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 September 30, 2016

OR

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

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

EHEALTH, INC.

(Exact name of registrant as specified in its charter)

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

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

(650) 584-2700
(Registrant's telephone number, including area code)
Not Applicable
(Former name, former address and former fiscal year, if changed since last report)

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulations S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). YES ☒ NO ☐

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

Large accelerated filer	☐	Accelerated filer	☒
Non-accelerated filer	☐	Smaller reporting company	☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act) YES ☐ NO ☒

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of October 31, 2016 was 18,341,531 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, 2015	September 30, 2016
Assets	(Note 1)	(unaudited)
Current assets:		
Cash and cash equivalents	$ 62,710	$ 67,268
Accounts receivable	9,647	7,613
Prepaid expenses and other current assets	5,185	5,964
Total current assets	77,542	80,845
Property and equipment, net	7,364	6,104
Other assets	4,697	4,348
Intangible assets, net	9,620	8,840
Goodwill	14,096	14,096
Total assets	$ 113,319	$ 114,233
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 3,012	$ 2,332
Accrued compensation and benefits	14,386	9,030
Accrued marketing expenses	10,698	1,656
Deferred revenue	392	1,416
Other current liabilities	3,448	3,922
Total current liabilities	31,936	18,356
Non-current liabilities	4,962	3,275
Stockholders' equity:		
Common stock	29	29
Additional paid-in capital	266,699	271,070
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	9,498	21,320
Accumulated other comprehensive income	193	181
Total stockholders' equity	76,421	92,602
Total liabilities and stockholders' equity	$ 113,319	$ 114,233

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 September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Revenue				
Commission	$ 34,942	$ 29,941	$ 130,157	$ 133,977
Other	3,282	2,138	9,248	9,223
Total revenue	38,224	32,079	139,405	143,200
Operating costs and expenses:				
Cost of revenue	443	30	3,527	2,747
Marketing and advertising	9,349	10,206	44,086	44,024
Customer care and enrollment	9,462	11,259	28,981	31,869
Technology and content	8,036	8,257	27,400	25,053
General and administrative	7,749	9,122	23,237	28,066
Restructuring charge (benefit)	—	(139)	4,541	(297)
Amortization of intangible assets	260	260	893	780
Total operating costs and expenses	35,299	38,995	132,665	132,242
Income (loss) from operations	2,925	(6,916)	6,740	10,958
Other income (expense)	(27)	7	(50)	(25)
Income (loss) before benefit for income taxes	2,898	(6,909)	6,690	10,933
Benefit for income taxes	(737)	(1,173)	(613)	(889)
Net income (loss)	$ 3,635	$ (5,736)	$ 7,303	$ 11,822
Net income (loss) per share:				
Basic	$ 0.20	$ (0.31)	$ 0.41	$ 0.65
Diluted	$ 0.20	$ (0.31)	$ 0.40	$ 0.65
Weighted-average number of shares used in per share amounts:				
Basic	18,093	18,329	17,969	18,247
Diluted	18,240	18,329	18,079	18,323
Comprehensive income (loss):				
Net income (loss)	$ 3,635	$ (5,736)	$ 7,303	$ 11,822
Foreign currency translation adjustment	10	(5)	15	(12)
Comprehensive income (loss)	$ 3,645	$ (5,741)	$ 7,318	$ 11,810

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

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

	Nine Months Ended September 30,	
	2015	**2016**
Operating activities		
Net income	$ 7,303	$ 11,822
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	3,122	2,749
Amortization of internally-developed software	449	659
Amortization of book-of-business consideration	1,998	1,608
Amortization of intangible assets	893	780
Stock-based compensation expense	5,434	5,356
Other non-cash items	180	(90)
Changes in operating assets and liabilities:		
Accounts receivable	(618)	2,034
Prepaid expenses and other assets	(1,150)	(1,236)
Accounts payable	(3,892)	(456)
Accrued compensation and benefits	3,037	(5,356)
Accrued marketing expenses	(7,411)	(9,042)
Deferred revenue	2,650	1,024
Accrued restructuring charge	489	(433)
Other liabilities	(12)	(636)
Net cash provided by operating activities	12,472	8,783
Investing activities		
Purchases of property and equipment and other assets	(2,335)	(3,165)
Net cash used in investing activities	(2,335)	(3,165)
Financing activities		
Net proceeds from exercise of common stock options	1,326	60
Cash used to net-share settle equity awards	(824)	(1,044)
Principal payments in connection with capital leases	(57)	(64)
Net cash provided by (used in) financing activities	445	(1,048)
Effect of exchange rate changes on cash and cash equivalents	19	(12)
Net increase in cash and cash equivalents	10,601	4,558
Cash and cash equivalents at beginning of period	51,415	62,710
Cash and cash equivalents at end of period	$ 62,016	$ 67,268

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

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 1 - Summary of Business and Significant Accounting Policies

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

Basis of Presentation—The accompanying condensed consolidated balance sheet as of September 30, 2016, the condensed consolidated statements of comprehensive income (loss) for the three and nine months ended September 30, 2015 and 2016 and the condensed consolidated statements of cash flows for the nine months ended September 30, 2015 and 2016, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2015 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2015, which was filed with the Securities and Exchange Commission on March 14, 2016. The accompanying statements should be read in conjunction with the audited consolidated financial statements and related notes contained in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles, or U.S. GAAP, for interim financial information. Accordingly, they do not include all of the financial information and footnotes required by U.S. GAAP for complete financial statements. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2015, and include all adjustments necessary for the fair presentation of eHealth's financial position as of September 30, 2016, its results of operations for the three and nine months ended September 30, 2015 and 2016 and its cash flows for the nine months ended September 30, 2015 and 2016. All adjustments are of a normal recurring nature. The results for the three and nine months ended September 30, 2016 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2016.

In connection with the recent changes in our senior management and a strategic review of our business, we recorded approximately $5.5 million of severance, management consulting and legal fees in the nine months ended September 30, 2016, of which $4.8 million is included in general and administrative expenses and $0.7 million is included in marketing and advertising expenses in the accompanying condensed consolidated statements of comprehensive income (loss).

Seasonality—A greater number of our Medicare-related health insurance 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. Additionally, substantially all of the Medicare Advantage and Medicare Part D prescription drug policies we have sold renew on January 1 of each year, resulting in our recognizing substantially all renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in our first quarter. Our Medicare plan-related commission revenue is highest in our first quarter and is higher in our fourth quarter compared to our second and third quarters.

The majority of our individual and family health insurance plans are sold in the annual open enrollment period as defined under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act. Individuals and families generally are not 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 or moving to another state.

Recent Accounting Pronouncements—In August 2015, the Financial Accounting Standard Board ("FASB") issued Accounting Standards Update ("ASU") No. 2015-14 (ASU 2015-14) "Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date." ASU 2015-14 defers the effective date by one year of ASU No. 2014-09, "Revenue from Contracts with Customers." ASU 2014-09 supersedes the revenue recognition requirements in "Revenue Recognition (Topic 605)" and requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that

reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. In accordance with the deferral, the new standard is effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period and can be adopted using either a full retrospective or modified retrospective approach. Early adoption is permitted for annual reporting periods beginning after December 15, 2016, including interim periods within that reporting period. We are currently in the process of evaluating the impact of the adoption of ASU 2014-09 on our consolidated financial statements.

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

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

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

In August 2016, the FASB issued ASU No. 2016-15 (ASU 2016-15), "Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments." ASU 2016-15 provides guidance on how certain cash receipts and cash payments are presented on the statement of cash flows. ASU 2016-15 is effective for annual reporting periods beginning after December 15, 2017. Early adoption is permitted. We are currently in the process of evaluating the impact of the adoption of ASU 2016-15 on our consolidated financial statements.

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

In March 2016, the FASB issued ASU No. 2016-09 (ASU 2016-09), "Improvements to Employee Share-Based Payment Accounting (Topic 718)." ASU 2016-09 simplifies various aspects related to how share-based payments are accounted for and presented in the consolidated financial statements. The amendments include income tax consequences, the accounting for forfeitures, the classification of awards as either equity or liabilities and the classification on the statement of cash flows. It is effective for the first interim period beginning after December 15, 2016 and early adoption is permitted. We adopted this standard in the first quarter of 2016. Under ASU 2016-09, eHealth classifies the excess income tax benefits from stock-based compensation arrangements as a discrete item within income tax expense, rather than recognizing such excess income tax benefits in additional paid-in capital. As required by ASU 2016-09, this guidance was applied using a modified retrospective transition method and was effective as of January 1, 2016. The adoption of this guidance did not have a material effect to retained earnings or other components of equity or net assets at the beginning of the period of adoption. Under ASU 2016-09, excess income tax benefits from stock-based compensation arrangements are classified as cash flows from operations rather than as cash flows from financing activities. We elected to apply the cash flow classification guidance of ASU 2016-09 prospectively for the nine-months ended September 30, 2016. Prior periods were not adjusted. Under ASU 2016-09, when shares are withheld from an employee's exercise of stock awards to fund our payment of the employee's taxes, the payment is

classified as a financing activity. The adoption of this provision did not have a material effect on the cash flow statements from prior periods. In addition, we have elected to continue to estimate the number of stock-based awards expected to vest, as permitted by ASU 2016-09, rather than electing to account for forfeitures as they occur.

Note 2 – Balance Sheet Accounts

Cash and Cash Equivalents—As of December 31, 2015 and September 30, 2016, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. At December 31, 2015 and September 30, 2016, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three and nine months ended September 30, 2015 and 2016.

As of December 31, 2015 and September 30, 2016, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2015	September 30, 2016
Cash	$ 8,086	$ 7,591
Money market funds	54,624	59,677
Total cash and cash equivalents	$ 62,710	$ 67,268

Our money market funds reflect unadjusted quoted prices in active markets for identical assets and are classified as Level 1 as of December 31, 2015 and September 30, 2016.

Accounts Receivable—As of December 31, 2015 and September 30, 2016, our accounts receivable consisted of the following (in thousands):

	December 31, 2015	September 30, 2016
Commission receivable	$ 6,136	$ 1,794
Accounts receivable—from other revenues	3,511	431
Commissions receivable—from Medicare renewals	—	5,388
Total accounts receivable	$ 9,647	$ 7,613

Note 3 – Stockholders' Equity

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

	Shares Available for Grant
Shares available for grant December 31, 2015	3,542
Restricted stock units granted	(763)
Options granted	(335)
Restricted stock units cancelled [1]	137
Options cancelled [2]	3
Shares available for grant at September 30, 2016	2,584

(1) Restricted stock units cancelled does not include restricted stock units cancelled under the 2006 Equity Incentive Plan, as our 2006 Equity Incentive Plan has been terminated with respect to the grant of additional awards.
(2) Options cancelled does not include stock options cancelled under the 2005 Stock Plan and 2006 Equity Incentive Plan, as these plans were terminated with respect to the grant of additional awards.

