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, 2014

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 April 30, 2014 was 19,023,927 shares.

EHEALTH, INC. FORM 10-Q

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PART I
FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

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

	December 31, 2013 (Note 1)	March 31, 2014 (unaudited)
Assets		
Current assets:		
Cash and cash equivalents	$ 107,055	$ 98,228
Accounts receivable	4,586	8,386
Deferred income taxes	4,459	5,323
Prepaid expenses and other current assets	8,364	10,422
Total current assets	124,464	122,359
Property and equipment, net	10,283	10,411
Deferred income taxes	4,569	5,333
Other assets	5,518	5,074
Intangible assets, net	7,496	11,949
Goodwill	14,096	14,096
Total assets	$ 166,426	$ 169,222
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 4,381	$ 2,407
Accrued compensation and benefits	10,291	8,900
Accrued marketing expenses	8,227	11,408
Deferred revenue	1,784	1,695
Other current liabilities	2,561	2,791
Total current liabilities	27,244	27,201
Non-current liabilities	6,165	5,897
Stockholders' equity:		
Common stock	28	29
Additional paid-in capital	252,361	257,004
Treasury stock, at cost	(149,998)	(149,998)
Retained earnings	30,466	28,913
Accumulated other comprehensive income	160	176
Total stockholders' equity	133,017	136,124
Total liabilities and stockholders' equity	$ 166,426	$ 169,222

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

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

	Three Months Ended March 31,	
	2013	2014
Revenue		
Commission	$ 38,251	$ 45,577
Other	4,956	5,363
Total revenue	43,207	50,940
Operating costs and expenses:		
Cost of revenue	2,651	2,113
Marketing and advertising	14,835	23,109
Customer care and enrollment	7,166	9,713
Technology and content	6,741	10,467
General and administrative	7,519	8,294
Amortization of intangible assets	354	354
Total operating costs and expenses	39,266	54,050
Income (loss) from operations	3,941	(3,110)
Other expense, net	(25)	(39)
Income (loss) before provision for income taxes	3,916	(3,149)
Provision (benefit) for income taxes	1,555	(1,596)
Net income (loss)	$ 2,361	$ (1,553)
Net income (loss) per share:		
Basic	$ 0.11	$ (0.08)
Diluted	$ 0.11	$ (0.08)
Weighted-average number of shares used in per share amounts:		
Basic	20,571	18,849
Diluted	21,166	18,849
Comprehensive income (loss):		
Net income (loss)	$ 2,361	$ (1,553)
Foreign currency translation adjustment	(3)	16
Comprehensive income (loss)	$ 2,358	$ (1,537)

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

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

	Three Months Ended March 31,	
	2013	2014
Operating activities		
Net income (loss)	$ 2,361	$ (1,553)
Adjustments to reconcile net income (loss) to net cash provided by operating activities:		
Deferred income taxes	(2,887)	(1,608)
Depreciation and amortization	642	999
Amortization of book-of-business consideration	2,097	1,574
Amortization of intangible assets	354	354
Stock-based compensation expense	1,634	2,445
Deferred rent and other	3	8
Changes in operating assets and liabilities:		
Accounts receivable	(2,896)	(3,800)
Prepaid expenses and other assets	568	(3,496)
Accounts payable	(1,595)	(1,973)
Accrued compensation and benefits	(1,614)	(1,385)
Accrued marketing expenses	108	3,181
Deferred revenue	438	(382)
Other current liabilities	249	226
Net cash used in operating activities	(538)	(5,410)
Investing activities		
Purchases of property and equipment	(1,539)	(1,115)
Purchase of intangible assets	-	(4,500)
Net cash used in investing activities	(1,539)	(5,615)
Financing activities		
Net proceeds from exercise of common stock options	1,223	2,283
Cash used to net-share settle equity awards	(820)	(3,304)
Excess tax benefits from stock-based compensation	3,457	3,220
Repurchase of common stock	(29,007)	-
Principal payments in connection with capital leases	(13)	(13)
Net cash (used in) provided by financing activities	(25,160)	2,186
Effect of exchange rate changes on cash and cash equivalents	(2)	12
Net decrease in cash and cash equivalents	(27,239)	(8,827)
Cash and cash equivalents at beginning of period	140,849	107,055
Cash and cash equivalents at end of period	$ 113,610	$ 98,228

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

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

Note 1 - Summary of Business and Significant Accounting Policies

Description of Business—eHealth, Inc. (the "Company," "eHealth," "we" or "us") is the leading 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 individual and family, Medicare-related, 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. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process. 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, 2014, the condensed consolidated statements of comprehensive income (loss) for the three months ended March 31, 2013 and 2014 and the condensed consolidated statements of cash flows for the three months ended March 31, 2013 and 2014, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2013 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2013, which was filed with the Securities and Exchange Commission on March 12, 2014. 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, 2013, and include all adjustments necessary for the fair presentation of eHealth's statement of financial position as of March 31, 2014, its results of operations for the three months ended March 31, 2013 and 2014 and its cash flows for the three months ended March 31, 2013 and 2014. All adjustments are of a normal recurring nature. The results for the three months ended March 31, 2014 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2014.

Seasonality—In years prior to 2013, the number of individual and family health insurance applications submitted through our ecommerce platform generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. This trend changed in the fourth quarter of 2013 and the first quarter of 2014 as a result of an increase in the number of individual and family applications submitted during the initial open enrollment period, which began on October 1, 2013 and ended on March 31, 2014, as mandated by the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act. Accordingly, the number of submitted individual and family plan applications increased significantly, relative to historical levels, during the fourth quarter of 2013 and the first quarter of 2014.

The majority of Medicare plans are sold in our fourth quarter 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. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter of the year resulting from the sale of new Medicare plans. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by seasonal submitted application patterns. As a result, in years prior to 2013, marketing and advertising expenses related to individual and family health insurance plans have been highest in our first and third quarters, while marketing and advertising expenses related to Medicare-related plans have been highest in our third and fourth quarters. However, the historical trend of marketing and advertising expenses related to individual and family health insurance plans was impacted by the initial open enrollment

period for individual and family plans that began in October 2013. These expenses increased significantly in the fourth quarter of 2013 and first quarter of 2014, relative to historical levels, consistent with the increase in submitted applications.

Based on these seasonal trends, historically our revenue was highest in the fourth quarter of the year and our profitability was highest in the first quarter. However, in connection with the initial open enrollment period for individual and family plans which began on October 1, 2013 and ended on March 31, 2014, we experienced a loss in both the fourth quarter of 2013 and the first quarter of 2014 as a result of significantly higher marketing and advertising expenses due to an increase in the number of individual and family health insurance applications during the health care reform annual enrollment period.

Recently Adopted Accounting Standards—Effective January 1, 2014, we adopted an accounting standards update with new guidance on the presentation of unrecognized tax benefits. This standard requires an entity to present an unrecognized tax benefit, or a portion of an unrecognized tax benefit, as a reduction to a deferred tax asset for a net operating loss carryforward, a similar tax loss, or a tax credit carryforward, except as follows: to the extent a net operating loss carryforward, a similar tax loss, or a tax credit carryforward is not available at the reporting date under the tax law of the applicable jurisdiction to settle any additional income taxes that would result from the disallowance of a tax position or the tax law of the applicable jurisdiction does not require the entity to use, and the entity does not intend to use, the deferred tax asset for such purpose, the unrecognized tax benefit should be presented in the financial statements as a liability and should not be combined with deferred tax assets. The adoption of this standard did not have a material effect on our condensed consolidated financial statements.

Effective January 1, 2014, we adopted an accounting standards update with new guidance with respect to the release of cumulative translation adjustments into net income when a parent sells either a part or all of its investment in a foreign entity. This standard requires the release of cumulative translation adjustments when a company no longer holds a controlling financial interest in a subsidiary or group of assets that is a business within a foreign entity, and provides guidance for the acquisition in stages of a controlling interest in a foreign entity. The adoption of this standard did not have a material effect on our condensed consolidated financial statements.

Note 2 – Balance Sheet Accounts

Cash and Cash Equivalents—As of December 31, 2013 and March 31, 2014, 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, 2013 and March 31, 2014, 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, 2013 and 2014.

As of December 31, 2013 and March 31, 2014, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2013	March 31, 2014
Cash	$ 16,935	$ 17,107
Money market funds	90,120	81,121
Total cash and cash equivalents	$ 107,055	$ 98,228

We used observable prices in active markets in determining the classification of our money market funds as Level 1 as of December 31, 2013 and March 31, 2014.

Accounts Receivable—As of December 31, 2013 and March 31, 2014, our accounts receivable consisted of the following (in thousands):

	December 31, 2013	March 31, 2014
Accounts receivable - from other revenues	$ 2,322	$ 1,711

Commissions receivable	2,264	6,675
Total accounts receivable	$ 4,586	$ 8,386

Intangible Assets—On March 31, 2014, we purchased an internet domain name, www.Medicare.com, for $4.8 million. Cash consideration paid in connection with the purchase of the domain name totaled $4.5 million. The consideration paid also included $0.3 million of outstanding receivables from the owner of the domain name that were settled upon completion of the purchase. The related intangible asset was assigned an indefinite useful life. The carrying amounts, accumulated amortization, net carrying value and weighted average remaining life of our definite-lived amortizable intangible assets, as well as our indefinite-lived non-amortizable intangible trademarks and website addresses, are presented in the tables below (dollars in thousands, weighted-average useful life is as of March 31, 2014):

	December 31, 2013			March 31, 2014			Weighted Average Useful Life
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	March 31, 2014
Technology	$ 1,752	$ (1,277)	$ 475	$ 1,752	$ (1,364)	$ 388	1.1 years
Pharmacy and customer relationships	10,410	(4,267)	6,143	10,410	(4,512)	5,898	6.0 years
Trade names, trademarks and website addresses	907	(336)	571	907	(358)	549	6.1 years
Total intangible assets subject to amortization	$ 13,069	$ (5,880)	7,189	$ 13,069	$ (6,234)	6,835	
Indefinite-lived trademarks and domain names			307			5,114	Indefinite
Intangible assets			$ 7,496			$ 11,949	

During both the three months ended March 31, 2013 and 2014, amortization expense related to intangible assets totaled $354,000.

As of March 31, 2014, expected amortization expense in future periods is as follows (in thousands):

Years Ending December 31,	Technology	Pharmacy and Customer Relationships	Trade Names, Trademarks and Website Addresses	Total
2014 (nine months)	258	734	69	1,061
2015	118	979	91	1,188
2016	5	979	91	1,075
2017	5	979	91	1,075
2018	2	959	91	1,052
Thereafter	-	1,268	116	1,384
Total	$ 388	$ 5,898	$ 549	$ 6,835

Note 3 – Stockholders' Equity

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

	Shares Available for Grant (1)
Shares available for grant December 31, 2013	4,085
Additional shares authorized (2)	751
Restricted stock units granted	-

Options granted	-
Restricted stock units cancelled	3
Options cancelled	6
Shares available for grant March 31, 2014	4,845

(1)Shares available for grant do not include treasury stock shares that could also become available for grant if we determined to do so.

(2)On January 1, 2014, the number of shares authorized for issuance under the 2006 Equity Incentive Plan was automatically increased pursuant to the terms of the 2006 Equity Incentive 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):

	Number of Stock Options	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding at December 31, 2013	1,979	$ 17.91	4.20	$ 56,569
Granted	-	$ -		
Exercised	(137)	$ 16.63		$ 4,643
Cancelled	(6)	$ 17.90		
Balance outstanding at March 31, 2014	1,836	$ 18.01	3.98	$ 60,218
Vested and expected to vest at March 31, 2014	1,767	$ 17.86	3.92	$ 58,187
Exercisable at March 31, 2014	1,162	$ 16.29	3.16	$ 40,095

(1)The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2013 and March 31, 2014 and the exercise price of in-the-money options as of those dates.

The total grant date fair value of stock options vested during the three months ended March 31, 2013 and 2014 was $1.3 million and $0.6 million, respectively.

The following table summarizes restricted stock unit activity, including performance-based restricted stock unit activity, under the Stock Plans (in thousands, except 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, 2013	779	$ 19.57	2.30	$ 36,220
Granted	-	-		
Vested	(163)	$ 17.42		
Cancelled	(3)	$ 18.58		
Balance outstanding as of March 31, 2014	613	$ 20.14	2.18	$ 31,120

(1) Includes restricted stock units with both service and performance-based vesting criteria granted to our executive officers.

