our results of operations or fluctuations in our operating results;
- actual or anticipated changes in the expectations of investors or securities analysts, including changes in financial estimates or investment recommendations by securities analysts who follow our business and changes in perceptions relating to the economy;
- speculation in the press or investment community;
- technological advances or introduction of new products by us or our competitors;
- actual or anticipated developments in our competitors' businesses or the competitive landscape generally;
- litigation involving us, our industry or both;
- actual or anticipated regulatory developments in the United States or foreign countries, including health care reform legislation in the United States;
- major catastrophic events;
- announcements or developments relating to the economy;

- our sale of common stock or other securities in the future;

- the trading volume of our common stock, as well as sales of large blocks of our stock; or

- departures of key personnel.

These factors, as well as general economic and political conditions and the announcement of proposed and completed acquisitions or other significant transactions, or any difficulties associated with such transactions, by us or our strategic partners, customers or our current competitors, may materially adversely affect the market price of our common stock in the future. In the past, following periods of volatility in the market price of a company's securities, securities class action litigation has often been instituted against that company. As discussed in Item 1, Legal Proceedings, securities class action litigation has

Table of Contents

been filed against us. Such litigation could result in substantial cost and a diversion of management's attention and resources. In addition, volatility, lack of positive performance in our stock price or changes to our overall compensation program, including our equity incentive program, may adversely affect our ability to retain key employees.

Our actual operating results may differ significantly from our guidance.

From time to time, we have released, and may continue to release guidance in earnings conference calls, earnings releases, or otherwise, regarding our future performance that represents our management's estimates as of the date of release. This guidance, which includes forward-looking statements, has been and will be based on projections prepared by our management. These projections are not prepared with a view toward compliance with published guidelines of the American Institute of Certified Public Accountants, and neither our registered public accountants nor any other independent expert or outside party compiles or examines the projections. Accordingly, no such person expresses any opinion or any other form of assurance with respect to the projections.

Projections are based upon a number of assumptions and estimates that, while presented with numerical specificity, are inherently subject to significant business, economic and competitive uncertainties and contingencies, many of which are beyond our control and are based upon specific assumptions with respect to future business decisions, some of which will change. We may state possible outcomes as high and low ranges. Any range we provide is not intended to imply that actual results could not fall outside of the suggested ranges. The principal reason that we release guidance is to provide a basis for our management to discuss our business outlook with analysts and investors. We do not accept any responsibility for any projections or reports published by any such third parties.

Guidance is necessarily speculative in nature, and it can be expected that some or all of the assumptions underlying the guidance furnished by us will not materialize or will vary significantly from actual results. For example, our actual financial results for the fiscal year 2014 did not fall within the ranges previously provided by our guidance. Accordingly, our guidance is only an estimate of what management believes is realizable as of the date of release. Actual results may vary from our guidance and the variations may be material. In light of the foregoing, investors are urged not to rely upon our guidance in making an investment decision regarding our common stock.

Any failure to successfully implement our operating strategy or the occurrence of any of the events or circumstances set forth in this "Risk Factors" section could result in the actual operating results being different from our guidance, and the differences may be adverse and material.

A limited number of stockholders have the ability to influence the outcome of director elections and other matters requiring stockholder approval.

A small number of stockholders and their affiliated entities beneficially owned more than 50% percent of our outstanding common stock as of March 31, 2016. These stockholders, if they act together, could exert substantial influence over matters requiring approval by our stockholders, including the election of directors, the amendment of our certificate of incorporation and bylaws and the approval of mergers or other business combination transactions. This concentration of ownership may discourage, delay or prevent a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their stock as part of a sale of our company and might reduce our stock price. These actions may be taken even if they are opposed by other stockholders.

Certain provisions in our charter documents and Delaware law could discourage takeover attempts and lead to management entrenchment.

Our certificate of incorporation and bylaws contain provisions that could have the effect of delaying or preventing changes in control or changes in our management without the consent of our board of directors. These provisions include:

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;
- cumulative voting in the election of directors is prohibited, which limits the ability of minority stockholders to elect director candidates;
- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or the resignation, death or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors;

Table of Contents

- the ability of our board of directors to determine to issue shares of preferred stock and to determine the price and other terms of those shares, including preferences and voting rights, without stockholder approval, which could be used to significantly dilute the ownership of a hostile acquiror;

- a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders;

- the requirement that a special meeting of stockholders may be called only by the chairman of the board of directors, the chief executive officer or the board of directors, which may delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; and

- advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquiror from conducting a solicitation of proxies to elect the acquiror's own slate of directors or otherwise attempting to obtain control of us.

We are also subject to certain anti-takeover provisions under Delaware law. Under Delaware law, a corporation may, in general, not engage in a business combination with any holder of 15% or more of its capital stock unless the holder has held the stock for three years or, among other things, the board of directors has approved the transaction.

Table of Contents

ITEM 6. EXHIBITS

(a) Exhibits

Except as so indicated in Exhibits 32.1 and 32.2, the following exhibits are filed as part of, or incorporated by reference into, this quarterly report on Form 10-Q.

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein Form	Date
10.1	†*	Executive Bonus Plan 2016		
31.1	†	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
31.2	†	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
32.1	‡	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.		
32.2	‡	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.		
101.INS	**	XBRL Instance Document		
101.SCH	**	XBRL Taxonomy Extension Schema Document		
101.CAL	**	XBRL Taxonomy Extension Calculation Linkbase Document		
101.DEF	**	XBRL Taxonomy Extension Definition Linkbase Document		
101.LAB	**	XBRL Taxonomy Extension Label Linkbase Document		
101.PRE	**	XBRL Taxonomy Extension Presentation Linkbase Document		

† Filed herewith.

‡ Furnished herewith.

* Indicates a management contract or compensatory plan or arrangement.

** Pursuant to applicable securities laws and regulations, these interactive data files are deemed furnished and not filed or part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act, are deemed furnished and not filed for purposes of Section 18 of the Exchange Act and otherwise are not subject to liability under these sections.

Table of Contents

SIGNATURES

Pursuant to the requirements 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 on the 9th day of May 2016.

eHealth, Inc.

/s/ Gary L. Lauer
Gary L. Lauer
Chief Executive Officer
(Duly Authorized Officer on Behalf of the Registrant)

/s/ Stuart M. Huizinga
Stuart M. Huizinga
Chief Financial Officer
(Principal Financial Officer)

Table of Contents

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