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

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

	Number of Stock Options [1]	Weighted- Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value [2]
Balance outstanding at December 31, 2015	1,275	$ 18.79	2.79	$ —
Granted	335	$ 13.22		
Exercised	(5)	$ 12.98		
Cancelled	(605)	$ 16.63		
Balance outstanding at September 30, 2016	1,000	$ 18.25	3.67	$ 45
Vested and expected to vest at September 30, 2016	954	$ 18.47	3.53	$ 40
Exercisable at September 30, 2016	682	$ 20.05	1.81	$ 1

(1) Includes certain stock options with both service and market-based vesting criteria granted to our executive officers.
(2) The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2015 and September 30, 2016 and the exercise price of in-the-money options as of those dates.

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

	Number of Restricted Stock Units [1]	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value [2]
Balance outstanding as of December 31, 2015	966	$ 15.62	2.83	$ 9,636
Granted	764	$ 11.39		
Vested	(280)	$ 18.78		
Cancelled	(208)	$ 10.22		
Balance outstanding at September 30, 2016	1,242	$ 13.36	2.77	$ 13,901

(1) Includes certain restricted stock units with both service and performance-based or market-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, 2015 and September 30, 2016 multiplied by the number of restricted stock units outstanding as of December 31, 2015 and September 30, 2016, respectively.

Stock Repurchase Programs—We had no stock repurchase activity during the three and nine months ended September 30, 2016. In addition to 10,663,888 shares repurchased under our past repurchase programs as of September 30, 2016, we have in treasury 451,987 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2015 and September 30, 2016, we had a total of 11,025,933 shares and 11,115,875 shares, respectively, held in treasury.

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

The following table summarizes stock-based compensation expense recorded during the three and nine months ended September 30, 2015 and 2016 (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Stock options	$ 351	$ 191	$ 1,184	$ 825
Restricted stock units	1,225	1,156	4,250	4,531
Total stock-based compensation expense	$ 1,576	$ 1,347	$ 5,434	$ 5,356

The following table summarizes stock-based compensation expense by operating function for the three and nine months ended September 30, 2015 and 2016 (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Marketing and advertising	$ 461	$ 19	$ 1,498	$ 1,038
Customer care and enrollment	110	90	366	360
Technology and content	362	384	1,308	1,293
General and administrative	643	854	2,149	2,665
Restructuring charge	—	—	113	—
Total stock-based compensation expense	$ 1,576	$ 1,347	$ 5,434	$ 5,356

Note 4 – Income Taxes

The following table summarizes our benefit for income taxes and our effective tax rates for the three and nine months ended September 30, 2015 and 2016 (in thousands, except effective tax rate):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Income (loss) before benefit for income taxes	$ 2,898	$ (6,909)	$ 6,690	$ 10,933
Benefit for income taxes	$ (737)	$ (1,173)	$ (613)	$ (889)
Effective tax rate	(25.4)%	17.0%	(9.2)%	(8.1)%

In the three and nine months ended September 30, 2016, we recorded benefit for income taxes of $1.2 million and $0.9 million, respectively, primarily related to a $1.4 million decrease in our liability for unrecognized tax benefits due to the expiration of the related statute of limitations, partially offset by a provision for income taxes related to minimum tax and a foreign tax rate differential. We recorded a valuation allowance against the US deferred tax assets at the end of fiscal year 2014 and continue to maintain that full valuation allowance as of September 30, 2016 as we believe it is not more likely than not that the net deferred tax assets will be realized.

In the three and nine months ended September 30, 2015, we recorded a benefit for income taxes of $0.7 million and $0.6 million, respectively, primarily related to a $0.8 million decrease in our liability for unrecognized tax benefits due to the expiration of the related statute of limitations, partially offset by a provision for income taxes related to minimum taxes and a foreign tax rate differential.

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 5 – Net Income (Loss) Per Share

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

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 September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Basic:				
Numerator:				
Net income (loss)	$ 3,635	$ (5,736)	$ 7,303	$ 11,822
Denominator:				
Weighted-average number of common stock shares outstanding	18,093	18,329	17,969	18,247
Net income (loss) per share—basic:	$ 0.20	$ (0.31)	$ 0.41	$ 0.65
Diluted:				
Numerator:				
Net income (loss)	$ 3,635	$ (5,736)	$ 7,303	$ 11,822
Denominator:				
Weighted-average number of common stock shares outstanding	18,093	18,329	17,969	18,247
Weighted-average number of options	42	—	29	22
Weighted-average number of restricted stock units	105	—	81	54
Total common stock shares used in diluted per share calculation [(1)]	18,240	18,329	18,079	18,323
Net income (loss) per share—diluted:	$ 0.20	$ (0.31)	$ 0.40	$ 0.65

(1) Total common stock shares used in the diluted per share calculation excludes market-based stock unit awards for which the related contingency had not been met as of September 30, 2016.

For each of the three and nine month periods ended September 30, 2015 and 2016, we had securities outstanding that could potentially dilute net income (loss) per share, but the shares from the assumed exercise of these securities were excluded in the computation of diluted net income (loss) per share as their effect would have been anti-dilutive for the periods presented. The number of outstanding weighted-average anti-dilutive shares that were excluded from the computation of diluted net income (loss) per share consisted of the following (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Common stock options	1,205	1,443	1,313	1,307
Restricted stock units	218	700	339	271
Total	1,423	2,143	1,652	1,578

Note 6 – Geographic Information and Significant Customers

Geographic Information— Our long-lived assets consisted primarily of property and equipment, internally-developed software, goodwill and other indefinite-lived intangible assets and finite-lived intangible assets. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area as of December 31, 2015 and September 30, 2016 were as follows (in thousands):

	December 31, 2015	September 30, 2016
United States	$ 35,341	$ 32,796
China	436	388
Total	$ 35,777	$ 33,184

Significant Customers—Substantially all revenue for the three and nine months ended September 30, 2015 and 2016 was generated from customers located in the United States. Health insurance carriers representing 10% or more of our total revenue in the three and nine months ended September 30, 2015 and 2016 are presented in the table below:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Humana	19%	9%	24%	23%
UnitedHealthcare [1]	11%	15%	10%	12%
Aetna [2]	9%	8%	9%	10%
Anthem [3]	10%	10%	10%	8%

(1) UnitedHealthcare includes other carriers owned by UnitedHealthcare.

(2) Aetna includes other carriers owned by Aetna.

(3) Anthem includes other carriers owned by Anthem.

Commission revenue attributable to Medicare-related health insurance plans was approximately 22% and 44% of our commission revenue in the three and nine months ended September 30, 2016, respectively. Commission revenue attributable to Medicare-related health insurance plans was approximately 19% and 33% of our commission revenue in the three and nine months ended September 30, 2015, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 62% and 44% of our commission revenue in the three and nine months ended September 30, 2016, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 62% and 52% of our commission revenue in the three and nine months ended September 30, 2015. We define our individual and family plan offerings as major medical individual and family health insurance plans, which do not include small business, Medicare-related health insurance plan offerings and other ancillary products such as short-term, stand-alone dental, life, vision, and accident insurance plan offerings.

As of September 30, 2016, two customers represented 47% and 16% of our $7.6 million outstanding accounts receivable balance. As of December 31, 2015, three customers represented 24%, 18% and 15%, respectively, of our $9.6 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2015 and September 30, 2016. We believe the potential for collection issues with any of our customers is minimal as of September 30, 2016. Accordingly, our estimate for uncollectible amounts at September 30, 2016 was not material.

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 7 – Restructuring Charge

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

In the three and nine months ended September 30, 2016, we reversed $0.1 million and $0.3 million, respectively, related to facility exit costs as we reoccupied office space we had previously vacated and were also released from a lease for other office space we had previously vacated.

The following table summarizes the total cash and non-cash restructuring charge recorded during the three and nine months ended September 30, 2015 and 2016, respectively (in thousands):

	Three Months Ended September 30, 2016		Nine Months Ended September 30, 2016	
	2015	2016	2015	2016
Employee termination costs	$ —	$ —	$ 3,791	$ —
Non-cash employee termination costs - stock-based compensation	—	—	113	—
Facility and other termination costs	—	(139)	637	(297)
Total restructuring charge (benefit)	$ —	$ (139)	$ 4,541	$ (297)

The following table summarizes the cash-based restructuring charge liability activity during the nine months ended September 30, 2016 (in thousands):

	Nine Months Ended September 30, 2016				
	Beginning balance	Charges	Payments	Benefits	Ending balance
Employee termination costs	$ 12	$ —	$ (12)	$ —	$ —
Facility and other termination costs (benefit)	421	—	(124)	(297)	—
Total restructuring liability	$ 433	$ —	$ (136)	$ (297)	$ —

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 8 - Commitments and Contingencies

Legal Proceedings— In May 2016, we received a Notice of Proposed Agency Action and Opportunity for Hearing (the "Notice") from the Office of the Montana State Auditor, Commissioner of Securities & Insurance ("CSI"). The Notice proposed that the CSI take disciplinary action against a number of parties, including us, for alleged violations of the Montana Insurance Code. Specifically, with respect to us, the Notice alleged that we sold short-term health insurance to at least 211 individuals between January 1, 2012 and April 20, 2015 without being appointed by the relevant health insurance carrier in violation of Montana law. The Notice also alleged that we misrepresented pertinent facts or insurance policy provisions in connection with the sale of short-term health insurance and made certain omissions and/or misrepresentations regarding short-term health insurance. The CSI sought the following relief in the Notice (i) imposition of fines against us not to exceed $5,000 per violation; (ii) issuance of a cease and desist order to enjoin us from violations of the Montana Insurance Code; and (iii) suspension or revocation of our license to sell health insurance in Montana. In September 2016, the CSI dismissed us from the action without prejudice. We were not required to pay any amount or suffer any adverse consequence in connection with the dismissal.