(2) The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31, 2013 and March 31, 2014 multiplied by the number of restricted stock units outstanding as of December 31, 2013 and March 31, 2014, respectively.

The fair value of the restricted stock units is based on eHealth's stock price on the date of grant, and compensation expense related to these awards is recognized on a straight-line basis over the vesting period. The fair value of performance-based restricted stock units is based on eHealth's stock price on the date of grant, and compensation expense related to these awards is recognized on an accelerated basis over the vesting period. The total grant date fair value of restricted stock units vested during the three months ended March 31, 2013 and 2014 was $2.0 million and $8.4 million, respectively.

Stock Repurchase Programs—On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock and on March 6, 2013, we announced that our board of directors increased the approved repurchase amount under this program to $60 million. Purchases under this program were made in the open market. The cost of the repurchased shares was funded from available working capital. We completed repurchasing common stock under this program in June 2013 having repurchased 2,957,179 shares for $60.0 million at an average price of $20.29 per share.

On March 31, 2014, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $50 million of our common stock. We expect to fund the repurchase program from available working capital. As of March 31, 2014, no common stock has been repurchased under this program.

For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method.

There was no stock activity under our stock repurchase programs during the three months ended March 31, 2014.

In addition to the shares repurchased under our repurchase programs as of March 31, 2014, we have in treasury 274,113 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, 2013 and March 31, 2014, we had a total of 9,519,286 shares and 9,583,382 shares, respectively, held in treasury.

Stock-Based Compensation—There were no stock options granted to employees during the three months ended March 31, 2013 or March 31, 2014.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

The following table summarizes stock-based compensation expense recorded during the three months ended March 31, 2013 and 2014 (in thousands):

	Three Months Ended March 31,	
	2013	2014
Common stock options	$ 792	$ 642
Restricted stock units	842	1,803
Total stock-based compensation expense	$ 1,634	$ 2,445

The following table summarizes stock-based compensation expense by operating function for the three months ended March 31, 2013 and 2014 (in thousands):

	Three Months Ended March 31,	
	2013	2014
Marketing and advertising	$ 459	$ 657
Customer care and enrollment	88	96
Technology and content	319	562
General and administrative	768	1,130
Total stock-based compensation expense	$ 1,634	$ 2,445

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, 2013 and 2014 (in thousands, except effective tax rate):

	Three Months Ended March 31,	
	2013	2014
Income (loss) before provision (benefit) for income taxes	$ 3,916	$ (3,149)
Provision (benefit) for income taxes	$ 1,555	$ (1,596)
Effective tax rate	39.7%	50.7%

Our effective tax rate in the three months ended March 31, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses, partially offset by a tax benefit resulting from the extension of the federal research tax credit through December 31, 2013. Our effective tax rate in the three months ended March 31, 2014 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses.

During the three months ended March 31, 2013 and 2014, excess federal and state tax benefits related to share-based payments, resulted in increases of $3.5 million and $3.2 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. These amounts are also classified in the condensed consolidated statements of cash flows as both a reduction to operating cash flows and as a financing cash inflow.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

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, restricted stock 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.

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,	
	2013	**2014**
Basic:		
Numerator:		
Net income (loss) allocated to common stock	$ 2,361	$ (1,553)
Denominator:		
Net weighted average number of common stock shares outstanding	20,571	18,849
Net income (loss) per share—basic:	$ 0.11	$ (0.08)
Diluted:		
Numerator:		
Net income (loss) allocated to common stock	$ 2,361	$ (1,553)
Denominator:		
Net weighted average number of common stock shares outstanding	20,571	18,849
Weighted average number of options	461	-
Weighted average number of restricted stock units	134	-
Total common stock shares used in per share calculation	21,166	18,849
Net income (loss) per share—diluted:	$ 0.11	$ (0.08)

For each of the three-month periods ended March 31, 2013 and 2014, 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. 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,	
	2013	2014
Common stock options	894	1,932
Restricted share units	-	745
Total	894	2,677

Note 6 – Geographic Information and Significant Customers

Geographic Information—As of December 31, 2013 and March 31, 2014, our long-lived assets consisted primarily of property and equipment, 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, 2013	As of March 31, 2014
United States	$ 37,046	$ 41,191
China	347	339
Total	$ 37,393	$ 41,530

Significant Customers—Substantially all revenue for the three months ended March 31, 2013 and 2014 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, 2013 and 2014 are presented in the table below:

	Three Months Ended March 31,	
	2013	2014
Humana	23%	26%
WellPoint (1)	12%	11%
UnitedHealthcare (2)	11%	11%
Aetna (3)	7%	11%

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

Commission revenue attributable to major medical individual and family health insurance plans was approximately 67% and 60% of our commission revenue in the three months ended March 31, 2013 and 2014, 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, accident and student insurance plan offerings.

As of December 31, 2013, two customers represented 37% and 15%, respectively, of our $4.6 million outstanding accounts receivable balance. As of March 31, 2014, three customers represented 60%, 12% and 10%, respectively of our $8.4 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2013 and March 31, 2014. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2014. Accordingly, our estimate for uncollectible amounts at March 31, 2014 was not material.

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; increasing customer care center staff in the second and third quarters; our expectations relating to average commission dollars per policy for individual and family policies that we sell in 2014; the impact of health care reform laws on the health insurance industry, on our business and on the adoption of the Internet for the purchase of health insurance; our ability to leverage our technology to expand our marketplace; our strategies; the impact of open enrollment periods; seasonality, including the seasonality of our marketing and advertising expenses and their relation to the Medicare and individual and family health insurance open enrollment periods; revenue growth rates for each quarter of 2014; expansion of the individual and family health insurance market and increase in demand for individual and family health insurance; our ability to enter into agreements with and meet requirements to offer qualified health plans through state and federal health insurance exchanges; the impact of the technology and integration challenges of the health insurance exchanges on health insurance enrollment; expectations relating to revenue (including commission revenue, lead referral revenue, advertising revenue and other revenue), sources of revenue, cost of revenue, the collectability of our accounts receivable, profitability, operating expenses, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses, general and administrative expenses and profitability; our future commission rate structure; our overall individual and family health insurance commission rate structure; our expectations regarding the timing of our recognition of revenue; proposed changes relating to payments made to health insurance carriers and agents by the Centers of Medicare and Medicaid Services; the timing of accurate reporting of commission revenue and membership from health insurance carriers; an increase in our commission revenue in absolute dollars in 2014 relative to 2013; an increase in our average commission revenue per policy for individual and family policies in 2014; the amount of fees we pay to marketing partners; seasonal and absolute increases in our customer care and enrollment costs; investments and increases in technology and content expenses; increases in general and administrative expenses; our estimate of the number of continuing members on all policies; our ability to convert subsidy-eligible individuals and families into members; the sufficiency of our cash generated from operations and our current cash and cash equivalents; the timing and amount of our future lease obligations; the timing of open enrollment periods including restrictions on changes outside of such periods and our readiness therefore; our ability to sell individual and family health insurance outside of open enrollment periods; our expectations and projections relating to membership and commission rates; changes to our significant customers; the timing and source of our Medicare-related revenue; estimates relating to critical accounting policies and related impact on our financial statements; future capital requirements; expansion into new business areas and additional geographic regions; 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 discussed in this report, and in particular, the risks discussed under the heading "Risk Factors" in Part II, Item 1A 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 2014, 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 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, and apply for and purchase individual and family, Medicare-related, 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 platform. We have also invested significant time and resources in obtaining licenses to sell health insurance in all 50 states and the District of Columbia, developing diverse member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with leading insurance carriers, enabling us to offer thousands of health insurance plans

online. Our ecommerce platforms can be accessed directly through our website as well as through our network of marketing partners.

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platform. Commission revenue represented 89% of total revenue in both the three months ended March 31, 2013 and 2014. Historically, the commission payments we receive on individual and family, small business and ancillary health insurance policies we sold were a percentage of the premium on the policy. During 2013, we received communications from many carriers indicating that in 2014 our individual and family health insurance commissions would change from being calculated on a percentage-of-premium basis to a flat amount per-member-per-month. The commission payments that we receive for individual and family, small business and ancillary health insurance policies are typically made to us on a monthly basis for as long as the policy remains active with us.

We actively market the availability of Medicare-related health insurance plans through our online Medicare plan platforms *www.eHealthMedicare.com*, *www.Medicare.com* and *www.PlanPrescriber.com*. Our Medicare plan platforms enable consumers to research and compare Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Commission payments we receive for Medicare Advantage and Medicare Part D prescription drug plans sold by us are typically fixed and are earned over a period of at least six years, depending on the carrier arrangement, and are paid to us either monthly or annually.

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. Additionally, health insurance pricing, which is set by the health insurance carrier and approved by regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

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 changed and will continue to change, the health insurance industry in substantial ways. Among several other provisions, these laws and the regulations implementing them include a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer and contribute to their employees group health insurance coverage or face tax penalties if they do not do so in 2015 and thereafter; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; requirements for minimum individual and small business health insurance benefit levels, including prohibitions on lifetime coverage limits and limitations on annual coverage limits; 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; establishment of state and/or federal government-run health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for the purchase of individual health insurance during specified times of the year; Medicaid expansion so that a greater number of individuals will be insured under Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels if they are eligible and purchase individual or small group health insurance through the state or federal health insurance exchange. While many aspects of health care reform became effective in 2014, health insurance carriers have been required as a part of health care reform to maintain medical loss ratios of eighty percent in their individual and family health insurance business since the beginning of 2011. Under health care reform an eighty-five percent medical loss ratio requirement for Medicare Advantage plans became effective in 2014.

The initial open enrollment period under health care reform began in October 2013 and ended in March 2014. Individuals and families cannot purchase individual and family health insurance outside this period until the open enrollment period for the following year, 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. Moreover, in order to be eligible for a subsidy, qualified individuals must purchase subsidy-qualifying health plans through a government-run health insurance exchange during the open enrollment period or a special enrollment period. A substantial number of our existing members may be eligible for subsidies in connection with their purchase of health insurance. During the third quarter of 2013, we entered into two agreements with the Centers for Medicare and Medicaid Services, or CMS, to allow us to enroll subsidy-eligible individuals in qualified health insurance plans online in the 36 states where the federal government is operating an exchange during the initial open enrollment period. Pursuant to the agreements as well as applicable law and regulations, we must satisfy a number of conditions and requirements to enroll subsidy eligible individuals in qualified health plans. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans. If we are not able to satisfy these conditions and requirements as well as enter into functioning relationships with government-run health insurance exchanges to offer qualified health plans that are required for individuals to receive a subsidy, we may lose existing members and new

members. Approximately 5% of our total submitted applications in the first quarter of 2014 related to enrollment of subsidy-eligible individuals into qualified health plans, almost all of which were submitted through the health insurance exchange in states where the federal government is operating the exchange. The online customer experience in the federal exchange driven process was cumbersome and often required significant telephonic interaction between the customer and our customer care. We continue to push the federal exchange to adopt a website and processes that are efficient, scalable and online. If the federal exchange does not do so, our ability to enroll individuals who are eligible for subsidies will be negatively impacted. Additionally, we have not entered into a similar relationship with any of the states that are operating their own exchanges.

While aspects of health care reform may positively impact our business, the aggregate future impact of the implementation of health care reform on our business and financial results is uncertain. Our ability to continue to act as a health insurance agent for our members who switch to a new health insurance product will be dependent upon a number of factors, including health insurance company practices, individual financial circumstances, our members' existing health insurance plans, the price of health insurance and our ability to expand our offering to include subsidy-eligible health insurance plans. Moreover, we are facing new competition in the form of government run health insurance exchanges. Our ability to act as a health insurance agent to health care reform subsidy-eligible individuals is dependent upon government run health insurance exchanges developing and implementing an efficient, scalable and online enrollment process, and our ability to successfully enter into agreements and integrate with those government-run exchanges. In order to enroll individuals in subsidy-eligible plans, we also need to meet a number of requirements relating to the display of information on our websites as well as new and comprehensive privacy and security requirements. Our ability to maintain compliance with these and other requirements could present significant challenges for us. The implementation of open enrollment periods for the purchase of individual health insurance also presents challenges to our ability to enroll a significant number of individuals into health insurance over a limited period of time. We expect the restriction on individuals being able to make plan changes outside of open enrollment periods will result in a reduction in the number of health insurance policies purchased through us outside of the open enrollment period. The impact of health care reform on our health insurance carrier partners and their reaction is also unclear. For instance, 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. Given the disruption that the implementation of health care reform may have on the health insurance market, health care reform could in the aggregate have a material adverse effect on our business and results of operations.