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations in any jurisdiction, we could be subject to various fines and penalties, including revocation of our license to sell insurance in those states, and our business and financial results would be harmed. Revocation of any of our licenses or penalties in one jurisdiction could cause our license to be revoked or for us to face penalties in other jurisdictions. In addition, without a health insurance license in a jurisdiction, carriers would not pay us commissions for the products we sold in that jurisdiction, and we would not be able to sell new health insurance products in that jurisdiction. We could also be harmed to the extent that related publicity damages our reputation as a trusted source of objective information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome. At December 31, 2015 and September 30, 2016 we had no material liabilities included in our consolidated balance sheet for outstanding legal claims.

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

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to submitted applications and membership; our expectations relating to revenue, sources of revenue, cost of revenue, the collectability of our accounts receivable, operating expenses and profitability; our expectations regarding our strategy and investments and impact to our operating results; our efforts to accelerate growth in the Medicare Advantage and Medicare Supplement market; our focus on the small business market; our expectations regarding the impact of healthcare reform on our business; our ability to enroll and plans relating to the enrollment of individuals and families into qualified health plans through government health insurance exchanges; our expectations regarding commission rates, conversion rates, membership attrition and retention rates; our increased focus in public policy and lobbying efforts; our expectations relating to the seasonality of our business; our expectations relating to the renewal of Medicare-related health insurance plans and the timing of our generation of renewal commission revenue on those plans; the timing of our receipt of commission payments; our critical accounting policies and related estimates; our belief that cash generated from operations and our current cash and cash equivalents will be sufficient to fund operations for the next twelve months; future capital requirements; expected competition from government-run health insurance exchanges and other sources; the timing and source of our Medicare-related revenue; political, legislative and legal challenges; the merits of any lawsuits filed against us; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those risks associated with the impact of healthcare reform; our ability to retain existing members and enroll a large number of new members during the annual healthcare reform open enrollment period and Medicare annual enrollment period; the impact of annual enrollment period for the purchase of individual and family health insurance and its timing on our recognition of revenue; our ability to sell qualified health insurance plans to subsidy-eligible individuals and to enroll subsidy eligible individuals through government-run health insurance exchanges; competition, including competition from government-run health insurance exchanges; seasonality of our business and the fluctuation of our operating results; our ability to retain existing members and limit member turnover; changes in consumer behaviors and their selection of individual and family health insurance products, including the selection of products for which we receive lower commissions; product offerings among carriers and the resulting impact on our commission revenue; carriers exiting the market of selling individual and family health insurance and the resulting impact on our supply and commission revenue; our ability to execute on our growth strategy in the Medicare and small business health insurance markets; the impact of increased health insurance costs on demand; our ability to timely receive and accurately predict the amount of commission payments from health insurance carriers; timing of commission payments from health insurance carriers; medical loss ratio requirements; delays in our receipt of items required to recognize Medicare revenue; changes in member conversion rates; our ability to accurately estimate membership; our relationships with health insurance carriers; customer concentration and consolidation of the health insurance industry; our success in marketing and selling health insurance plans and our unit cost of acquisition; our ability to hire, train and retain licensed health insurance agents and other employees; the need for health insurance carrier and regulatory approvals in connection with the marketing of Medicare-related insurance products; costs of acquiring new members; scalability of the Medicare business; lack of membership growth and retention rates; consumers satisfaction of our service; changes in competitive landscape; our ability to attract and to convert online visitors into paying members; changes in products offered on our ecommerce platform; changes in commission rates; maintaining and enhancing our brand identity; our ability to derive desired benefits from investments in our business, including membership growth initiatives; dependence on acceptance of the Internet as a marketplace for the purchase and sale of health insurance; reliance on marketing partners; timing of receipt and accuracy of commission reports; payment practices of health insurance carriers; dependence on our operations in China; changes in laws and regulations, including in connection with healthcare reform and/or with respect to the marketing and sale of Medicare plans; compliance with insurance and other laws and regulations; exposure to security risks; and the performance, reliability and availability of our ecommerce platform and underlying network infrastructure. Other risks include the risks discussed under the heading "Risk Factors" of this report and those discussed in our other Securities and Exchange Commission filings. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2016, and the audited consolidated financial statements and related notes contained therein. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements.

Overview

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

We have invested heavily in technology and content related to our ecommerce platforms. We have also invested significant time and resources in obtaining licenses to sell health insurance in all 50 states and the District of Columbia, developing member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with leading health insurance carriers, enabling us to offer thousands of health insurance plans online. Our ecommerce platforms can be accessed directly through our websites as well as through our network of marketing partners.

Sources of Revenue

Commission Revenue

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platforms. Commission revenue represented 91% and 93% of total revenue in the three and nine months ended September 30, 2015, respectively, and represented 93% and 94% of total revenue in the three and nine months ended September 30, 2016, respectively.

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

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

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

In addition to Medicare plans, we also actively market the availability of individual and family, small business and ancillary health insurance plans through our ecommerce platforms (*www.eHealth.com* and *www.eHealthInsurance.com*), and

generate revenue from commissions we receive from health insurance carriers whose plans are purchased through us, as well as commission override payments we receive for achieving sales volume thresholds or other objectives. We sell ancillary health insurance plans, which primarily consist of short-term, dental, life, vision, and accident insurance plans, alongside individual and family health insurance plans and also as standalone products.

In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that changed and will continue to change the health insurance industry in substantial ways. We have described various aspects of health care reform in *Part II, Item 1A. Risk Factors - Risks Related to Our Business.* Various aspects of health care reform may impact our business positively. For instance, the mandate that individuals and families have qualified health insurance or face a tax penalty and the government providing individuals and families' subsidies in the form of premium tax credits and cost sharing reductions are provisions in the law that could benefit our business. Notwithstanding these aspects of health care reform, the implementation of health care reform has significantly reduced our individual and family health insurance membership and individual and family health insurance commission revenue and could in the future have a material adverse effect on our business and results of operations. Health care reform established annual open enrollment periods for the purchase of individual and family health insurance. For coverage effective in 2015, the open enrollment period ran from November 15, 2014 through February 15, 2015, and for coverage effective in 2016, the annual open enrollment period ran from November 1, 2015 through January 31, 2016. For coverage effective in 2017, the current enrollment period began on November 1, 2016 and is scheduled to run through January 31, 2017. Individuals and families generally are not able to purchase individual and family health insurance outside of the annual enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance or moving to another state. The open enrollment period has changed the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. It also presents challenges to our ability to enroll a significant number of individuals and families into health insurance over a limited period of time and significantly reduces our ability to obtain new health insurance members outside of the open enrollment period. In addition, CMS tightened the requirements for individuals to qualify for a special enrollment period starting in 2016. We have not enrolled a significant number of individuals in individual and family health insurance outside of the open enrollment period.

A substantial number of individuals and families are eligible for subsidies under health care reform. Health care reform's establishment of government-run health insurance exchanges, through which individuals and families must purchase qualified health plans to receive government subsidies, has increased our competition as individual and families may purchase qualified health plans directly from government exchanges. While they are not required to do so, government-run exchanges are permitted to allow agents and brokers to enroll individuals and families into qualified health plans through government-run exchanges. We have entered into an agreement with, and enrolled individuals and families into qualified health plans through, the Federally Facilitated Marketplace, or FFM, run by CMS. The FFM operated some part of the health insurance exchange in 37 states during the last health care reform open enrollment period.

Our ability to act as a health insurance agent for subsidy-eligible individuals purchasing qualified health plans through the FFM depends upon the FFM developing and maintaining an efficient, scalable and online enrollment process, and our ability to successfully enter into and maintain our agreement and integrate with the FFM. CMS has discretion to allow us to enroll individuals in qualified health plans through the FFM and broad authority over the requirements that we must meet in order to be able to do so. In addition to issuing new requirements, CMS has the authority to interpret existing requirements. In order to enroll individuals in subsidy-eligible plans over the Internet through the FFM, we need to meet a number of requirements relating to the display of information on our websites, as well as new and comprehensive privacy and security requirements. These requirements are evolving. For example, we were required to translate significant portions of our website into Spanish for the current open enrollment period in certain jurisdictions in order to be able to offer qualified health plans to individuals in states where greater than 10% of the state's population is Spanish speaking (currently Texas). Our ability to maintain compliance with the various requirements to enroll individuals through the FFM has presented, and could in the future present, significant challenges for us.

CMS directed us and other web-based entities to make changes after the end of the last open enrollment period to the process we developed for enrolling individuals into qualified health plans through the FFM. As a result of the changes that we made to our online process in response to CMS requirements, which require that we use a different and more cumbersome pathway through which individuals are enrolled in qualified health plans, we experienced a substantial reduction in the rate at which individuals and families starting the application process for qualified health plans and subsidies became members. Near the time CMS directed us to change our process for enrolling individuals in qualified health plans, CMS indicated that it anticipated it would improve the alternative process that CMS directed us to use. To date, CMS has not made meaningful improvements to the process and has indicated that it no longer anticipates making important improvements. While we have engaged in discussions with CMS to allow us to use a process similar to the process we used during the last open enrollment

period, CMS has determined to not allow us to do so. We expect that the reduced conversion rates for the process that CMS has directed us to use for enrolling individuals in qualified health plans will persist during the open enrollment period that began on November 1, 2016 and is scheduled to end January 31, 2017. The reduced conversion rates result in higher marketing and advertising costs per submitted application and reduce the cost-effectiveness of our direct and online marketing programs. As a result, we reduced our individual and family health insurance marketing spend outside of the open enrollment period in 2016 and plan reduced individual and family health insurance marketing spend during the current open enrollment period. As a result of these circumstances, we expect to enroll a significantly lower number of individuals and families into individual and family health insurance plans during the current open enrollment period compared to the last open enrollment period, which would positively impact our 2016 financial results due to the reduction in marketing and advertising expenses, but contribute to significantly reduced individual and family health insurance membership and commission revenue for us in 2017 compared to 2016.

The future impact of health care reform on health insurance carriers that pay us our commission revenue is also unclear. Health insurance carriers have the ability to enter into or withdraw from health insurance markets and unilaterally change their relationship with us, including altering the manner and geographic areas in which they permit us to sell their products, changing the commission rates we receive for acting as a health insurance agent, and changing our relationship with them in any number of ways. As a result of higher medical utilization rates than carriers projected and for other reasons, major health insurance carriers for which we have sold individual and family health insurance have announced their exit from the individual and family health insurance market altogether or in a large number of states. Some of these carriers have indicated that they only plan to sell individual and family health insurance through government exchanges, such as the FFM. These circumstances will result in our offering a reduced number of individual and family health insurance plans on our website compared to last year's open enrollment period, including several states and zip codes where we have no individual and family health insurance plans to offer. We anticipate that the reduction in the number of individual and family health insurance plans we are able to offer will lead to a decrease in demand for the individual and family health insurance that we sell. In addition, a significant number of our individual and family health insurance members purchased their individual and family health insurance from carriers exiting the individual and family health insurance market. As a result, we expect to see increased attrition in our individual and family membership, because those members will need to shop for and purchase individual and family health insurance from another health insurance carrier during the current open enrollment period, if they desire to maintain individual and family health insurance. If they do not purchase their individual and family health insurance through us, they will no longer be our members and we will not receive the related commission revenue. If additional health insurance carriers determine not to sell individual and family health insurance in certain states or altogether, the impact on our individual and family membership and commission revenue will likely be more pronounced. We believe increased attrition and a reduction of the demand for individual and family health insurance plans that we sell will contribute to significant reduced individual and family insurance membership and commission revenue for us in 2017 compared to 2016.

Given the significant losses that carriers have sustained in connection with their sale of individual and family health insurance, several health insurance carriers with which we have a relationship, including large national health insurance carriers, made changes to the commissions they pay us, including reducing or eliminating our commissions for individual and family health insurance enrollments outside of the open enrollment period, reducing or eliminating our commissions for individual and family health insurance plans sold during the current open enrollment period and/or reducing our 2017 renewal commissions for individual and family health insurance plans we previously sold in prior years. As a result, we expect to see a meaningful reduction in our average commission rates for plans sold during the current open enrollment period compared to the last open enrollment period and for our aggregate individual and family health insurance plan membership in 2017 compared to 2016. While we do expect to see premium inflation offsetting some of the negative impact of lower commission rates, given that some of the carriers pay us based on percentage of premiums, the exact impact of these rate changes on our commission revenue will largely depend on the mix of individual and family health insurance products that we sell during the current open enrollment period as well as the mix of active individual and family health insurance plans held by our individual and family health insurance membership in 2017 and in future years. Additionally, to the extent an increase in the health insurance premiums consumers pay for the individual and family health insurance reduces demand for the individual and family health insurance that we sell or there is an overall deterioration in the commissions that we receive for plans that we sell in the current open enrollment period compared to the last open enrollment period, our business, operating results and financial conditions would be harmed.

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

- the number of applications for Medicare-related, individual and family, small business and ancillary health insurance we submit to health insurance carriers;
- the number of members on submitted applications;

- the rate at which the individuals on those applications turn into paying members;
- the commission rates we receive for the health insurance plans that we sell; and
- our membership retention.

Submitted Applications. Historically, we have experienced a significant increase in the number of Medicare-related submitted applications during the Medicare annual enrollment period, which occurs during the fourth quarter of each year. Medicare Advantage applications submitted during the first, second and third quarters accounted for 45% of our total Medicare submitted applications in 2015, compared to 34% in 2014. Total Medicare product applications submitted outside of the annual enrollment period accounted for 55% of our total Medicare submitted applications in 2015, while 45% were submitted during the annual enrollment period in 2015. During the third quarter of 2016, submitted applications for Medicare Advantage products grew 16% compared to the third quarter of 2015, while submitted applications for all Medicare products, which also include Medicare Supplement and Medical Part D prescription drug plans, grew 26%. These growth rates represent a deceleration compared to strong growth rates we experienced in our Medicare business in the first half of 2016 and were driven in large part by a reduction in lead volume from certain business development partners as a result of CMS rule-related changes to their advertising and a change in sales and marketing guidelines issued by CMS. The change in sales and marketing guidelines resulted in our making changes to our Medicare product sales and marketing processes during the third quarter of 2016, which impacted the effectiveness of our call center agents in converting leads into submitted applications during the third quarter of 2016.

The number of individual and family health insurance applications submitted through us has historically been highest during the health care reform open enrollment period, which has begun in the fourth quarter and run into the first quarter of the following year. Individual and family applications submitted through us during the first quarter of 2016 were lower than the number of applications submitted through us during the fourth quarter of 2015, and 47% below the number of applications submitted through us during the first quarter of 2015. During the second and third quarters of 2016, individual and family applications submitted through us decreased 59% and 60%, respectively, compared to the second and third quarters of 2015. The second and third quarters are outside the health care reform open enrollment periods and the number of individual and family health insurance submitted applications in these periods has historically decreased compared to the first and fourth quarters. This trend has so far persisted in 2016. We expect our individual and family submitted applications will increase significantly during the fourth quarter of 2016, relative to the second and third quarters of 2016, as a result of the open enrollment period. However, since CMS will not allow us to use a process similar to the process we used during the last open enrollment period for enrolling individuals into qualified health plans through the FFM, we expect to enroll a significantly lower number of individuals into individual and family health insurance plans during the current open enrollment period, compared to the last open enrollment period, which would significantly and negatively impact our individual and family health insurance commission revenue in 2016 and in future years.

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

Approval Rates and Initial Payment Rates. Approval rates for Medicare-related health insurance remained relatively consistent in 2014, 2015 and during the first nine months of 2016. Initial payment rates for approved Medicare-related health insurance plans remained relatively consistent in 2014 and 2015, but declined slightly in the second and third quarters of 2016 due to a change in carrier mix. As a result of the health care reform prohibition on using pre-existing health conditions as a reason to deny health insurance applications, we have experienced higher approval rates on individual and family plan applications submitted during the open enrollment periods compared to periods before health care reform implementation. Individual and family health insurance approval rates have historically been lower outside of the open enrollment period than for applications submitted during the open enrollment period. In addition, during the first and second quarters of 2015, our individual and family plan commission revenue benefited from carriers paying us earlier on policies approved during the open enrollment period that ended in 2015 compared to the prior open enrollment period. The timing of carrier payments received during the first and second quarters of 2016 were similar to the first and second quarters of 2015. We believe that the more timely payment of commissions resulted from carriers being better prepared to handle large application volumes, and we also

took steps to work with our carrier partners to ensure that their processes resulted in more timely commission payments to us in 2015 and thus far in 2016.

Commission Rates. The average commission dollars per-member-per-month that we receive for new health insurance plan members varies based upon a number of factors, including the ratio of policies that we sold for which we receive per member-per-month commissions compared to percentage-of-premium commissions, the premiums on the policies we sold, the mix of our members by health insurance carrier and the commission rates we receive from each carrier. Additionally, commission rates may vary by carrier, by geography and by the type of plan purchased by a member.

In the first plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application but during the effective year of the plan, we are paid a fixed commission that is prorated for the number of months remaining in the calendar year. Additionally, if the plan is the first Medicare Advantage or Medicare Part D prescription drug plan issued to the member, we may receive a higher commission rate that covers a full twelve-month period, regardless of the month the plan was effective. Beginning with and subsequent to the second plan year, we typically receive fixed, monthly commissions for Medicare Advantage plans and fixed, annual commissions for Medicare Part D prescription drug plans. During 2015 and 2016, for certain categories of enrollments that occur outside of the annual enrollment period, CMS allowed carriers to either prorate the commission payment for the number of months remaining in the calendar year or pay the broker a full year of commissions up-front. A number of carriers for which we sell Medicare products recently changed from paying us a full-year of commissions up-front to pro-rating their payments based on the number of months remaining in the calendar year, which negatively impacted our Medicare commission revenue in the third quarter of 2016 compared to the third quarter of 2015. We earn commission revenue for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically until either the policy is cancelled or we otherwise do not remain the agent on the policy. Commission payments we receive for Medicare Supplement policies sold by us are typically a percentage of the premium on the policy and paid to us until the policy is cancelled or we otherwise do not remain the agent on the policy. See *Critical Accounting Policies and Estimates* in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of Medicare plan commission revenue.

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

As a result of our commission structure, much of our revenue for a given financial reporting period relates to health insurance plans that we sold prior to the beginning of the period and is recurring in nature. However, the increased volume of health insurance applications submitted during the annual open enrollment periods compared to applications submitted outside of the annual open enrollment period has caused us to experience shifts in the concentration of our membership by health insurance carrier and type of plan purchased and corresponding fluctuations in our average commission rate. For example, we observed higher commissions on many of the individual and family health insurance plans that we sold during the 2015 open enrollment period for coverage effective in 2016 compared to policies that we sold during the 2014 open enrollment period for coverage effective in 2015. Recently, given the significant losses that carriers have sustained in connection with their sale of individual and family health insurance, several health insurance carriers with which we have a relationship, including large national health insurance carriers, made changes to the commissions they pay us, including reducing or eliminating our commissions for individual and family health insurance enrollments outside of the open enrollment period, reducing or eliminating our commissions for individual and family health insurance plans sold during the current open enrollment period and/or reducing our 2017 renewal commissions for individual and family health insurance plans we previously sold in prior years. As a result, we expect to see a meaningful reduction in our average commission rates for plans sold during the current open enrollment period compared to the last open enrollment period and for our aggregate individual and family health insurance plan membership in 2017 compared to 2016. While we do expect to see premium inflation offsetting some of the negative impact of lower commission rates, given that some of the carriers pay us based on percentage of premiums, the exact impact of these rate changes on our commission revenue will largely depend on the mix of individual and family health insurance products that we sell during the current open enrollment period as well as the mix of active individual and family health insurance plans held by our individual and family health insurance membership in 2017 and in future years. Additionally, to the extent an increase in the health insurance premiums consumers pay for the individual and family health insurance reduces demand for the individual and family health insurance that we sell or there is an overall deterioration in the commissions that we receive for plans that we sell in the current open enrollment period compared to the last open enrollment period, our business, operating results and financial conditions would be harmed.

Retention Rates. Our commission revenue is also influenced by our member retention rates. Retention rates are typically lower in the first policy year and improve each subsequent year. Additionally, the member retention rates on our individual and family membership were negatively impacted by health care reform throughout 2014, 2015 and the first three quarters of 2016. The number of new individual and family health insurance members added during the second and third quarter of 2016 and the second, third and fourth quarters of 2015 was not enough to offset the loss of existing members, resulting in a decline in individual and family health insurance estimated membership during those periods. As described in greater detail in *Summary of Selected Metrics*, our individual and family plan membership estimates are based on historical member attrition rates as we do not learn of membership cancellations for a period of time. We are now seeing that our actual attrition rates during the first half of 2016 were greater than the attrition rates we experienced in our individual and family health insurance business prior to that period. We believe the increased attrition related to premium inflation in the individual and family plan market. In addition, a significant number of our individual and family health insurance members purchased their individual and family health insurance from carriers exiting the individual and family health insurance market. As a result, we may see further increased attrition in our individual and family membership, because those members will need shop for and purchase individual and family health insurance from another health insurance carrier during the current open enrollment period if they desire to maintain individual and family health insurance. If they do not purchase their individual and family health insurance through us, they will no longer be our members and we will not receive the related commission revenue. If additional health insurance carriers determine not to sell qualified health plans or exit the business of selling individual and family health insurance in certain states or altogether, the impact on our individual and family membership and commission revenue will likely be more pronounced.