We derive 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. In return, we are typically paid a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications. We also offer Medicare advertising services, which allow Medicare plan carriers to purchase advertising on a separate website developed, hosted and maintained by us. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue over the service period.

We derive revenue from licensing the use of our health insurance ecommerce technology and typically receive a fixed, up-front fee or performance-based fees, or a combination of both. Our technology platform enables health insurance carriers and agents to market and distribute health insurance plans online. We also have licensed our ecommerce technology for use by government agencies.

Sources of Revenue

Commission Revenue

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through us. Commissions for individual and family and small business health insurance plans have generally represented a percentage of the insurance premium and, to a much lesser extent, commission override payments that insurance carriers pay us for achieving sales volume thresholds or other objectives. Commission rates vary by carrier and by the type of plan purchased by a member. Commission rates can vary based upon the amount of time that the policy has been active, with commission rates for individual and family plans typically being higher in the first twelve months of the policy. After the first twelve months, commission rates generally decline significantly. As a result, if we do not add a sufficient number of members on new policies, our revenue growth will be negatively impacted. Individuals, families and small businesses purchasing health insurance through us typically pay their premiums on a monthly basis. Insurance carriers typically pay commissions to us on these policies monthly, after they receive the premium payment from the member. We

generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. As a result, the majority of our commission revenue is recurring in nature.

Many health insurance carriers amended our individual and family health insurance commission rates effective in January 2014 and changed the basis on which they pay commissions from a percentage-of-premium to a flat amount per-member-per-month. Similar to percentage-of-premium commissions, the amount paid per-member-per-month generally declines after the initial policy year. We conducted an analysis on individual and family health insurance policies that we sold between July 2011 and June 2012 to estimate the impact of these commission changes. The analysis indicated that the average commission dollars per-member-per-month calculated using the 2014 rates on these policies would be equal to, or slightly higher than, our actual average commission dollars per-member-per-month that we received under the rates in effect prior to the commission changes. We selected the policies sold between July 2011 and June 2012 to conduct the analysis, because the commissions we were receiving on these policies were at the commission rates in effect after the 2011 reduction in commission rates that we experienced as a result of the health care reform medical loss requirements and the use of these policies for the analysis allowed for us to experience the payment of both first year and renewal commissions on the policies. Notwithstanding our analysis, the actual commission dollars per-member-per-month that we receive for new members in 2014 and beyond will depend upon a number of factors, including the ratio of policies that we sell for which we receive per member-per-month commissions compared to percentage-of-premium commissions, the premiums on the policies we sell, the mix of our members by health insurance carrier and the commission rates we receive from the carrier. We experienced a shift in the concentration of our members by carrier as a result of the health care reform annual enrollment period that ended on March 31, 2014. Due to healthcare reform, some health insurance carriers exited or reduced selling efforts in certain markets during the annual enrollment period, while expanding in others. The overall impact of the change in the concentration of our membership by carrier is unknown, but it could positively or negatively impact our average commission dollars per member.

We generally recognize individual and family and small business health insurance plan revenue when commissions are reported to us by a health insurance carrier, net of an estimate for future forfeiture amounts payable to carriers due to policy cancellations. Commissions are reported to us by a cash payment and commission statement. We generally receive these communications simultaneously. In instances when we receive the cash payment and commission statement separately and in different accounting periods, we recognize revenue in the period that we receive the earliest communication, provided we receive the second corroborating communication shortly after the end of the accounting period. If the second corroborating communication is not received shortly after the end of the accounting period, we recognize revenue in the period the second communication is received. We use the data in the commission statements to help identify the members for which we are receiving a commission payment, the amount received for each member and to estimate forfeitures payable to carriers. As a result, we recognize the net amount of compensation earned as the agent in the transaction. Commission override revenue, which we recognize on the same basis as premium commissions, is generally reported to us in a more irregular pattern than premium commissions. As a result, our revenue for a particular quarter could be higher or lower than expectations due to the timing of the reporting of commission override revenue to us.

Historically, the number of individual and family health insurance applications submitted through our ecommerce platform generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. This trend changed in the fourth quarter of 2013 and the first quarter of 2014 as a result of an increase in the number of individual and family applications submitted during the initial open enrollment period under health care reform which began on October 1, 2013 and ended on March 31, 2014. The number of submitted individual and family plan applications increased significantly, relative to historical levels, during the fourth quarter of 2013 and first quarter of 2014. We expect the number of submitted individual and family applications in the second and third quarters of 2014 to decline compared to prior periods. Revenue for the increased number of submitted individual and family plan applications in the fourth quarter of 2013 and the first quarter of 2014 was generally not recognized in those same respective quarters due to many of the submitted applications occurring at the end of each quarter. Approximately 50% of the submitted individual and family plan applications in the first quarter of 2014 were submitted during the last two weeks of March 2014. Also, the number of individual and family plan members per submitted application declined during the first quarter of 2014 as a higher percentage of individuals and smaller sized families submitted individual and family health insurance applications than in prior periods. At the same time, for plans effective in 2014 we have experienced higher approval rates on submitted individual and family plan applications when compared to prior periods.

Member retention rates on our individual membership base were negatively impacted by health care reform during the fourth quarter of 2013 and the first quarter of 2014 primarily due to the transition from health care insurance plans that are not compliant with the requirements of health care reform to compliant health care insurance plans on January 1, 2014 and from the assumed purchase of qualified health care plans by our members directly from government run health insurance exchanges. Based on our estimated individual and family health insurance membership as of March 31, 2014 our new membership growth during the health care reform open enrollment period offset the impact of the decrease in our membership retention rate during the open enrollment period. However, given the large amount of health insurance purchasing activity that occurred at the end of the open enrollment period and the amount of time it takes for us to learn of changes in our membership, we will not have a full view of the impact of the open enrollment period on our membership until later in the year.

The second annual open enrollment period for individual and family health insurance is scheduled to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates for the annual open enrollment period are unknown. 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. We expect that open enrollment periods will change the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. We expect that applications submitted for individual and family health insurance to decline during the second and third quarters of the year, outside of the annual open enrollment periods compared to the same periods in 2013.

We actively market the availability of Medicare-related insurance plans through our online Medicare plan platforms, including *www.eHealthMedicare.com*, *www.Medicare.com* and *www.PlanPrescriber.com*. These platforms enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We offer online application and telephonic enrollment capabilities for certain Medicare plans. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, through either online applications or telephonically, we generate revenue from commissions we receive from health insurance carriers. The commission payments we receive for Medicare Supplement plans are typically a percentage of the premium on the policy that we sold and are paid to us on a monthly basis for as long as a policy remains active with us. For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission from insurance carriers after the policy is approved by the carrier and either a fixed, monthly commission beginning with and subsequent to the second policy year for a Medicare Advantage policy or a fixed, annual commission beginning with and subsequent to the second policy year for a Medicare Part D prescription drug policy. Additionally, these commission rates may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. We may earn commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans typically for a period of at least six years, depending on the carrier arrangement, provided that the policy remains active with us.

We recognize commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans for the entire policy year once the annual or first monthly commission amount for the policy year is reported to us by the carrier, net of an estimate for future forfeiture amounts due to policy cancellations. For commissions paid to us on a monthly basis, we record a receivable for the commission amounts to be received over the remainder of the policy year, net of an estimate for commission amounts not expected to be collected due to policy cancellations, which is included in Accounts Receivable in the accompanying consolidated balance sheets. We continue to receive the commission payments from the relevant insurance carrier until the earlier of the cancellation of the policy, our no longer remaining the agent on the policy, or our commission term with the carrier expires, typically for a period of at least six years from the effective date of the policy, depending on the carrier arrangement. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier. Our services are complete when a carrier has approved an application in the initial year and when a member has renewed in a renewal year. The seller’s price is fixed or determinable and collectability is reasonably assured when a carrier has approved an application and the carrier reports to us the annual or first monthly renewal commission amount for each policy year.

The majority of Medicare plans are sold in our fourth quarter 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. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter resulting from the sale of new Medicare plans. During the years 2013 and 2012, 64% and 59%, respectively, of our new Medicare approved members were enrolled during the fourth quarters of 2013 and 2012. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first

quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

We market and sell ancillary health insurance plans, which include short-term, dental, life, vision, accident and student insurance plans, on our website www.eHealthinsurance.com. Historically, we have sold ancillary health insurance plans alongside individual and family health insurance plans and also as standalone products. Ancillary health insurance plans are not subject to the same open enrollment period as individual and family health insurance. We recognize commission revenue for ancillary health insurance plans similar to our recognition of individual and family health insurance plan commission revenues. Revenue is recognized when commissions are reported to us by a health insurance carrier, net of an estimate for future forfeiture amounts payable to carriers due to policy cancellations. Submitted applications for ancillary health insurance plans increased 92% during the first quarter of 2014 compared to the first quarter of 2013. Since ancillary health insurance plans have traditionally been sold with individual and family plans, which are now mainly sold during open enrollment periods, but can also be bought as standalone products outside of open enrollment periods, the seasonality of our sale of ancillary health insurance plans is unclear.

Commission revenue attributable to major medical individual and family health insurance plans was 67% and 60% of commission revenue in the three months ended March 31, 2013 and 2014, respectively. The decline in the percentage of commission revenue attributable to major medical individual and family health insurance plans in the three months ended March 31, 2014, compared to the three months ended March 31, 2013, was due primarily to an increase in commission revenue attributable to Medicare-related insurance plans and, to a lesser extent, ancillary health insurance plans, consisting primarily of dental, accident and vision insurance plan offerings.

We expect commission revenue to increase in absolute dollars in 2014 compared to 2013, primarily as a result of increases in Medicare plan, individual and family plan and ancillary plan commission revenues.

Other Revenue

In addition to the commission revenue we derive from the sale of health insurance plans, we derive other revenue from our online sponsorship and advertising program, from licensing the use of our ecommerce technology and from generating and delivering leads, primarily for Medicare plans.

Online Sponsorship and Advertising. We offer advertising services for our Medicare plan carriers to purchase advertising on separate websites developed, hosted and maintained by us for a pre-determined amount of time. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue over the service period. We also derive revenue from online sponsorship and advertising programs that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications.

Technology Licensing. We derive 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. In our technology licensing business, we are paid implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications. Typically, we are paid a one-time implementation fee commencing once the technology is available for use by the third party, which we recognize on a straight-line basis over the term of the agreement. In addition, we generate revenue based on performance criteria that are either measured based on data tracked by us, or based on data tracked by the third party. In instances where the performance criteria data are tracked by us, we recognize revenue in the period of performance. In instances where the performance criteria data are tracked by the third party, we recognize revenue when the amounts earned are fixed or determinable and collection is reasonably assured. Typically, this occurs through our receipt of a cash payment from the third party along with a detailed statement containing the data that is tracked by the third party.

We expect other revenue to decline in absolute dollars in 2014 compared to 2013 due primarily to a decrease in online sponsorship and advertising revenue.

Member Acquisition

An important factor in our revenue growth is the growth of our member base. Our marketing initiatives are an important component of our strategy to grow our member base and are focused on three primary member acquisition channels: direct,

marketing partners and online advertising. Our marketing initiatives are primarily designed to encourage consumers to complete an application for health insurance. Our marketing channels are as follows:

Direct. Our direct member acquisition channel consists of consumers who access our website addresses, including *www.eHealth.com*, *www.eHealthInsurance.com*, *www.eHealthMedicare.com*, *www.Medicare.com* and *www.PlanPrescriber.com*, either directly or through algorithmic natural search listings on Internet search engines and directories. For the three months ended March 31, 2013 and 2014, applications submitted through us for individual and family health insurance from our direct channel constituted 48% and 36%, respectively, of all individual and family health insurance applications submitted on our website.

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. Growth in our marketing partner channel depends upon our expanding marketing programs with existing partners and adding new partners to our network. For the three months ended March 31, 2013 and 2014, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 32% and 44%, respectively, of all individual and family health insurance applications submitted on our website.