Other Revenue

Online Sponsorship and Advertising. We generate revenue from our online sponsorship and advertising program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website and allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us. In return, we are typically paid a flat fee or, with respect to individual and family health insurance plans, a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications. Health insurance carriers commit to sponsorship and advertising on a quarterly basis, if at all, and generally determine prior to the quarter whether to purchase sponsorship and advertising from us and how much they are willing to spend. As a result, our sponsorship and advertising revenue is difficult to predict. As a result of the decrease in individual and family health insurance submitted applications in the first, second and third quarters of 2016 compared to 2015, our online sponsorship revenue related to individual and family health insurance plans similarly declined during these periods, a trend that we expect to continue in the fourth quarter of 2016.

Technology Licensing. We generate revenue from licensing the use of our health insurance ecommerce technology. Our technology platform enables health insurance carriers and agents to market and distribute health insurance plans online. Health insurance carriers or agents that license our technology typically pay us implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications.

Lead Referrals. We generate revenue from referral fees paid to us based on Medicare-related and individual and family health insurance leads generated by our ecommerce platforms that are delivered and sold to third parties.

See *Critical Accounting Policies and Estimates* in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015 for details regarding our recognition of online sponsorship and advertising revenue, technology licensing revenue and lead referral revenue.

Member Acquisition

Marketing initiatives are an important component of our strategy to increase revenue. Our marketing initiatives are focused on three primary member acquisition channels: direct, marketing partners and online advertising and are primarily designed to encourage consumers to complete an application for health insurance. For the three months ended September 30, 2015 and 2016, applications submitted through us for Medicare-related, individual and family, small business and ancillary health insurance from our three member acquisition channels as a percentage of all health insurance applications submitted on our websites were as follows:

	Three Months Ended September 30,	
	2015	2016
Source of total submitted applications (as a percentage of total submitted applications for the period):		
Direct	64%	66%
Marketing partners	31%	27%
Online advertising	5%	7%
Total	100%	100%

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

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

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

Operating Costs and Expenses

Cost of Revenue

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

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

Marketing and Advertising

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

Since a significant portion of our marketing and advertising expenses consists of expenses incurred as a result of payments owed to our marketing partners in connection with health insurance applications submitted on our ecommerce platforms and other forms of marketing, such as direct mail, email marketing, television, radio and retargeting campaigns, those

expenses are influenced by seasonal submitted application patterns. As a result of the annual open enrollment periods for both Medicare-related and individual and family health insurance, marketing and advertising expenses increase during the fourth quarter of each year. Additionally, since the health care reform open enrollment periods for individual and family health insurance has continued into the following year, marketing and advertising expenses have increased during the first quarter of each year, but to a lesser extent than the fourth quarter. During the second and third quarters, marketing and advertising expenses decrease, consistent with the decrease in submitted applications compared to periods during the open enrollment periods. We expect these seasonal trends to continue in 2016.

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

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

We have experienced substantially reduced conversion rates for qualified health plans since the last open enrollment period and anticipate that we will experience substantially reduced conversion rates for qualified health plans during the current open enrollment period, compared to the last open enrollment period. As a result, we have reduced our individual and family health insurance marketing expenditures and reduced individual and family marketing expenses for the current open enrollment period. Accordingly, we expect to enroll a significantly lower number of individuals into individual and family health plans during the current open enrollment period, compared to the last open enrollment period. The reduced enrollment, however will adversely impact our revenue and profitability in 2017 and beyond.

Customer Care and Enrollment

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

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.

General and Administrative

General and administrative expenses include compensation and benefits costs for staff working in our executive, finance, investor relations, government affairs, legal, human resources, internal audit, facilities and internal information technology departments. These expenses also include fees paid for outside professional services, including audit, tax, legal, government affairs and information technology fees. We incurred significant general and administrative expenses in the second and third quarters of 2016 in connection with the departure of our chief executive officer and chief financial officer, a strategic review of our business as well as government affairs and lobbying expenses relating to our individual and family health insurance business.

Restructuring Charge

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

In the second and third quarters of 2016, we reversed $0.3 million related to facility exit costs as we reoccupied office space we had previously vacated and were also released from a lease for other office space we had previously vacated.

Strategic Review

In connection with recent changes in our executive management team, we conducted a strategic review of our business operations, examining potential areas of investment and strategic emphasis. As a result of this review, we have identified the following three key growth opportunities:

- Leverage our technology strength and marketing expertise to accelerate our growth in Medicare product sales, including Medicare Advantage and Medicare Supplement plans.
- Utilize the strong platform built for our individual and family health insurance business to pursue large, attractive opportunities in the small business group insurance market.
- Pursue cross-selling and adjacent revenue opportunities in our Medicare and small business group businesses.

In each of these areas of strategic growth emphasis, we intend to invest in and expand our technology-based product offerings, update our technology platform, utilize strategic partnerships to expand our product and market reach, and invest in optimizing our brand and our websites. In our individual and family health insurance business, we plan to continue to focus on profitability and cash flow maximization, while further reducing our individual and family plan-related marketing expenses. The significant level of investment required to implement these strategic plans will likely have a negative impact on future earnings for the fourth quarter of 2016 and for 2017.

Changes in Senior Management

In May 2016, we announced the resignation of Gary L. Lauer from his positions as chairperson of our board of directors and chief executive officer and the appointment of Scott N. Flanders, a member of our board of directors, as our chief executive officer. These executive changes increased general and administrative expenses, including severance costs, other personnel costs and stock-based compensation in the second quarter of 2016.

In June 2016, we announced the resignation of William T. Shaughnessy from his positions as president, chief operating officer and a member of our board of directors. This executive departure increased marketing and advertising expenses, including severance costs, other personnel costs and stock-based compensation in the second quarter of 2016.

In July 2016, we announced the resignation of Stuart M. Huizinga from his positions as our senior vice president and chief financial officer and the appointment of David K. Francis as our senior vice president and chief financial officer. Mr. Huizinga continued to serve as our principal financial officer and principal accounting officer to help finalize our Quarterly Report on Form 10-Q for the quarter ended June 30, 2016, and he resigned such roles on September 30, 2016, at which time

Mr. Francis began his service as our chief financial officer and Jay W. Jennings began his service as our principal accounting officer. These executive changes resulted in increased general and administrative expenses, including severance costs, other personnel costs and stock-based compensation in the three and nine months ended September 30, 2016.

In October 2016, we announced the appointment of Robert S. Hurley as president, Medicare products and Tom G. Tsao as President, small business, individual and family products. Mr. Hurley previously served as executive vice president of sales and operations, and Mr. Tsao previously served as executive vice president, chief technology and product officer. We also announced that Mr. Francis will add the responsibilities of chief operations officer to his current responsibilities as senior vice president, chief financial officer, and principal financial officer. Among his other responsibilities, Mr. Francis will head key operational aspects of our business, including telesales and product and technology development.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics for the three months ended September 30, 2015 and 2016 and as of September 30, 2015 and 2016:

	Three Months Ended September 30,		
	2015	**2016**	**Percentage Change**
Submitted applications:			
Medicare submitted applications (1)	19,200	24,100	26 %
IFP submitted applications (2)	22,500	8,900	(60)%
Other submitted applications (3)	70,600	56,400	(20)%
Total submitted applications (4)	112,300	89,400	(20)%
Medicare Advantage submitted applications (5)	14,800	17,100	16 %
Commission revenue (in thousands):			
Medicare commission revenue (6)	$ 6,578	$ 6,558	— %
IFP commission revenue (7)	21,535	17,137	(20)%
Other commission revenue (8)	6,829	6,246	(9)%
Total commission revenue (9)	$ 34,942	$ 29,941	(14)%

	As of September 30		
	2015	**2016**	**Percentage Change**
Estimated membership:			
Medicare estimated membership (10)	182,700	242,500	33 %
IFP estimated membership (11)	518,000	390,400	(25)%
Other estimated membership (12)	397,400	355,600	(11)%
Total estimated membership (13)	1,098,100	988,500	(10)%

Notes:

(1)	Medicare-related health insurance applications submitted on our website or through our customer care center during the period, including Medicare Advantage, Medicare Part D prescription drug and Medicare Supplement plans. Applications are counted as submitted when the applicant completes the application and either clicks the submit button on our website or provides verbal authorization to submit the application. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application.
(2)	Major medical Individual and Family plan ("IFP") health insurance applications submitted on our website during the period. Applications are counted as submitted when the applicant completes the application, clicks the submit button on our website and submits the application to us. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application. We define our IFP offerings as major medical individual and family health insurance plans, which does not include Medicare-related, small business or ancillary plans (primarily consisting of short-term, dental, life, vision, and accident insurance plans).
(3)	Applications for health insurance plans other than Medicare and IFP submitted on our website during the period. Applications for ancillary plans are counted as submitted when the applicant completes the application, clicks the submit button on our website and submits the application to us. Applications for small business plans are counted as submitted when the applicant completes the application, the employees complete their applications, the applicant submits the application to us and we submit the application to the carrier. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application.
(4)	Applications for all health insurance plans submitted on our website or through our customer care center during the period. See notes (1), (2) and (3) above for more information as to what constitutes a submitted application.
(5)	Medicare Advantage plan health insurance applications submitted on our website or through our customer care center during the period. Applications are counted as submitted when the applicant completes the application and either clicks the submit button on our website or provides verbal authorization to submit the application. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application. Medicare Advantage submitted applications are included in Medicare submitted applications - See Note 1 above.
(6)	Commission revenue recognized on all Medicare-related health insurance during the period.
(7)	Commission revenue recognized on all IFP health insurance during the period, including commission overrides.
(8)	Commission revenue recognized on all insurance other than Medicare-related health insurance and IFP health insurance during the period.
(9)	Total commission revenue recognized on all insurance plans during the period.
(10)	Estimated number of members active on Medicare-related health insurance as of the date indicated. See the note below for additional information regarding our calculation of Medicare estimated membership.
(11)	Estimated number of members active on IFP health insurance plans as of the date indicated. See the note below for additional information regarding our calculation of IFP estimated membership.
(12)	Estimated number of members active on insurance plans other than Medicare-related health insurance and IFP health insurance plans as of the date indicated. See the note below for additional information regarding our calculation of other estimated membership.
(13)	Estimated number of members active on all insurance plans as of the date indicated. See the note below for additional information regarding our calculation of total estimated membership.