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 banner advertising and email marketing. For both the three months ended March 31, 2013 and 2014, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 20% of all individual and family health insurance applications submitted on our website.

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. Total consideration paid in connection with these transfers amounted to $13.9 million. Consideration for all book-of-business transfers is being amortized to cost of revenue as we recognize commission revenue related to the transferred members.

We expect cost of revenue to increase in absolute dollars in 2014 due primarily to an increase in payments for referrals to our website by marketing partners with whom we have revenue-sharing arrangements.

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. Our direct channel expenses primarily consist of costs for direct mail and email marketing and may also include costs for television, radio, and print advertising.

Our marketing partner channel expenses consist primarily of fees paid to marketing partners with which we have a relationship. 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. Many 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. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by seasonal submitted application patterns. As a result, marketing and advertising expenses related to individual and family health insurance plans has historically been highest in our first and third quarters, while marketing and advertising expenses related to Medicare-related plans has historically been highest in our third and fourth quarters. However, as a result of an increase in the number of individual and family applications submitted during the initial open enrollment period under health care reform, which began on October 1, 2013 and ended on March 31, 2014, we experienced a substantial increase in marketing and advertising expenses related to individual and family plans during the fourth quarter of 2013 and the first quarter of 2014. We expect marketing and advertising costs to decrease in the second and third quarters with a decrease in submitted individual and family plan applications outside of the annual open enrollment period. We expect profitability to increase in the second and third quarters of the year as a result of these lower marketing and advertising costs.

The majority of Medicare plans are sold in our fourth quarter 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. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our website, those expenses are influenced by these patterns. In addition, 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. An increase in submitted applications resulting from marketing partner referrals could cause our net income to be lower than our expectation, since the revenue to be derived from submitted applications that are approved by health insurance carriers will not be recognized until future periods.

Paid keyword search advertising on search engines represents the majority of expenses in our online advertising channel. We incur expenses associated with search engine advertising in the period in which the consumer clicks on the advertisement. 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. For example, due to the substantial increase in the number of consumers referred to our website from paid keyword search advertising during the Medicare annual enrollment period in the fourth quarter of 2013, as well as the initial open enrollment period for individual and family plans during the fourth quarter of 2013 and the first quarter of 2014, we experienced a significant increase in online advertising expenses during both the fourth quarter of 2013 and first quarter of 2014 compared to the other quarters of 2013. We also increased our discretionary spending for Medicare plan-related online advertising in the third and fourth quarters of 2013 compared to the first and second quarters in conjunction with the Medicare annual enrollment period. Because the majority of our Medicare plan-related revenue for new sales is not generated until the fourth quarter, our discretionary online advertising expenses had a negative impact on our profitability during the third quarter of 2013. For individual and family plans, we increased our discretionary spending in both the fourth quarter of 2013 and the first quarter of 2014 in conjunction with the initial open enrollment period. Because the revenue related to new individual and family plan members is recognized over the life of the policy, our discretionary online advertising for individual and family plans had a negative impact on our profitability during both the fourth quarter of 2013 and the first quarter of 2014. The seasonal patterns caused by the individual and family health insurance is new and is subject to change in future periods, particularly in connection with any change in the timing of the open enrollment periods. The Medicare plan-related seasonal patterns also occurred in 2012, and we expect them to occur again in 2014.

During the fourth quarter of 2013 and the first quarter of 2014, the source of our submitted individual and family plan applications shifted from our lower cost direct marketing channel to our higher cost marketing partner channel. Additionally, the cost per submitted individual and family plan application increased for our direct marketing, online advertising and marketing partner channels in Q1 2014.

We expect our marketing and advertising expenses to increase in absolute dollars in 2014 compared to 2013 due primarily to increases in submitted individual and family plan applications and Medicare-related plan applications from both our online advertising and marketing partner channels during 2014.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits costs for personnel engaged in pre-sales assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the underwriting process. In preparation for the Medicare annual enrollment period and to a lesser extent the initial open enrollment period for individuals and family plans, we begin ramping up our customer care center staff during our second and third quarters to handle the anticipated increased volume of health insurance transactions during the fourth quarter. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to the first and second quarters. In the first quarter of 2014, we retained some enrollment personnel during the initial open enrollment period under health care reform that ended on March 31, 2014 to handle the increased volume of individual and family plan applications. Because the majority of our Medicare plan-related revenue related to new sales is not generated until the fourth quarter, our temporary customer care center staffing costs incurred in the third quarter has had a significant negative impact on our profitability during that quarter. These seasonal trends are expected to continue in 2014.

We expect customer care and enrollment expenses to increase in absolute dollars in 2014 compared to 2013 as a result of additional personnel we have hired and expect to hire to service the expected increase in the volume of Medicare demand and the expected increase in the volume of individual and family demand in 2014 and due to an increase in expenditures to further develop our sales capabilities.

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.

We expect to increase our technology and content spending throughout 2014 in absolute dollars compared in 2013 as a result of an increase in labor and personnel costs in our product management and engineering departments in order to increase functionality to meet the conditions required to offer and sell subsidy-eligible health insurance plans, to enhance our online user experience, and for our planned investment in the development of employer-based health insurance exchange technology. We expect that technology and content spending will be impacted in future years by additional infrastructure necessary to maintain compliance with these conditions.

General and Administrative

General and administrative expenses include compensation and benefits costs for staff working in our executive, finance, corporate development, 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.

We expect our general and administrative expenses to increase in absolute dollars in 2014 compared to 2013 as we add infrastructure to support company growth.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics for the three months ended March 31, 2013 and 2014 and as of March 31, 2013 and 2014:

Key Metrics:	**Three Months Ended March 31, 2013**	**Three Months Ended March 31, 2014**
Operating cash flows (1)	$ (538,000)	$ (5,410,000)
IFP submitted applications (2)	126,900	169,500
IFP approved members (3)	114,400	145,100
Total approved members (4)	206,600	283,700

Commission revenue (5)	$	38,251,000	$	45,577,000
Commission revenue per estimated member for the period (6)	$	37.56	$	36.01

	As of March 31, 2013	As of March 31, 2014
IFP estimated membership (7)	738,900	800,200
Medicare estimated membership (8)	75,300	111,700
Other estimated membership (9)	239,600	374,300
Total estimated membership (10)	1,053,800	1,286,200

Other Metrics:	**Three Months Ended March 31, 2013**	**Three Months Ended March 31, 2014**
Source of IFP submitted applications (as a percentage of total IFP applications for the period):		
Direct (11)	48%	36%
Marketing partners (12)	32%	44%
Online advertising (13)	20%	20%
Total	100%	100%

Notes:

(1)	Net cash provided by operating activities for the period from the condensed consolidated statements of cash flows.
(2)	IFP applications submitted on eHealth's website during the period. Applications are counted as submitted when the applicant completes the application, provides a method for payment and clicks the submit button on our website and submits the application to us. The applicant generally has 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 include applications for IFP plans for which we receive commissions as well as other forms of payment. We define our "IFP" offerings as major medical individual and family health insurance plans, which does not include small business, short-term, stand-alone dental, life, student or Medicare-related health insurance plans.
(3)	New IFP members reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.
(4)	New members for all products reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.
(5)	Commission revenue (from all sources) recognized during the period from the condensed consolidated statements of comprehensive income (loss).
(6)	Calculated as commission revenue recognized during the period (see note (5) above) divided by average estimated membership for the period (calculated as beginning and ending estimated membership for all plans for the period, divided by two).
(7)	Estimated number of members active on IFP insurance policies as of the date indicated.
(8)	Estimated number of members active on Medicare-related insurance policies as of the date indicated.
(9)	Estimated number of members active on insurance policies other than IFP and Medicare-related policies as of the date indicated.
(10)	Estimated number of members active on all insurance policies, including Medicare-related policies, as of the date indicated.
(11)	Percentage of IFP submitted applications from applicants who came directly to the eHealth website through algorithmic search engine results or otherwise. See note (2) above for further information as to what constitutes a submitted application.
(12)	Percentage of IFP submitted applications from applicants sourced through eHealth's network of marketing partners. See note (2) above for further information as to what constitutes a submitted application.
(13)	Percentage of IFP submitted applications from applicants sourced through paid search and other online advertising activities. See note (2) above for further information as to what constitutes a submitted application.

Our insurance carrier partners bill and collect insurance premiums paid by our members. Carrier partners 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:

- Historically, to calculate the estimated number of members active on individual and family health insurance policies, we take the sum of (i) the number of individual and family health insurance 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 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). However, for the purpose of estimating the number of members active on individual and family plan insurance policies as of March 31, 2014 we have taken an additional step to bring our estimate of member cancellation more current compared to the historical methodology. Specifically, we looked at the percentage of members for whom we had a commission payment in December of 2013 but no payment in January of 2014, compared that to our historical sequential membership change between these two months in the prior year and increased the estimated member cancellation rate by the resulting difference to account for potentially higher churn on January 1, 2014 as a result of the health care reform. We, however, assumed member cancellations consistent with our historical experience for the months of October through December of 2013 and February and March of 2014.

- For ancillary insurance policies (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-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 Medicare-related insurance policies, we take the number of members for whom we have received or applied a commission payment prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations, including rapid disenrollment).

- For small business health insurance policies, 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. Additionally, our carrier partners often do not communicate this 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 policies will be counted as a member more than once. For example, a member who is active on both an individual and family health insurance policy and a standalone dental policy 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 our 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 reflect updated information regarding our membership in the membership estimate for the period we receive such updated information, if applicable. 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 economic and other conditions on our membership retention. Health care reform could cause the assumptions and estimates 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, 2014, 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, 2013, for a complete discussion of our critical accounting policies and estimates.

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, 2013 and 2014 (dollars in thousands):

	Three Months Ended March 31,			
	2013		2014	
Revenue:				
Commission	$ 38,251	89 %	$ 45,577	89 %
Other	4,956	11	5,363	11
Total revenue	43,207	100	50,940	100
Operating costs and expenses:				
Cost of revenue	2,651	6	2,113	4
Marketing and advertising	14,835	34	23,109	45
Customer care and enrollment	7,166	17	9,713	19
Technology and content	6,741	16	10,467	21
General and administrative	7,519	17	8,294	16
Amortization of intangible assets	354	1	354	1
Total operating costs and expenses	39,266	91	54,050	106
Income (loss) from operations	3,941	9	(3,110)	(6)
Interest and other expense, net	(25)	-	(39)	-
Income (loss) before provision (benefit) for income taxes	3,916	9	(3,149)	(6)
Provision (benefit) for income taxes	1,555	4	(1,596)	(3)
Net income (loss)	$ 2,361	5 %	$ (1,553)	(3)%

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

	Three Months Ended March 31,	
	2013	2014
Marketing and advertising	$ 459	$ 657
Customer care and enrollment	88	96
Technology and content	319	562
General and administrative	768	1,130
Total stock-based compensation expense	$ 1,634	$ 2,445

Three Months Ended March 31, 2013 and 2014

Revenue

The following table presents our commission, other revenue and total revenue for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
Commission	$ 38,251	$ 45,577	$ 7,326	19%
Percentage of total revenue	89%	89%		
Other	$ 4,956	$ 5,363	$ 407	8%
Percentage of total revenue	11%	11%		
Total revenue	$ 43,207	$ 50,940	$ 7,733	18%

Three Months Ended March 31, 2013 and 2014—Commission revenue increased $7.3 million, or 19%, in the three months ended March 31, 2014, compared to the three months ended March 31, 2013, due primarily to a $4.1 million increase in Medicare-related commission revenue. Additionally, individual and family health insurance commission revenue increased $1.8 million and commission revenue related to ancillary health insurance products, consisting primarily of short-term, dental, vision and accident insurance plan offerings, increased $1.5 million. The increases in Medicare-related, ancillary and individual and family insurance commission revenues are due to increased membership for the three months ended March 31, 2014 compared to the three months ended March 31, 2013.

Other revenue increased $0.4 million, or 8%, in the three months ended March 31, 2014, compared to the three months ended March 31, 2013, due primarily to a $0.4 million increase in technology licensing revenue.

Operating Costs and Expenses

Cost of Revenue

The following table presents our cost of revenue for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
Cost of revenue	$ 2,651	$ 2,113	$ (538)	(20%)
Percentage of total revenue	6%	4%		

Three Months Ended March 31, 2013 and 2014—Cost of revenue decreased $0.5 million, or 20%, in the three months ended March 31, 2014, compared to the three months ended March 31, 2013, due to a decrease of $0.5 million in amortization expense associated with consideration we paid in connection with several book-of-business transactions in which we acquired broker of record status on a number of Medicare health insurance plans. The amount of book-of-business consideration we amortize to cost of revenue each quarter is proportional to the amount of commission revenue we recognize on the underlying policies each quarter.

Marketing and Advertising

The following table presents our marketing and advertising expenses for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%

Marketing and advertising	$ 14,835	$ 23,109	$ 8,274	56%
Percentage of total revenue	34%	45%		

Three Months Ended March 31, 2013 and 2014—Marketing and advertising expenses increased $8.3 million, or 56%, in the three months ended March 31, 2014 compared to the three months ended March 31, 2013, primarily due to an increase of variable advertising costs of $7.5 million. Fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website increased $4.3 million, online advertising costs increased $2.1 million and direct marketing costs increased $1.2 million, all primarily related to the increase in submitted individual and family health insurance applications. Additionally, compensation, including stock-based compensation, and other personnel costs increased $0.7 million as a result of an increase in marketing and advertising personnel.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
Customer care and enrollment	$ 7,166	$ 9,713	$ 2,547	36%
Percentage of total revenue	17%	19%		

Three Months Ended March 31, 2013 and 2014—Customer care and enrollment expenses increased $2.5 million, or 36%, in the three months ended March 31, 2014 compared to the three months ended March 31, 2013, due primarily to additional customer care center personnel hired to service the increased enrollment in Medicare plans during the three months ended December 31, 2013 and retained to service the increased enrollment in individual and family health insurance plans in the three months ended March 31, 2014. As a result, compensation, including stock-based compensation, licensing and other personnel costs increased $2.3 million.

Technology and Content

The following table presents our technology and content expenses for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
Technology and content	$ 6,741	$ 10,467	$ 3,726	55%
Percentage of total revenue	16%	21%		

Three Months Ended March 31, 2013 and 2014—Technology and content expenses increased $3.7 million, or 55%, in the three months ended March 31, 2014 compared to the three months ended March 31, 2013, primarily due to an increase of $2.8 million in compensation, including stock-based compensation, and other personnel costs as a result of an increase in technology and content personnel. Additionally, technology and content expenses increased due to an increase of $0.2 million in depreciation expense, an increase of $0.2 million in spending to support website operation and infrastructure maintenance costs and an increase of $0.5 million in information technology and facilities costs related to an increase in technology and content personnel.

General and Administrative

The following table presents our general and administrative expenses for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
General and administrative	$ 7,519	$ 8,294	$ 775	10%

Percentage of total revenue	17%	16%

Three Months Ended March 31, 2013 and 2014—General and administrative expenses increased $0.8 million, or 10%, in the three months ended March 31, 2014 compared to the three months ended March 31, 2013, due primarily to an increase of $1.1 million in compensation, including stock-based compensation, other personnel costs and depreciation expense as a result of an increase in general and administrative personnel as we add infrastructure to support company growth, partially offset by decreases in other corporate expenses.

Amortization of Intangible Assets

The following table presents our amortization of intangible assets for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
Amortization of intangible assets	$ 354	$ 354	$ -	0%
Percentage of total revenue	1%	1%		

Three Months Ended March 31, 2013 and 2014—Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber remained flat in the three months ended March 31, 2014 compared to the three months ended March 31, 2013.

Other Expense, Net

The following table presents our other expense, net, for the three months ended March 31, 2013 and 2014 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		Change	
	2013	2014	$	%
Other expense, net	$ (25)	$ (39)	$ (14)	56%
Percentage of total revenue	(0%)	(0%)		

Three Months Ended March 31, 2013 and 2014—Administrative bank fees, foreign exchange losses, management fees and interest expense on our capital lease obligations more than offset interest earned on our invested cash and foreign exchange gains in the three months ended March 31, 2014.

Provision (Benefit) for Income Taxes

The following table presents our provision (benefit) for income taxes for the three months ended March 31, 2013 and 2014 and the dollar changes from the prior year periods (dollars in thousands):

	Three Months Ended March 31,		
	2013	2014	Change $
Provision (benefit) for income taxes	$ 1,555	$ (1,596)	$ (3,151)
Percentage of total revenue	4%	(3%)	

Three Months Ended March 31, 2013 and 2014—In the three months ended March 31, 2013 and 2014, we recorded a provision for income taxes representing effective tax rates of 39.7% and 50.7%, respectively. Our effective tax rate for the three months ended March 31, 2013 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses, partially offset by a tax benefit resulting from the extension of the federal research tax credit through December 31, 2013. Our effective tax rate for the three months ended March 31, 2014 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses.

Liquidity and Capital Resources

At March 31, 2014, our cash and cash equivalents totaled $98.2 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, 2013, our cash and cash equivalents totaled $107.1 million. The decrease in cash and cash equivalents reflects $1.1 million used to purchase property and equipment, $4.5 million to purchase intangible assets and $5.4 million

used in operating activities, partially offset by cash flows provided by financing activities from the exercise of common stock options. The intangible asset purchased during the first quarter was the Internet domain name www.Medicare.com.

On September 10, 2012, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock and on March 6, 2013, we announced that our board of directors increased the approved repurchase amount under this program to $60 million. Purchases under this program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

On March 31, 2014, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $50 million of our common stock. We expect to fund the repurchase program from available working capital. As of March 31, 2014, no common stock has been repurchased under this program.

For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method. There was no stock repurchase activity under our stock repurchase programs during the three months ended March 31, 2014. For accounting purposes, common stock repurchased under our stock repurchase programs is recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method.

In addition to the shares repurchased under our repurchase programs as of March 31, 2014, we have in treasury 274,113 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, 2013 and March 31, 2014, we had a total of 9,519,286 shares and 9,583,382 shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the three months ended March 31, 2013 and 2014 (in thousands):

	Three Months Ended March 31,	
	2013	2014
Net cash used in operating activities	$ (538)	$ (5,410)
Net cash used in investing activities	$ (1,539)	$ (5,615)
Net cash (used in) provided by financing activities	$ (25,160)	$ 2,186

During the three months ended March 31, 2013 and 2014, excess federal and state tax benefits related to share-based payments, resulted in increases of $3.5 million and $3.2 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. These amounts are also classified in the condensed consolidated statements of cash flows as both a reduction to operating cash flows and as a financing cash inflow.

Operating Activities

Cash 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.

Historically, we have experienced a reduction in operating cash flows during the first quarter of the year compared to the other quarters due to the payment of annual performance bonuses to employees in the first quarter of the year. Additionally, a significant portion of our marketing and advertising expenses are driven by the number of health insurance

applications submitted on our ecommerce platform. Since our marketing and advertising costs are expensed as incurred and the revenue from approved applications is recognized 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 the fourth quarter of 2013 and the first quarter of 2014, we experienced a substantial increase in marketing and advertising expenses related to the increase in the number of individual and family plan applications submitted during the initial open enrollment period, which had a negative impact on cash flows. In addition to the initial open enrollment period that ended on March 31, 2014, the annual open enrollment period for individual and family health insurance is proposed to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates of annual open enrollment period are unknown. We expect marketing and advertising costs to increase during the first and fourth quarters of the year due to an increase in submitted applications during the annual enrollment periods for individual and family health insurance and Medicare Advantage and Medicare Part D prescription drug plans. We expect marketing and advertising costs to decrease during the second and third quarters due to the reduce number of health insurance applications we expect outside of annual enrollment periods.

Three Months Ended March 31, 2014— Our operating activities used cash of $5.4 million during the three months ended March 31, 2014 and consisted of net loss of $1.6 million, increased by cash used by operating assets and liabilities and other activities of $7.6 million and offset by non-cash items of $3.8 million. Adjustments for non-cash items primarily consisted of $2.9 million of depreciation and amortization, including amortization of book-of-business consideration and amortization of intangible assets, and $2.4 million of stock-based compensation expense, partially offset by $1.6 million of deferred income taxes. Cash used by operating assets and liabilities and other activities primarily consisted of an increase of $3.8 million in accounts receivable, an increase of $3.5 million in prepaid expenses and other assets, a decrease of $2.0 million in accounts payable, and a decrease in accrued compensation and benefits of $1.4 million, partially offset by an increase of $3.2 million in accrued marketing expenses.

Three Months Ended March 31, 2013— Our operating activities used cash of $0.5 million during the three months ended March 31, 2013 and consisted of net income of $2.4 million, increased by non-cash items of 1.8 million and offset by cash used by operating assets and liabilities and other activities of $4.7 million. Adjustments for non-cash items primarily consisted of $3.1 million of depreciation and amortization, including amortization of book-of-business consideration and amortization of intangible assets, and $1.6 million of stock-based compensation expense, partially offset by $2.9 million of deferred income taxes, consisting primarily of excess tax benefits from stock-based compensation. Cash used by operating assets and liabilities and other activities primarily consisted of an increase of $2.9 million in accounts receivable, an decrease of $1.6 million in accounts payable, a decrease of $1.6 million in accrued compensation and other benefits, partially offset by a decrease of $0.6 million in prepaid assets, and an increase in $0.4 million in deferred revenue. Accounts receivable increased due primarily to an increase in commission receivable related to Medicare plans renewing in the three months ended March 31, 2013. Accounts payable decreased due primarily to the timing of payments to our vendors and accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2012.

Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software to enhance our website and to support our growth and during the three months ended March 31, 2014 include consideration paid for the purchase of an intangible asset.

Three Months Ended March 31, 2014—Net cash used in investing activities of $5.6 million during the three months ended March 31, 2014 was due to $1.1 million used to purchase property and equipment and $4.5 million used in the purchase of an intangible asset, the Internet domain name www.Medicare.com. Additional non-cash consideration for www.Medicare.com included settlement of a $0.3 million outstanding receivable from the owner upon completion of the purchase.

Three Months Ended March 31, 2013— Net cash used in investing activities of $1.5 million during the three months ended March 31, 2013 was attributable entirely to capital expenditures.

Financing Activities

Our financing activities primarily consist of net proceeds from the exercise of common stock options, cash used to net-share settle equity awards and excess tax benefits from stock-based compensation. 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, 2014—Net cash provided by financing activities of $2.2 million during the three months ended March 31, 2014 was due to $2.3 million of proceeds from the exercise of common stock options and $3.2 million of excess tax benefits from stock-based compensation, partially offset by $3.3 million used to net-share settle the tax obligation related to vesting equity awards

Three Months Ended March 31, 2013—Net cash used in financing activities of $25.2 million during the three months ended March 31, 2013 was due to $29.0 million used to repurchase 1.6 million shares of our common stock and $0.8 million used to net-share settle the tax obligation related to vesting equity awards, partially offset by $1.2 million of net proceeds from the exercise of common stock options and $3.5 million of excess tax benefits from stock-based compensation.

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 March 2012, we entered into an agreement to lease a building in Mountain View, California, adjacent to our headquarters office. The term of the operating lease is ten years from the date the building was delivered to us in August 2013 and the base rent is approximately $0.6 million for the first year of the lease. The base rent increases annually by 3%. Future minimum payments related to this operating lease total $7.0 million over the ten-year term of the lease plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease. Lease payments began in the third quarter of 2013.

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.

In April 2013, we entered into an agreement to lease approximately 20,000 square feet of office space in Westford, Massachusetts. The lease commenced in July 2013 and is for a term of 5 years and 3 months. Future minimum payments will total approximately $2.1 million over the term of the lease.

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, 2014 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2014 (nine months)	$ 2,842	$ 1,060	$ 3,902
2015	2,736	250	2,986
2016	2,782	-	2,782
2017	2,766	-	2,766
2018	1,938	-	1,938
Thereafter	4,565	-	4,565
Total	$ 17,629	$ 1,310	$ 18,939

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.

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, 2013 and March 31, 2014, our cash and cash equivalents were invested as follows (in thousands):

	December 31, 2013	March 31, 2014
Cash (1)	$ 16,935	$ 17,107
Money market funds (2)	90,120	81,121
Total cash and cash equivalents	$ 107,055	$ 98,228

(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 Renminbi and are not insured by the U.S. federal government.