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

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

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

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

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). To the extent we determine we have received substantially all of the commission payments related to a given month during the one to three-month period being estimated, we will take the number of members for whom we have received or applied a commission payment during the month of estimation. The one to three-month period varies by insurance product and is largely dependent upon the timeliness of commission payment and related reporting from the related carriers. For small business health insurance plans, we estimate the number of members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier in the period it is reported. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us. Health insurance carriers often do not communicate policy cancellation information to us. We often are made aware of policy cancellations at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

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

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

Critical Accounting Policies and Estimates

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

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

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

During the nine months ended September 30, 2016, there were no significant changes to our critical accounting policies and estimates. Please refer to *Management's Discussion and Analysis of Financial Condition and Results of Operations* contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2015, for a complete discussion of our critical accounting policies and estimates.

Results of Operations

The following tables set forth our operating results and the related percentage of total revenues for the three and nine months ended September 30, 2015 and 2016 (dollars in thousands):

	Three Months Ended September 30,				Nine Months Ended September 30,			
	2015		2016		2015		2016	
Revenue:								
Commission	$ 34,942	91 %	$ 29,941	93 %	$ 130,157	93 %	$ 133,977	94 %
Other	3,282	9	2,138	7	9,248	7	9,223	6
Total revenue	38,224	100	32,079	100	139,405	100	143,200	100
Operating costs and expenses:								
Cost of revenue	443	1	30	—	3,527	3	2,747	2
Marketing and advertising	9,349	24	10,206	32	44,086	32	44,024	31
Customer care and enrollment	9,462	25	11,259	35	28,981	21	31,869	22
Technology and content	8,036	21	8,257	26	27,400	20	25,053	17
General and administrative	7,749	20	9,122	28	23,237	17	28,066	20
Restructuring charge (benefit)	—	—	(139)	—	4,541	3	(297)	—
Amortization of intangible assets	260	1	260	1	893	1	780	1
Total operating costs and expenses	35,299	92	38,995	122	132,665	95	132,242	92
Income (loss) from operations	2,925	8	(6,916)	(22)	6,740	5	10,958	8
Other income (expense)	(27)	—	7	—	(50)	—	(25)	—
Income (loss) before benefit for income taxes	2,898	8	(6,909)	(22)	6,690	5	10,933	8
Benefit for income taxes	(737)	(2)	(1,173)	(4)	(613)	—	(889)	(1)
Net income (loss)	$ 3,635	10 %	$ (5,736)	(18)%	$ 7,303	5 %	$ 11,822	8 %

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Marketing and advertising	$ 461	$ 19	$ 1,498	$ 1,038
Customer care and enrollment	110	90	366	360
Technology and content	362	384	1,308	1,293
General and administrative	643	854	2,149	2,665
Restructuring charge	—	—	113	—
Total stock-based compensation expense	$ 1,576	$ 1,347	$ 5,434	$ 5,356

Three and Nine Months Ended September 30, 2015 and 2016

Revenue

The following tables present our commission, other revenue and total revenue for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Commission	$ 34,942	$ 29,941	$ (5,001)	(14)%
Percentage of total revenue	91%	93%		
Other	$ 3,282	$ 2,138	$ (1,144)	(35)%
Percentage of total revenue	9%	7%		
Total revenue	$ 38,224	$ 32,079	$ (6,145)	(16)%

Commission revenue decreased $5.0 million, or 14%, in the three months ended September 30, 2016 compared to the three months ended September 30, 2015, due to a decrease of $4.4 million in individual and family health insurance commission revenue and a decrease of $0.6 million in ancillary health insurance commission revenue, consisting primarily of short-term, dental, vision and accident plan offerings. The decrease in individual and family health insurance commission revenue was primarily due to decreased individual and family health insurance estimated membership for the period ended September 30, 2016 compared to the period ended September 30, 2015. The decrease in ancillary health insurance commission revenue was primarily due to decreased short-term health insurance estimated membership, and to a lesser extent dental and accident health insurance estimated membership, for the period ended September 30, 2016 compared to the period ended September 30, 2015**.**

Other revenue decreased $1.1 million, or 35%, in the three months ended September 30, 2016, compared to the three months ended September 30, 2015, due primarily to a decrease in online sponsorship and advertising revenue and technology licensing revenue.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percent
Commission	$ 130,157	$ 133,977	$ 3,820	3 %
Percentage of total revenue	93%	94%		
Other	$ 9,248	$ 9,223	$ (25)	— %
Percentage of total revenue	7%	6%		
Total revenue	$ 139,405	$ 143,200	$ 3,795	3 %

Commission revenue increased $3.8 million, or 3%, in the nine months ended September 30, 2016, compared to the nine months ended September 30, 2015, primarily due to an increase of $15.6 million in Medicare-related commission revenue, partially offset by decreases of $9.1 million in individual and family health insurance commission revenue, $1.3 million in commission override revenue, and $1.3 million in ancillary health insurance commission revenue, consisting primarily of short-term, dental, vision and accident plan offerings. The increase in Medicare-related commission revenue is primarily due to increased Medicare estimated membership for the period ended September 30, 2016 compared to the period ended September 30, 2015. Commission revenue from renewals of Medicare Advantage and Medicare Part D prescription drug plans were approximately $29 million in the first quarter of 2016, representing approximately 52% annual growth compared to the first quarter of 2015. The decrease in individual and family plan commission revenue is primarily due to decreased individual and family health insurance estimated membership for the period ended September 30, 2016 compared to the period ended September 30, 2015. The decrease in ancillary health insurance commission revenue is primarily due to decreased dental health insurance estimated membership, and to a lesser extent short-term and accident health insurance estimated membership, for the period ended September 30, 2016 compared to the period ended September 30, 2015.

Other revenue decreased slightly in the nine months ended September 30, 2016, compared to the nine months ended September 30, 2015.

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

Operating Costs and Expenses

Cost of Revenue

The following tables present our cost of revenue for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Cost of revenue	$ 443	$ 30	$ (413)	(93)%
Percentage of total revenue	1%	—%		

Cost of revenue decreased $0.4 million, or 93%, in the three months ended September 30, 2016 compared to the three months ended September 30, 2015, due primarily to a correction of an immaterial error and to fewer payments to marketing partners with whom we have revenue-sharing arrangements.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Cost of revenue	$ 3,527	$ 2,747	$ (780)	(22)%
Percentage of total revenue	2%	2%		

Cost of revenue decreased $0.8 million, or 22%, in the nine months ended September 30, 2016, compared to the nine months ended September 30, 2015, due primarily to a decrease in amortization expense associated with the consideration we paid to a broker partner in connection with the transfer of several Medicare plan books-of-business to us whereby we became the broker of record on the underlying policies and to fewer payments to marketing partners with whom we have revenue-sharing arrangements.

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

Marketing and Advertising

The following tables present our marketing and advertising expenses for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Marketing and advertising	$ 9,349	$ 10,206	$ 857	9%
Percentage of total revenue	24%	32%		

Marketing and advertising expenses increased $0.9 million, or 9%, in the three months ended September 30, 2016 compared to the three months ended September 30, 2015, due primarily to a $1.7 million increase in variable advertising costs partially offset by a $0.4 million decrease in salaries, benefits and other personnel costs and a $0.4 million decrease in stock-based compensation resulting from executive departures.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Marketing and advertising	$ 44,086	$ 44,024	$ (62)	— %
Percentage of total revenue	32%	31%		

Marketing and advertising expenses decreased $0.1 million in the nine months ended September 30, 2016 compared to the nine months ended September 30, 2015, due primarily to a $1.2 million decrease in salaries, benefits and other personnel costs due to the reduction-in-force announced in March 2015, and a $0.5 million decrease largely due to reversal of stock based compensation resulting from executive departures, partially offset by a $1.5 million increase in variable advertising costs.

We expect our marketing and advertising expenses to increase in absolute dollars in 2016 compared to 2015 due primarily to an increase in variable advertising costs related to our Medicare-related health insurance business, particularly during the Medicare annual enrollment period in the fourth quarter.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Customer care and enrollment	$ 9,462	$ 11,259	$ 1,797	19%
Percentage of total revenue	25%	35%		

Customer care and enrollment expenses increased $1.8 million, or 19%, in the three months ended September 30, 2016 compared to the three months ended September 30, 2015, due primarily to a $1.5 million increase in compensation, benefits and other personnel costs relating to the Medicare-related health insurance business and a $0.3 million increase in facilities and other operating costs.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Customer care and enrollment	$ 28,981	$ 31,869	$ 2,888	10%
Percentage of total revenue	21%	22%		

Customer care and enrollment expenses increased $2.9 million, or 10%, in the nine months ended September 30, 2016 compared to the nine months ended September 30, 2015, due primarily to a $2.3 million increase in compensation, benefits and other personnel costs relating to the Medicare-related health insurance business and a $0.4 million increase in facilities and other operating costs.

We expect customer care and enrollment expenses to increase in absolute dollars in 2016 compared to 2015 as we retained a larger number of agents after the last Medicare annual enrollment period and have hired additional customer care center personnel in connection with the current Medicare annual enrollment period to support the growth of our Medicare-related health insurance business.

Technology and Content

The following tables present our technology and content expenses for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percent
Technology and content	$ 8,036	$ 8,257	$ 221	3%
Percentage of total revenue	21%	26%		

Technology and content expenses increased slightly in the three months ended September 30, 2016 compared to the three months ended September 30, 2015.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percent
Technology and content	$ 27,400	$ 25,053	$ (2,347)	(9)%
Percentage of total revenue	20%	17%		

Technology and content expenses decreased $2.3 million, or 9%, in the nine months ended September 30, 2016 compared to the nine months ended September 30, 2015, primarily due to a $2.8 million decrease in compensation, benefits and other personnel costs due to the reduction-in-force announced in March 2015, partially offset by a $0.4 million increase in facilities and other operating costs.