(2) At December 31, 2013 and March 31, 2014 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, 2013, two health insurance carriers represented 37% and 15%, respectively, for a combined total of 52% of our $4.6 million outstanding accounts receivable balance. As of March 31, 2014, three health insurance carriers represented 60%, 12% and 10% respectively, for a combined total 82% of our $8.4 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2013 and March 31, 2014. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2014. Accordingly, our estimate for uncollectible amounts at March 31, 2014 was not material.

Significant Customers

Substantially all revenue for the three months ended March 31, 2013 and 2014 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, 2013 and 2014 are presented in the table below:

	Three Months Ended March 31,	
	2013	2014
Humana	23%	26%
WellPoint (1)	12%	11%
UnitedHealthcare (2)	11%	11%
Aetna (3)	7%	11%

(1) Wellpoint includes other carriers owned by Wellpoint.
(2) UnitedHealthcare includes other carriers owned by UnitedHealthcare.
(3) 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.

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, 2014 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.

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.

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, they include 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, a prohibition against insurance companies using pre-existing health conditions as a reason to deny the application of children for 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 commission revenue; and cause health insurance carriers to 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 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 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 plans with effective dates in 2014 has generally increased as a result of the new standards for increased health insurance benefits, among other things. While the individual and family health insurance plans that we sold and that were effective in 2013 and prior to 2013 may not be as expensive, many of these plans do not have post-healthcare reform benefits or meet other standards under health care reform. Moreover, certain health insurance companies determined to terminate these 2013 plans or modified them effective January 1, 2014 with an increase in the cost of the plan in response to health care reform implementation. Any of these circumstances could cause us to suffer a substantial reduction in our membership, which would 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 healthcare 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 existing holders of individual and family health insurance to maintain their policies, which could contribute to a decline in our membership and materially harm our business, operating results and financial condition.

As a part of healthcare reform, each state was required to implement a health insurance exchange by October 2013 where individuals and small businesses can purchase health insurance. For states that did 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, is operating some part of the health insurance exchange in 36 states. It may operate the health insurance exchange for a fewer or greater number of states in the future. Among other things, 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 must purchase qualified health plans through a government exchange to receive their subsidy. The exchanges are a new source of competition for us. 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. Moreover, the exchanges will compete with us for new members. Competitive pressure from health insurance exchanges may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, and may otherwise harm our business, operating results and financial condition.

A federal regulation promulgated under the Patient Protection and Affordable Care Act has been issued that 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 without individual health insurance enrollment capability) 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 substantial number of our existing members may be eligible for subsidies in connection with their purchase of health insurance. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members. If we are not able to satisfy these conditions and requirements as well as enter into functioning relationships with government-run health insurance exchanges to scalably enroll individuals and families into the qualified health insurance plans that are required for individuals to receive a subsidy, we may lose existing members and new members, which would harm our business, operating results and financial condition.

During the third quarter of 2013, we 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. While we have entered into these agreements, we have not been able to integrate with the FFM to offer individuals and families the ability to enroll online in subsidy-qualifying health insurance through the FFM in a scalable way, due to technology and other issues the FFM is experiencing

as well as the FFM not having implemented an integration with agents and brokers to enroll individuals into qualified health plans in an efficient and scalable manner. There are risks and uncertainties relating to our ability to enroll individuals into qualified health plans through the FFM in the future. Among other things, we must maintain our agreement with the FFM which needs to be renewed every year; satisfy the requirements contained in the relevant agreements as well as applicable laws and regulations; maintain a compliant web 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 maintain an integration with the FFM so that information may be passed to and from us relating to enrollment and qualified health plan and subsidy eligibility. We also depend upon the federal government for a number of things relating to our ability to enroll individuals 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 agents and brokers to enroll individuals in qualified health plans 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. If we are not successful in integrating with the FFM in these ways, if the FFM does not develop an integration with agents and brokers that enables online enrollment in an ecommerce friendly experience or if after integrating with the FFM the FFM experiences technical or other problems in connection with the enrollment of individuals in health insurance, we may lose existing members and new members or may not receive commissions for the plans that we sell through the FFM, which would harm our business, operating results and financial condition.

Individuals and families whose incomes are between 133% and 400% of the federal poverty level are generally entitled beginning in 2014 to subsidies in connection with their purchase of health insurance. These qualified health plans are required to be purchased during an initial open enrollment period that began in October 2013 and ended in March 2014, and qualified individuals can thereafter purchase or change their qualified health plan only during subsequent annual enrollment periods of limited duration, subject to states extending the period and exceptions for special enrollment periods for certain qualifying events. States and health insurance carriers also have generally adopted open enrollment periods for the purchase of both subsidy-eligible and non-subsidy eligible health insurance outside of government-run health insurance exchanges. It may be difficult for us to handle as a business any increased volume of health insurance transactions that would occur in a short period of time during the enrollment periods. If our ability to market and sell individual and family health insurance is impeded during an annual enrollment period, whether as a result of technology failures, interruptions in the operation of our website, or otherwise, our business, operating results and financial condition could be harmed. Moreover, we expect to process substantially fewer health insurance applications outside of the enrollment periods. In the aggregate, a shift to open enrollment periods of limited duration in the individual and family and small business health insurance markets may result in a reduction in our membership and revenue; 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 qualified health plans and other health plans will overlap with the annual enrollment period for Medicare plans. In addition, we depend upon health insurance carriers and government-run health insurance exchanges to adopt 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. Health insurance exchanges, including the FFM, have not developed these systems and processes which have negatively impacted our ability to sell qualified health plans since the end of the open enrollment period. If these systems and processes are not timely developed or are not compatible with our platform for selling individual and family health insurance, our ability to sell individual and family health insurance outside of the open enrollment period would be negatively impacted, which would harm our business, operating results and financial condition.

We depend upon health insurance companies to allow us to sell qualified health plans and to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to sell individual and family qualified health insurance plans, or if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans, we could lose a substantial number of existing and potential members and commission revenue we receive as a result of the sale of individual and family and small business health insurance products, which would materially harm our business, operating results and financial condition. In part to attempt to satisfy 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 increased operating expenses and expect to continue to do so. These past and expected increased operating expenses may not result in increased revenue for a number of reasons both within and outside of our control. If our revenues do not increase to offset

these expected increases in costs and operating expenses, our financial condition and results of operations could be negatively affected.

A large number of lawsuits have been filed challenging various aspects of the Patient Protection and Affordable Care Act and related regulations. For example, certain lawsuits have been filed that challenge the ability of individuals to receive subsidies if they purchase their qualified health plan through the FFM as opposed to an exchange established by a state. In the event lawsuits attacking the Patient Protection and Affordable Care Act and related regulations are successful and result in the unenforceability of aspects of the law or regulations that are beneficial to our business, our business, operating results and financial condition could be harmed. In addition, the FFM and state health insurance exchanges have experienced a large number of technical and other issues that have been reported to have adversely impacted enrollment in health insurance through the exchanges. Any delay of or change in the mandate that individuals purchase health insurance or pay a tax penalty contained in the Patient Protection and Affordable Care Act as a result of these our other circumstances could harm our business, operating results and financial condition.

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 individual and family, small group or Medicare Advantage plan 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 healthcare 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 policy holders 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 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, or because they do not want to be associated with our brand. In addition, many aspects of health care reform implemented in 2014 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. 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 traditional in-house agents and carrier websites, to sell their own plans and, in turn, could limit or prohibit us from selling their plans on our ecommerce platform. Carriers may choose to exclude us from their most profitable or popular plans or may determine not to distribute insurance plans in the individual and family and small business markets in certain geographies or altogether. The termination or amendment of our relationship with a carrier could reduce the variety of health insurance

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

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. In the future, we may be forced to offer insurance policies 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. We derived 23% and 26% of our total revenue in the three months ended March 31, 2013 and 2014, respectively, from Humana. We derived 12% and 11% of our total revenue in the three months ended March 31, 2013 and 2014, respectively, from carriers owned by Wellpoint. We derived 11% of our total revenue in both the three months ended March 31, 2013 and 2014, from carriers owned by UnitedHealthcare. We derived 7% and 11% of our total revenue in the three months ended March 31, 2013 and 2014, respectively, from carriers owned by Aetna. 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, which could materially harm our business, operating results and financial condition.

Our revenues and earnings may decline.

During the fourth quarter of 2013 and the first quarter of 2014 our profitability was significantly impacted primarily related to increased marketing and advertising expenses associated with an increase in submitted applications during the initial open enrollment period under the federal Patient Protection and Affordable Care Act. Although applications submitted during this period are expected to contribute to revenue in future periods, it is unclear whether our profitability will return to historical levels. For example, it is not clear how our member retention rates will be impacted by policy cancellations or consumers purchasing their health insurance from sources other than us as a result of health care reform. It also is not clear how many of those who submitted applications will become paying members for whom we receive commissions. We also have in the past and may in the future continue to make significant expenditures related to the development of our business, including expenditures relating to marketing, website technology development and the development of our business selling Medicare-related health insurance plans. Our ability to grow revenue and earnings will depend on a number of factors, including the success of our Medicare plan marketing and sales business, our ability to attract individuals, families and small businesses to purchase health insurance through our ecommerce platform, our maintaining our relationships with health insurance carriers and the commission rates we receive for our sale of health insurance plans and our ability to maintain our relationship with existing members within historical levels. If we are not successful in these areas, our business, operating results and financial condition will be harmed.

Our revenue will be adversely impacted if our membership does not grow. 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. The Medicare-related commission rates that we receive may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. Accordingly, to the extent that our net addition of new members slows, our revenue would be adversely impacted due to a decline in commissions we receive for members whose policies have been active for less than twelve months in addition to the reduction in revenue growth that would occur solely as a result of a decline in our membership.

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 and health care reform. Our commission rate per member has, and could in the future, decrease as a result of either reductions in contractual commission rates or unfavorable changes in health insurance carrier override commission programs, each of which are beyond our control and may occur on short notice. To the extent these and other factors cause our commission rate per member to decline, our rate of revenue growth may decline and our business, operating results and financial condition would be harmed.

During the fourth quarter of 2013 and the first quarter of 2014 and as a result of the health care reform annual enrollment period, we experienced a shift in the concentration of our members with particular health insurance carriers. Due to healthcare reform, some health insurance carriers have exited or reduced selling efforts in certain markets, while expanding in others, leading to changes in the health insurance carrier composition of our revenues. Given that individual

and family health insurance purchasing is concentrated during the annual enrollment period, we may experience shifts in the mix of plans purchased through us, due to the competitiveness of the plan or otherwise, in a limited period of time, which could impact the commission revenue that we receive as we do not receive the same commission rates from each carrier. Given that a portion of health insurance carriers continue to base their commissions on a percentage of the plan premium, changes in average premiums of plans purchased through us could also impact the commission revenue that we receive. If consumers purchase products for which we receive lower commissions and we experience a reduction in our commission rate per member, our business, operating results and financial condition could be harmed.

We may not be successful in our efforts to market and sell Medicare-related health insurance plans as a health insurance agent.

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 carrier partners' Medicare products. If our Medicare carrier partners 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.

In addition, we may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carrier partners. 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 not allowing them 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 this or any other reason, 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 would harm our business operating results and financial condition.

CMS must approve our websites 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. Moreover, we use Medicare plan cost and benefit data collected and made publicly available by CMS. In the event that CMS disapproves, or delays approval, of our websites or call center scripts, or 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 proposed regulations relating to health insurance agent compensation in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans. The proposed regulations would change the maximum compensation structure for agent compensation for new enrollments in renewal years from 50% of the initial-year compensation payment to 35% of a fair market value determined by CMS each year. This value is currently used to determine only the initial-year agent compensation an agent would receive in connection with the sale of a Medicare Advantage or prescription drug plan. In addition, the proposed regulation would permit health insurance carriers to pay agents 35% of the annually-determined fair market value for all of the renewal years that the member stayed on the plan, while in previous years there were restrictions placed on renewal year agent compensation that would not permit payment of health insurance agent compensation after 6 years. CMS also proposed regulations that would prohibit payment of agent compensation until the beginning of the plan year that an enrollment is effective, while we are currently paid agent

compensation prior to that time for some enrollments that occur during the Medicare annual enrollment period. It is unclear whether these proposed regulations will become final regulations or whether they will be modified, but the final regulations may 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, and our business, operating results and financial condition could be harmed. In addition, the impact these proposed regulations would have on the timing of our revenue recognition is unclear, but they could have the impact of delaying our recognition of revenue.

Our success in expanding into 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 platform to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the modification of our existing user experience for new plans targeted at a different demographic;

- our success in marketing our ecommerce platform to Medicare-eligible individuals and in entering into business development relationships to drive Medicare-eligible individuals to our ecommerce platform;

- our effectiveness in entering into and maintaining relationships with marketing partners, including existing pharmacy chain 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 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 platform.

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.

Our ability to sell Medicare-related health insurance plans as a health insurance agent depends on our ability to timely hire, train and retain licensed health insurance agents for our customer care center operations and our ability to maintain information technology systems to facilitate their sale of Medicare plans.

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 the majority of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we are required to hire and train a significant number of additional employees on a temporary or seasonal basis in a limited period of time. 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.

The success of our Medicare plan customer care center operations also 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 and customer relationship management systems in our Medicare customer care center operations related to these and other functions, and we are dependent on third parties for some of them, including our telephone and call recording systems. The effectiveness and stability of our Medicare customer care center systems 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 or any inability to handle increased volume during the annual enrollment period would harm our business, operating results and financial condition.

Factors beyond our control may negatively impact our ability to market and sell Medicare plans.

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 and the benefits under Medicare Advantage plans to decrease, 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. CMS also has proposed changing the rules relating to compensation of agents in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans, which could cause a reduction in our compensation as a health insurance agent in connection with the sale of these plans. 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 in connection with the sale of these plans, our business, operating results and financial condition would be harmed.

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws and regulations, and any noncompliance with them 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 approved on a regular basis by CMS and 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, CMS rules currently prohibit health

insurance agents from enrolling individuals into Medicare Advantage and Medicare Part D prescription drug plans online. Individuals are currently able to enroll in these plans online after shopping for these plans on our website given that we have established relationships with health insurance carriers to complete the enrollment on a platform owned or licensed by the carrier. If CMS determines to change its rules to prohibit enrollment in that manner, it 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 our PlanPrescriber acquisition.

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, or the amounts that health insurance agents are paid for selling these plans, our business, operating results and financial condition would be harmed.

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 fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially.

Our business model is characterized primarily by revenue based on commissions we receive from insurance carriers whose policies are purchased by our members. 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. 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.

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 platform by potential members referred to us by our marketing partners. As a result of this 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, which occurred in connection with the implementation of health care reform. The implementation of healthcare reform open enrollment periods for individual and family health insurance caused in the fourth quarter of 2013 and the first quarter of 2014 a substantial number of health insurance applications to be submitted through us and a substantial increase in marketing and advertising expenses. We experienced a loss in both the fourth quarter of 2013 and the first quarter of 2014 as a result of these significantly higher marketing and advertising expenses. 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.

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 cancelling 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 platform, 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.

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 platform and customer care centers seeking to purchase health insurance are converted into 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 platform or with our customer care center;
- regulatory requirements, including those 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 platform 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;
- 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 and the amount of time a carrier takes to make a decision on that application; and

- competitive offerings.

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 may make changes to our ecommerce platform 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 platform or telephonically via our customer care centers into members suffers, our membership growth rate may decline, which would harm our business, operating results and financial condition.

We are in the process of attempting to establish a relationship with the FFM so that we may sell qualified health insurance plans to health care reform subsidy eligible individuals and families in a scalable and efficient manner over the Internet in the 36 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 on the FFM website and through its systems. We are also dependent on these systems to convey to health insurance carriers that we are the agent in connection with the purchase of health insurance and should receive commissions for a sale. While we have been able to sell qualified health plans through the FFM, the experience is cumbersome, often involves telephonic interaction between the customer and our customer care centers and the FFM's website, technology and systems often do not work properly. Moreover, the process for enrolling individuals outside of the open enrollment period is mainly telephonic. These circumstances have had, and may continue to have, a significant negative impact on our ability to convert subsidy-eligible individuals and families into members. With respect to states operating their own health insurance exchanges, we have experienced similar issues or have not been able to establish relationships to enroll subsidy-eligible individuals and families. If we do not establish a scalable and efficient online enrollment experience with government run health insurance exchanges, our ability to convert subsidy-eligible individuals into members will be harmed and our business, operating results and financial condition will be harmed as well.

FFM's website, technology and systems have not worked properly, and we have encountered problems in integrating with it to provide a stable, easy to use and scalable solution. Assuming we complete integration with the FFM and are permitted to enroll individuals into qualified health plans through the FFM, we would be dependent upon FFM systems and its website experience 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. If the FFM website experience remains unstable, the experience of applying for qualified health plans and subsidies remains cumbersome, or we are not properly identified by FFM systems as the agent of record on health insurance plan sales, we will suffer a reduction in our membership and our commission revenue and our business, operating results and financial condition will be harmed.

If we are unable to retain our members, our business and operating results would be harmed.

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 cancelled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission revenue. Individuals, families and small businesses may choose to discontinue their health insurance policies for a variety of reasons. For example, individuals and families 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. In addition, our members may choose to purchase new policies through other sources or using a different agent if, for example, they are not satisfied with our customer service or the health insurance plans that we offer. 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.

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

The demand for health insurance marketed through our ecommerce platform 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. If health insurance carriers do not continue to allow us to sell a variety of high-quality, affordable health insurance plans in the individual and family, small business, ancillary and Medicare markets, or if their offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform or otherwise, our sales 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. These circumstances have and may continue to adversely impact demand for individual health insurance, and if individuals do not purchase health insurance through us as a result of these circumstances, our business, operating results and financial condition could 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.

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 platform 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 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. 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 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 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 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, 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 platform 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 and some of our marketing partners for both algorithmic search result listings and for paid advertisements, which has increased our marketing and advertising expenses. If this competition increases further, or if the fees associated with paid search advertisements increase as a result of algorithm changes or other factors, our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which could 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 to their customers. 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;
- 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 platform;

- 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 platform;

- 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. If we are unable to maintain successful relationships with our existing marketing partners or fail to establish successful relationships with new marketing partners, our business, operating results and financial condition will be harmed.

The impact that health care reform will have on our relationships with marketing partners is unclear. 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 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. There is no guarantee that we will be able to amend our agreements to reduce the compensation that we pay to acceptable levels in light of the commission rates that we receive. If we are not able to do so, our business, operating results and financial condition could be harmed. We may also lose marketing partner referrals if our competitors pay marketing partners more than we do, which could harm our business, operating results and financial condition. If we lose marketing partner referrals during the individual and family health insurance annual enrollment, 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 noncompliance with those laws, regulations and guidelines. For instance, 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 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 carrier the arrangement, provided that the policy remains active with us. 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, given that some of our members pay on a schedule less frequently than monthly (e.g., quarterly). 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. We may experience difficulty in satisfying the conditions required to offer plans to individuals and families who are entitled to subsidies under health care reform, and even if we are able to satisfy them, we depend upon government run health insurance exchanges to permit us to offer these plans and to have systems processes and a website that allows us to effectively do so. While we have entered into agreements with the health insurance exchange operated in 36 states by the Federal government, we have not been able to enroll individuals in subsidy-eligible qualified health insurance plans as a result of the federal health insurance exchange technical difficulties. We also depend upon health insurance carriers to allow us to sell these plans and to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to effectively sell individual and family health insurance products to health care reform subsidy-eligible individuals in a scalable and efficient manner, or if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans, we could lose a substantial number of existing and potential members and the related commission revenue we receive as a result of the sale of individual and family and small business health insurance products to them, which would materially harm our business, operating results and financial condition. We could also lose a substantial number of existing and potential members as a result of individuals who are not eligible for subsidies shopping for new health care reform health insurance plans and using other sources, including a government-run health insurance exchange, to do so. In addition, a substantial amount of individual and family health insurance purchasing activity is expected to occur over a limited period of time as a result of the new open enrollment periods for the purchase of individual and family health insurance, which overlaps with the Medicare annual open enrollment period. 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 as in the past due to significant spikes in volume, 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.

Our operating results fluctuate depending upon 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 have been delayed, such as during holiday periods. Any delay 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 result in a large amount of commission revenue from a carrier being recorded in a given quarter 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 implementation of open enrollment periods under health care reform for the purchase of individual health insurance may present challenges to our ability 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 a substantial amount of revenue until such time our health insurance carriers are able to resume reporting timely and accurate commission information to us.

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 are a number of agents that operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. Some local agents use “lead aggregator” services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to the traditional agent. In addition to health insurance brokers and agents, many health insurance carriers 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. We also compete with state and federal health insurance exchanges implemented as a result of health care reform. Health care reform also will result in health insurance plan cost and benefit data being more readily accessible, which could facilitate additional competition. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. In addition, CMS offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans. To remain competitive against our current and future competitors, we will need to continue to invest and improve the online shopping experience and functionalities of our website and other platforms that our current and future customers 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, 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.

We may not be able to compete successfully against our current or future competitors. 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 federal health insurance exchange, 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.

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 platform. 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 subsidiary in China has a subsidiary business insurance agency license in the Fujian province in China pursuant to which we may sell health, accident and life insurance in the Fujian province. Our license is up for renewal at the end of 2014. We have relationships with insurance companies to host on our technology platform certain of those companies' products that are offered throughout China. Additionally, we have entered, and may in the future continue to enter, into relationships with marketing partners to refer additional consumers to our website. We have limited experience marketing or selling insurance in China or in adapting our business and ecommerce platform to Chinese markets and cultures, legal and regulatory regimes or business customs. For instance, the laws and regulations applicable to our marketing and selling insurance online and assisting others in those efforts in China are unclear, and our operations may be in violation of them. In addition, insurance laws and regulations in China are in a state of development, and the laws and regulations may change to prohibit or restrict our marketing insurance online. The consequences of violating insurance and other applicable laws and regulations in China are unclear, but they could result in the termination of our license and our ability to host insurance products on our technology platform, payment of fines and damages and could harm our business as a whole. For various reasons, we may not expand in China, and even if we do, there can be no assurance that our ecommerce platform in China would ever generate a significant amount of revenue or otherwise be successful. Our success in establishing an insurance-related business in China also depends on many of the factors that influence the success of our business in the United States, including, but not limited to, our receiving regulatory approvals (including the renewal of our license), acceptance of the Internet and our ecommerce platform as a marketplace for the purchase of insurance, our success in marketing our ecommerce platform and in retaining members who purchase insurance through that platform, our ability to enter into and maintain relationships with insurance carriers, commission rates, the affordability of the insurance products offered, insurance carrier business practices, the effectiveness with which we establish a brand identity, performance, reliability and availability of our ecommerce platform, competition, the regulatory environment and the manner in which health care delivery is financed and changes to such environment or manner, our ability to attract and retain qualified personnel and network security.

Our participation and success in the insurance market in China may be impacted by additional factors given that outside of Xiamen city, the insurance products offered on our website are offered directly by insurance carriers. As a result, our success in selling insurance outside of Xiamen city depends on many factors, including our dependence on insurance carriers for the products on our website, the insurance carriers' relationship with consumers, our relationship with the insurance carriers, the insurance carriers' ability to maintain licenses and regulatory approvals, and the number, quality and

attractiveness of the insurance products offered by the insurance carriers through our platform. While there is no certainty that we would be able to expand our presence in the insurance industry in China, we may attempt to do so. If we decide to do so, we will need to receive additional government licenses and approvals or enter into additional relationships and we may face disadvantages in doing so as a result of our subsidiary in China being wholly foreign-owned.

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. Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. 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 platform, our sponsorship and advertising program will be adversely impacted. 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 platform as a medium for the purchase and sale of health insurance, our ability to attract consumers visiting our ecommerce platform 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 platform, 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. 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 able to adequately protect our intellectual property, which could harm our business and operating results.

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.

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.

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 additional personnel for all areas of our organization. We may not be successful in attracting and retaining personnel on a timely basis, on competitive terms or at all. If we are unable to attract and retain the necessary personnel, our business would be harmed.

If we fail to manage the expansion of our business, our business and operating results would be harmed.

We have expanded our operations significantly and have recently entered into the business of providing technology to employer-based health insurance exchanges. Our entering into this new area of business places increasing and significant demands on our management, our operational and financial systems and infrastructure and our other resources. If we do not effectively manage this expansion, the quality of our services could suffer, which could harm our business, operating results and financial condition. In order to successfully expand our business, we need to hire, integrate and retain highly skilled and motivated employees. We also need to continue to improve our existing systems for operational and financial management, including our reporting systems, procedures and controls. These improvements could require significant capital expenditures and place increasing demands on our management. We may not be successful in managing or expanding our operations or in maintaining adequate financial and operating systems and controls. If we do not successfully implement improvements in these areas, our business, operating results and financial condition will be harmed.