General and Administrative

The following tables present our general and administrative expenses for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percent
General and administrative	$ 7,749	$ 9,122	$ 1,373	18%
Percentage of total revenue	20%	28%		

General and administrative expenses increased $1.4 million, or 18%, in the three months ended September 30, 2016 compared to the three months ended September 30, 2015, due primarily to a $0.6 million increase in compensation, benefits and other personnel costs resulting from severance and relocation costs, a $0.2 million increase in stock-based compensation resulting from executive changes and a $0.4 increase in third party fees related to review and analysis of strategic plans.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
General and administrative	$ 23,237	$ 28,066	$ 4,829	21%
Percentage of total revenue	17%	20%		

General and administrative expenses increased $4.8 million, or 21%, in the nine months ended September 30, 2016 compared to the nine months ended September 30, 2015, due primarily to an increase of $2.0 million in compensation, benefits and other personnel costs resulting from severance and relocation costs and a $0.5 million increase in stock based compensation expense resulting from executive changes, a $0.9 million increase in legal fees and a $0.8 million increase in third party fees related to a review and analysis of strategic plans.

We expect general and administrative expenses to increase in absolute dollars in 2016 compared to 2015 as a result of severance costs, other personnel costs and stock-based compensation resulting from changes in our executive officers as well as third-party fees related to a review and analysis of strategic plans.

Restructuring Charge (benefit)

The following table presents our restructuring benefit for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Restructuring benefit	$ —	$ (139)	$ (139)	N/A
Percentage of total revenue	—%	— %		

During the three months ended September 30, 2016, we reversed $0.1 million related to facility exit costs as we were released from a lease for office space we had previously vacated.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Restructuring charge (benefit)	$ 4,541	$ (297)	$ (4,838)	(107)%
Percentage of total revenue	3%	— %		

The organizational restructuring and cost reduction plan was implemented in March 2015 resulted in a restructuring charge of $4.5 million. These costs consisted primarily of $3.9 million for employee termination benefits and related costs and $0.6 million for facility and other termination costs. For the nine months ended September 30, 2016, we reversed $0.3 million related to facility exit costs as we reoccupied office space we had previously vacated and were also released from a lease for other office space we had previously vacated.

Amortization of Intangible Assets

The following tables present our amortization of intangible assets for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Amortization of intangible assets	$ 260	$ 260	$ —	—%
Percentage of total revenue	1%	1%		

Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber was flat in the three months ended September 30, 2016 compared to the three months ended September 30, 2015.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Amortization of intangible assets	$ 893	$ 780	$ (113)	(13)%
Percentage of total revenue	1%	1%		

Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber decreased $0.1 million, or 13%, in the nine months ended September 30, 2016 compared to the nine months ended September 30, 2015 due to certain assets that have been fully amortized compared to the prior period.

Other Income (Expense)

The following table presents our other income (expense) for the three and nine months ended September 30, 2015 and 2016 and the dollar and percentage changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Other income (expense)	$ (27)	$ 7	$ 34	(126)%
Percentage of total revenue	— %	—%		

Interest earned on our invested cash and foreign exchange gains in the three months ended September 30, 2016 were partially offset by administrative bank fees, foreign exchange losses, management fees and interest expense on our capital lease obligations. In the three months ended September 30, 2015 administrative bank fees, foreign exchange losses, management fees and interest expense on our capital lease obligation were partially offset by interest earned on our invested cash and foreign exchange gains.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Other income (expense)	$ (50)	$ (25)	$ 25	(50)%
Percentage of total revenue	— %	— %		

Administrative bank fees, foreign exchange losses, management fees and interest expense on our capital lease obligations were partially offset by interest earned on our invested cash and foreign exchange gains in the nine months ended September 30, 2015 and 2016.

Benefit for Income Taxes

The following tables present our benefit for income taxes for the three and nine months ended September 30, 2015 and 2016 and the dollar changes from the prior year periods (dollars in thousands):

	Three Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Benefit for income taxes	$ (737)	$ (1,173)	$ (436)	59%
Percentage of total revenue	(2)%	(4)%		

In the three months ended September 30, 2015 and 2016, we recorded a benefit for income taxes of $0.7 million and $1.2 million, respectively, representing effective tax rates of (25.4)% and 17.0%, respectively. The benefit for income taxes in the third quarters of 2015 and 2016 primarily related to a decrease in our liability for unrecognized tax benefits due to the expiration of the related statute of limitations, partially offset by a provision for income taxes related to a minimum taxes and a foreign tax rate differential.

	Nine Months Ended September 30,		Change	
	2015	2016	Amount	Percentage
Benefit for income taxes	$ (613)	$ (889)	$ (276)	45%
Percentage of total revenue	— %	(1)%		

In the nine months ended September 30, 2015 and 2016, we recorded a benefit for income taxes of $0.6 million and $0.9 million, respectively, representing effective tax rates of (9)% and (8)%, respectively. The benefit for income taxes in the nine months ended September 30, 2015 and 2016, primarily related to a decrease in our liability for unrecognized tax benefits due to the expiration of the related statute of limitations, partially offset by a provision for income taxes related to a minimum taxes and a foreign tax rate differential. We expect the annual effective tax rate to remain consistent for the remaining period in fiscal 2016, excluding the impact of quarterly discrete items.

Liquidity and Capital Resources

At September 30, 2016, our cash and cash equivalents totaled $67.3 million. Cash equivalents, which are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, consist of money market funds. At December 31, 2015, our cash and cash equivalents totaled $62.7 million. The increase in cash and cash equivalents reflects $8.8 million provided by operating activities, offset by $3.2 million used to purchase property and equipment and other assets and $1.0 million used in net-share settled equity awards.

As of September 30, 2016, we have in treasury 451,987 shares that were previously surrendered by employees to satisfy tax withholdings in connection with the vesting of certain restricted stock units. As of December 31, 2015 and September 30, 2016, we had a total of 11,025,933 shares and 11,115,875 shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the nine months ended September 30, 2015 and 2016 (in thousands):

	Nine Months Ended September 30,	
	2015	2016
Net cash provided by operating activities	$ 12,472	$ 8,783
Net cash used in investing activities	$ (2,335)	$ (3,165)
Net cash provided by (used in) financing activities	$ 445	$ (1,048)

Operating Activities

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

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

A significant portion of our marketing and advertising expenses is driven by the number of health insurance applications submitted on our ecommerce platforms. Since our marketing and advertising costs are expensed and generally paid as incurred and the revenue and cash earned from approved applications is recognized and paid as commissions are subsequently reported to us, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter. During open enrollment periods for individual and family health insurance plans, we have experienced an increase in the number of submitted individual and family plan health insurance applications and marketing and advertising

expenses compared to outside of open enrollment periods. During the Medicare annual enrollment period, we have experienced an increase in the number of submitted Medicare-related health insurance applications and marketing and advertising expenses compared to outside of Medicare annual enrollment periods. The timing of open enrollment periods for individual and family health insurance and the Medicare annual enrollment period for Medicare-related health insurance may have positive or negative impacts on our quarterly cash flows. Consistent with prior years, marketing and advertising costs declined in the third quarter compared to the first and second quarters of 2016 and we expect marketing and advertising costs to increase during the fourth quarter of 2016 compared to the third quarter of 2016 due to an increase in submitted applications for Medicare plans and individual and family plans during the annual enrollment period, which will have a negative impact on our cash flows in the quarter.

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

Our operating activities provided cash of $8.8 million during the nine months ended September 30, 2016 and consisted of net income of $11.8 million, increased by non-cash items of $11.1 million and decreased from changes in net operating assets and liabilities and other activities of $14.1 million. Adjustments for non-cash items primarily consisted of $5.8 million of depreciation and amortization, including amortization of internally-developed software, book-of-business consideration and intangible assets and $5.4 million of stock-based compensation expense.

The cash decrease resulting from changes in in net operating assets and liabilities primarily consisted of a decrease of $9.0 million in accrued marketing expenses, a decrease of $5.4 million in accrued compensation and benefits, a decrease of $1.2 million in prepaid expenses and other assets, and a decrease of $0.5 million in accounts payable. These decreases were partially offset by an increase of $2.0 million in accounts receivable and $1.0 million increase in deferred revenue.

Cash provided by operating activities was $12.5 million during the nine months ended September 30, 2015 and consisted of net income of $7.3 million, increased by non-cash items of $12.1 million and decreased resulted from changes in net operating assets and liabilities and other activities of $6.9 million. Adjustments for non-cash items primarily consisted of $6.5 million of depreciation and amortization, including amortization of internally-developed software, book-of-business consideration and intangible assets and $5.4 million of stock-based compensation expense. The cash decrease resulting from changes in net operating assets and liabilities and other activities primarily consisted of a decrease of $0.6 million in accounts receivable, a decrease of $1.2 million in prepaid expenses and other assets, a decrease of $3.9 million in accounts payable, a decrease of $7.4 million in accrued marketing expenses, a decrease of $2.7 million in deferred revenue, an increase of $3.0 million in accrued compensation and benefits and an increase of $0.5 million in accrued restructuring charge.

Investing Activities

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

Net cash used in investing activities of $3.2 million during the nine months ended September 30, 2016 was due to purchases of property and equipment and other assets.

Net cash used in investing activities of $2.3 million during the nine months ended September 30, 2015 was due to $2.3 million used to purchase property and equipment and other assets.

Financing Activities

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

Net cash used in financing activities of $1.0 million during the nine months ended September 30, 2016 was due to $1.0 million used to net-share settle the tax obligation related to vesting equity awards.

Net cash provided by financing activities of $0.4 million during the nine months ended September 30, 2015 was due to proceeds of $1.3 million from the exercise of common stock options offset by $0.8 million used to net-share settle the tax obligation related to vesting equity awards.

Future Needs

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

Contractual Obligations and Commitments

Operating Lease Obligations

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

In connection with the Mountain View, California lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced in increments of 25% of the original amount thereof on the first, second and third anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease. The standby letter of credit has since been reduced to $0.1 million.

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 September 30, 2016 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total
2016 (remaining three months)	$ 1,096	$ 539	$ 1,635
2017	4,219	2,283	6,502
2018	3,048	878	3,926
2019	1,045	174	1,219
2020	1,075	—	1,075
Thereafter	2,445	—	2,445
Total	$ 12,928	$ 3,874	$ 16,802

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, 2015 and September 30, 2016, our cash and cash equivalents were invested as follows (in thousands):

	December 31, 2015	September 30, 2016
Cash [1]	$ 8,086	$ 7,591
Money market funds [2]	54,624	59,677
Total cash and cash equivalents	$ 62,710	$ 67,268

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

(2) At December 31, 2015 and September 30, 2016 money market funds consisted of U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

We do not require collateral or other security for our accounts receivable. As of September 30, 2016, one health insurance carrier represented 47% and 16%, respectively, of our $7.6 million outstanding accounts receivable balance. As of December 31, 2015, three health insurance carriers represented 24%, 18% and 15%, respectively, for a combined total of 57% of our $9.6 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2015 and September 30, 2016. We believe the potential for collection issues with any of our customers is minimal as of September 30, 2016. Accordingly, our estimate for uncollectible amounts at September 30, 2016 was not material.