Seasonality may cause fluctuations in our financial results.

Historically, the number of individual and family health insurance applications submitted through our ecommerce platform generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. This trend changed in the fourth quarter of 2013 and first quarter of 2014 as a result of an increase in the number of individual and family applications submitted during the initial open enrollment period under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act, which began on October 1, 2013 and ended on March 31, 2014. The number of submitted individual and family plan applications increased significantly, relative to historical levels, during the fourth quarter of 2013 and the first quarter of 2014.

In addition to the initial open enrollment period which ended in March 2014, the annual open enrollment period for individual and family health insurance is proposed to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates of annual open enrollment period are unknown. 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. We expect that open enrollment periods will change the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. We expect that applications submitted for individual and family health insurance to decline during the second and third quarters of the year, outside of the annual open enrollment periods.

The majority of the Medicare plans that we sell are sold in our fourth quarter 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. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter of the year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of Medicare policies sold during the annual enrollment period typically renew on January 1 of each year.

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by seasonal submitted application patterns. Marketing and advertising expenses related to individual and family health insurance plans has historically been highest in our first and third quarters. This changed during the fourth quarter of 2013 and first quarter of 2014 during which marketing and advertising expense related to individual and family health insurance plans increased significantly as a result of the increase in the number of applications submitted during the initial open enrollment period under the federal Patient

Protection and Affordable Care Act. We expect marketing and advertising costs to decrease in the second and third quarters with the decrease in submitted individual and family plan applications, outside of the annual open enrollment period. Marketing and advertising expenses related to our selling Medicare plans are highest in our third and fourth quarters. Additionally, in preparation for the Medicare annual enrollment period, we begin ramping up our temporary customer care center staff during our second and third quarters and employ our temporary customer care center staff until the end of the Medicare annual enrollment period in December. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters. In the first quarter of 2014, we retained some enrollment personnel during the initial open enrollment period that ended on March 31, 2014 to handle the increased volume of individual and family plan applications.

Based on these seasonal trends, our revenue has historically been highest in the fourth quarter of the year. In years prior to 2013 our profitability was relatively higher in the first and fourth quarters and substantially lower in the third quarter of the year. During the fourth quarter of 2013 and the first quarter of 2014 our profitability was adversely impacted by the increase in marketing and advertising expenses associated with individual and family health insurance plans related to the increase in submitted applications. We expect profitability to increase in the second and third quarters of the year as a result of lower marketing and advertising costs, outside of annual and open enrollment periods. The seasonality, caused by the individual and family health insurance is new, and is subject to change in future periods, particularly in connection with any change in the timing of the open enrollment periods. These seasonal trends have caused and will likely continue to cause, fluctuations in our quarterly financial results.

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, and we recently expanded our business operations into the sale of Medicare plans. 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 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 or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. For instance, in October 2010, the state of California approved budget legislation which substantially limited the utilization of net operating losses. The new law did not affect the amount of net operating losses and tax credits that we expect to ultimately use to offset future California taxes, but limited the amount we could utilize in 2010 and 2011, resulting in our paying higher cash taxes. 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 platform, 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 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. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers in connection with their applications for health insurance. As a result, we are subject to various federal, state and international 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 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 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. In addition, in the event that data security laws are implemented, or our health insurance carrier or other partners determine to impose new 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.

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 platform 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.

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. 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. 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.

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 greater than 5% stockholders and their affiliated entities beneficially owned more than 50% percent of our outstanding common stock as of March 31, 2014. 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;
- 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.

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.

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein Form	Date
10.12.2	*	Executive Bonus Plan 2014		
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.

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 2014.

/ 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)

EXHIBIT INDEX

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EHEALTH, INC.
EXECUTIVE BONUS PLAN
2014

1. **Plan Objectives**.

Reward management for achieving stated business objectives

Build long-term stockholder value

Provide competitive compensation for senior management

2. **Administration**. The Compensation Committee of eHealth, Inc. (the "Company") will administer the Executive Bonus Plan (the "Plan"). The Compensation Committee reserves the right at any time during the fiscal year to modify the Plan in total or in part. This Plan may be amended, suspended or terminated at any time at the sole and absolute discretion of the Compensation Committee.

3. **Eligibility**. Senior management of the Company as nominated by the CEO and approved by the Compensation Committee, but not including the CEO, (collectively, "Participants") are eligible to participate in this Plan. Participation in the Plan in one year does not imply continued Plan participation in any subsequent year. Participants must be employed at the time of payment to earn any payment under the Plan.

Eligible senior management hired during the Plan year will have their Target Incentive Percentage and Maximum Incentive Percentage set by the Compensation Committee (see Item 5 below). Such Participant's incentive payout will be pro-rated from the first day of employment; provided that the Compensation Committee determines that the Participant is eligible to participate. Employees hired after September 30, 2014 are not eligible for incentive payout for the 2014 Plan year, unless the Compensation Committee determines otherwise.

4. **Term**. Twelve (12) months, commencing on January 1, 2014 and ending on December 31, 2014.

5. **Target Incentive Payout**. The Compensation Committee will approve a Target Incentive Percentage and a Maximum Incentive Percentage for each Participant. The incentives under this Plan are expressed as a percentage of annual base salary as of the time the Compensation Committee approves a Participant's participation in the Plan (the "Annual Salary"). Attached, as Exhibit A, is a schedule of the Annual Salary, Target and Maximum Incentive Percentages and aggregate incentive for each 2014 Plan Participant. The aggregate "Target Incentive Award" for each Participant is equal to that Participant's Annual Salary multiplied by the Target Incentive Percentage for that Participant.

6. **Incentive Determination**. One hundred percent (100%) of each Participant's potential Target Incentive Award is based upon achievement of Revenue and EBITDA (GAAP Operating Income without stock compensation, amortization of acquired intangibles and depreciation and amortization) performance goals for the 2014 fiscal year of the Company (each, a "Goal"), as approved by the Compensation Committee in connection with the adoption of this Plan and subject to adjustment as set forth elsewhere in this Plan. The Revenue Goal comprises sixty percent (60%) of the total potential Target Incentive Award. The EBITDA Goal comprises forty percent (40%) of the total potential Target Incentive Award. In order to determine payouts based upon Goal performance achievement between whole percentages, the Compensation Committee shall apply straight-line interpolation.

On-Target Performance Payout. In the event the Company meets the Revenue Goal, a Participant shall receive sixty percent (60%) of the product determined by multiplying the Target Incentive Percentage of the Participant by the Participant's Annual Salary; in the event the Company meets the EBITDA Goal, a Participant shall receive forty percent (40%) of the product determined by multiplying the Target Incentive Percentage of the Participant by the Participant's Annual Salary (respectively, for each of the Goals, a "Goal Target Payout").

Below 95% Performance. If a Goal is achieved as to less than 95%, there will be no payout for that Goal.

95-99% Performance Payout. If a Goal is achieved at a 95% level, a Participant shall receive, in connection with the partial achievement of that Goal, 50% of the Goal Target Payout. If a Goal is achieved at the 96% level, a Participant shall receive, in connection with the partial achievement of that Goal, 60% of the Goal Target Payout. If a Goal is achieved at the 97% level, a Participant shall receive, in connection with the partial achievement of that Goal, 70% of the Goal Target Payout. If a Goal is achieved at the 98% level, a Participant shall receive, in connection with the partial achievement of that Goal, 80% of the Goal Target Payout. If a Goal is achieved at the 99% level, a Participant shall receive, in connection with the partial achievement of that Goal, 90% of the Goal Target Payout.

Above 100% Performance Payout – 2014 Revenue Goal. Subject to the other provisions of this Plan, for each percent achieved above 100% of the Revenue Goal, the Participant will receive an additional 5% of the Goal Target Payout for the Revenue Goal up to a maximum additional payment of 50% of the Goal Target Payout.

Above 100% Performance Payout – 2014 EBITDA Goal. If and only if the Revenue Goal is achieved at a level of 100% or more, then for each percent achieved above 100% of the EBITDA Goal, the Participant will receive an additional 2.5% of the Goal Target Payout up to a maximum additional Goal Target Payout of 50%.

The Company must be profitable on an operating basis (excluding non-cash charges) for a Participant to qualify for their maximum payout under the Plan for any Goal. If the Company is not profitable on an operating basis (excluding non-cash charges), the maximum possible payout for the achievement of all Goals shall be no more than 100% of the Participant's Target Incentive Award.

For purposes of determining achievement of a Goal, the Compensation Committee may exclude, in its sole discretion, (i) the effect of mergers and acquisitions closing in 2014 (if any), (ii) any extraordinary non-recurring items as described in Accounting Principles Board Opinion No. 30 or as otherwise determined by the Compensation Committee to be extraordinary or non-recurring in its sole discretion, and (iii) the effect of any changes in accounting principles affecting the Company's or a business units' reported results.

7. **Payment**. Payments under the Plan will be made following the release of the Company's earnings to the public, but in no event later than March 15, 2015. The Compensation Committee must approve all executive officer incentive awards prior to payment. All Plan payments will be made net of applicable withholding taxes.

8. **Employment at Will**. The employment of all employees at the Company is terminable at any time by either party, with or without cause being shown or advance notice by either party. This Plan shall not be construed to create a contract of employment for a specified period of time between eHealth and any employee.

9. **Entire Agreement**. This Plan is the entire agreement between eHealth and the Participants regarding the subject matter of this Plan and supersedes all prior bonus compensation or bonus incentive plans or any written or verbal representations regarding the subject matter of this Plan.

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EXHIBIT A

Salaries, Incentives and Incentive Percentages for 2014 Plan Participants

			INCENTIVE %		INCENTIVE $	
OFFICERS	**SALARY**	**TITLE**	**TARGET**	**MAX**	**TARGET**	**MAX**
Bernstein, Jeff	$ 260,000	SVP, Marketing	60%	90%	$ 156,000	$ 234,000
Gibbs, Sam	$ 250,000	President, Govt Systems	60%	90%	$ 150,000	$ 225,000
Huizinga, Stuart	$ 325,000	CFO	60%	90%	$ 195,000	$ 292,500
Hurley, Robert	$ 265,200	SVP	60%	90%	$ 159,120	$ 238,680
Tsao, Tom	$ 310,000	SVP	60%	90%	$ 186,000	$ 279,000
Shaughnessy, Bill	$ 525,000	President & COO	60%	90%	$ 315,000	$ 472,500
Sullivan, David	$ 254,900	SVP, BD & Partner Management	60%	90%	$ 152,940	$ 229,410
Wu, Jiang	$ 270,400	SVP	60%	90%	$ 162,240	$ 243,360

Exhibit 31.1

CERTIFICATION

I, Gary L. Lauer, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of eHealth, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during registrant's most recent fiscal quarter (the registrant's fourth quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 9, 2014

/s/ GARY L. LAUER

Gary L. Lauer

Chief Executive Officer

Exhibit 31.2

CERTIFICATION

I, Stuart M. Huizinga, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of eHealth, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during registrant's most recent fiscal quarter (the registrant's fourth quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of registrant's board of directors (or persons performing the equivalent functions):

   a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 9, 2014

/s/ STUART M. HUIZINGA

Stuart M. Huizinga

Chief Financial Officer

Exhibit 32.1

Certification of Chief Executive Officer, Pursuant to
18 U.S.C. Section 1350,
As Adopted Pursuant to
Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarterly period ended March 31, 2014, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gary L. Lauer, Chief Executive Officer of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

(1) The Form 10-Q, to which this certification is attached as Exhibit 32.1, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ GARY L. LAUER

Gary L. Lauer

Chief Executive Officer

May 9, 2014

A signed original of this written statement required by Section 906 has been provided to eHealth, Inc. and will be retained by eHealth, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

Exhibit 32.2

Certification of Chief Financial Officer, Pursuant to
18 U.S.C. Section 1350,
As Adopted Pursuant to
Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarterly period ended March 31, 2014, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

(1) The Form 10-Q, to which this certification is attached as Exhibit 32.2, fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) The information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ STUART M. HUIZINGA

Stuart M. Huizinga

Chief Financial Officer

May 9, 2014

A signed original of this written statement required by Section 906 has been provided to eHealth, Inc. and will be retained by eHealth, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.