Significant Customers

Substantially all revenue for the three and nine months ended September 30, 2015 and 2016 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three and nine months ended September 30, 2015 and 2016 are presented in the table below:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2015	2016	2015	2016
Humana	19%	9%	24%	23%
UnitedHealthcare [1]	11%	15%	10%	12%
Aetna [2]	9%	8%	9%	10%
Anthem [3]	10%	10%	10%	8%

(1) UnitedHealthcare includes other carriers owned by UnitedHealthcare.

(2) Aetna includes other carriers owned by Aetna.

(3) Anthem includes other carriers owned by Anthem.

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 September 30, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

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

PART II
OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

In May 2016, we received a Notice of Proposed Agency Action and Opportunity for Hearing (the "Notice") from the Office of the Montana State Auditor, Commissioner of Securities & Insurance ("CSI"). The Notice proposed that the CSI take disciplinary action against a number of parties, including us, for alleged violations of the Montana Insurance Code. Specifically, with respect to us, the Notice alleged we sold short-term health insurance to at least 211 individuals between January 1, 2012 and April 20, 2015 without being appointed by the relevant health insurance carrier in violation of Montana law. The Notice also alleged that we misrepresented pertinent facts or insurance policy provisions in connection with the sale of short-term health insurance and made certain omissions and/or misrepresentations regarding short-term health insurance. The CSI sought the following relief in the Notice (i) imposition of fines against us not to exceed $5,000 per violation; (ii) issuance of a cease and desist order to enjoin us from violations of the Montana Insurance Code; and (iii) suspension or revocation of our license to sell health insurance in Montana. In September 2016, the CSI dismissed us from the action without prejudice. We were not required to pay any amount or suffer any adverse consequence in connection with the dismissal.

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations in any jurisdiction, we could be subject to various fines and penalties, including revocation of our license to sell insurance in those states, and our business, operating results and financial condition would be harmed. Revocation of any of our licenses or penalties in one jurisdiction could cause our license to be revoked or for us to face penalties in other jurisdictions. In addition, without a health insurance license in a jurisdiction, carriers would not pay us commissions for the products we sold in that jurisdiction, and we would not be able to sell new health insurance products in that jurisdiction. We could also be harmed to the extent that related publicity damages our reputation as a trusted source of objective information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome.

ITEM 1A. RISK FACTORS

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

Risks Related to Our Business

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

Our business depends upon the private sector of the United States health insurance system, its relative role in financing health care delivery and health insurance carriers' use of, and payment of commissions to, agents and brokers to market health insurance plans. In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the industry in which we operate in substantial ways. Among several other provisions, health care reform includes a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer their employees group health insurance coverage or face tax penalties; requirements relating to employer contribution to employee health coverage; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; prohibitions on rescission of health insurance; prohibitions on lifetime coverage limits; requirements for guaranteed renewability of health insurance plans; health insurance premium setting guidelines; limitations on deductibles and cost-sharing; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality and, if they do not, to provide rebates to policyholders; minimum benefit levels for health insurance plans, including actuarial value standards and limitations on annual coverage limits; taxes and assessments on health insurance carriers; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for the purchase of individual and family health insurance; assistance for member run health insurance issuers; creation of multi-state health insurance plans to be offered on the exchanges and with oversight from the Office of Personnel Management; requirements for uniform disclosure relating to the costs and benefits of health insurance; government subsidized high risk pools; an expansion of Medicaid so that more individuals will be insured under state Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels. Many of the significant aspects of health care reform went into effect in 2014, although certain provisions were effective prior to 2014, such as medical loss ratio requirements for individual and family and small business health insurance and a requirement that persons 26 years of age and younger be able to stay on a parent's health insurance plan. Health care reform legislation required various departments of the executive branch to adopt regulations implementing its provisions. In addition, state governments have adopted, and will continue to adopt, changes to their existing laws and regulations in light of federal health care reform legislation and regulations. The implementation of health care reform has increased and could further increase our competition and could reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals, families or small businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause a substantial reduction in our membership and revenue; cause us to incur increased expense across our business and cause health insurance carriers to reduce our commissions and other amounts they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. In addition, various aspects of health care reform have caused and could continue to cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to reduce or eliminate the commissions we receive from them as a result of our sale of health insurance plans, to exit the business of selling insurance plans in a particular jurisdiction, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower or no commissions, any of which could materially harm our business, operating results and financial condition.

Beginning in 2014, health insurance carriers offering coverage in the individual or small business health insurance market must continue to ensure that such coverage meets certain actuarial value standards, includes certain minimum health benefits and is not subject to lifetime or, for most health insurance benefits, annual dollar amount coverage limits. Moreover, health insurance carriers cannot deny individuals health insurance for health

reasons. Individuals also are required to hold plans providing minimum essential coverage to meet the mandate for health insurance and avoid a tax penalty. The cost of health insurance has generally increased and several health insurance carriers have indicated that they are suffering financial losses in their individual and family health insurance business. As a result, major health insurance carriers and other health insurance carriers for which we have sold individual and family health insurance have announced their exit from the individual and family health insurance business altogether or in a large number of states. Some of these carriers have indicated that they only plan to sell individual and family health insurance through government exchanges, such as the FFM. As a result, the number of individual and family health insurance plans offered on our website will be reduced compared to last year's open enrollment period, including several states and zip codes where we have no individual and family health insurance plans to offer, which we anticipate will decrease demand for the individual and family health insurance that we sell and harm our business, operating results and financial condition. In addition, a significant number of our members have purchased their individual and family health insurance from carriers exiting the individual and family health insurance market. These members will lose their health insurance plans and will need to shop for and purchase individual and family health insurance from another health insurance carrier during the current open enrollment period if they desire to maintain individual and family health insurance. These circumstances could result in increased attrition in our membership, a reduction in our commission revenue and otherwise harm our business, operating results and financial condition. If additional health insurance carriers determine not to sell qualified health plans or exit the business of selling individual and family health insurance in certain states or altogether, the impact on our individual and family membership and commission revenue will likely be more pronounced. In addition, we anticipate that premiums for individual and family health insurance will generally increase, perhaps substantially. If the cost of health insurance increases, we could experience a reduction in demand for the individual and family health insurance that we sell, which could cause us to suffer a substantial reduction in our membership and materially harm our business, operating results and financial condition. Moreover, compared to the increased cost of individual and family health insurance plans, government subsidies to purchase health insurance and the health care reform tax penalty may not be sufficient enough to drive a substantial number of new entrants into the individual and family health insurance market or incentivize our existing members to maintain their individual and family health insurance plans, which could contribute to a decline in our membership and materially harm our business, operating results and financial condition.

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

As a result of health care reform, individual and family health insurance is required to be purchased during an open enrollment period. The prior open enrollment period for individual and family health insurance began on November 1, 2015 and ended on January 31, 2016 for coverage effective in 2016. The open enrollment period for 2017 coverage began on November 1, 2016 and is scheduled to run through January 31, 2017. Outside of the open enrollment period, individuals and families can only purchase new or change their existing individual and family health insurance if they qualify for a special enrollment period, which requires certain qualifying events such as losing employer-sponsored health insurance or moving to another state. Our revenue depends in large part on the number of paying individual and family health insurance members we are successful in retaining and the number of individual and family health insurance members we acquire during the health care reform open enrollment period. We may not be successful in retaining or acquiring individual and family health insurance plan members for a number of reasons. If we are unsuccessful, our business, operating results and financial condition would be harmed. For example, we have experienced increased member attrition rates since the implementation of health care reform. We also experienced lower than expected individual and family health insurance application volumes during the last two open enrollment periods. These circumstances have resulted in lower individual and family health insurance plan membership. Open enrollment periods of limited duration in the individual and family health insurance markets have resulted, and may in the future result, in a reduction in our membership and revenue; an increase in our expenses, particularly during the open enrollment periods; and otherwise may harm our business, operating results and financial condition, particularly given that the open enrollment period for individual and family health insurance overlaps with the annual enrollment period for the Medicare plans that we sell.

It may be difficult for the health insurance agents we employ and our systems and processes to handle as a business the increased volume of health insurance transactions that occur in a short period of time during the health care annual open enrollment period and/or the Medicare annual enrollment period. We hire a significant number of additional employees on a temporary or seasonal basis in a limited period of time to address the expected increase in the volume of health insurance transactions during the Medicare annual enrollment period. We must ensure that these employees are timely licensed, trained and certified and have the appropriate authority to sell health insurance in a number of states. We depend upon state departments of insurance, government exchanges and health insurance carriers

for the licensing, certification and appointment of our health insurance agent employees. If our ability to market and sell individual and family health insurance or Medicare-related health insurance is constrained during an enrollment period for any reason, such as technology failures, reduced allocation of resources, any inability to timely license, train, certify and authorize our employees to sell health insurance, interruptions in the operation of our website or systems, or issues with government-run health insurance exchanges, we could suffer a reduction in our membership and our business, operating results and financial condition could be harmed. In addition, we have reduced our employee and other resources as a part of expense reduction measures. Our expense reductions measures have negatively impacted the resources that we dedicate to the sale of individual and family health insurance, have caused us to sell less individual and family health insurance, and could harm our business, operating results and financial condition in the future.

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

In an attempt to attract and enroll a large number of individuals during the Medicare annual enrollment period and the health care reform open enrollment period, we may invest in areas of our business, including technology and content, customer care and enrollment, and marketing. For example, during 2014, our individual and family health insurance technology and content expense increased as a result of our investment in our technology platform. We also have in the past increased staffing in our customer care center in anticipation of higher demand and application volume during the open enrollment period for individual and family health insurance coverage. Despite our investment in these and other areas, our individual and family health insurance membership declined. While we may not determine to invest heavily in the health care reform open enrollment period, any investment we make in either the Medicare annual enrollment period or the health care reform open enrollment period may not result in a significant number of paying members. If it does not, our future profitability will be negatively impacted and our business, operating results and financial condition would be harmed.

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

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

and maintain solutions that allow us to enroll large numbers of individuals and families in qualified plans over the Internet both during and outside of open enrollment periods, we will lose existing members and new members, and may incur additional expense, which would harm our business, operating results and financial condition. In addition, many health insurance carriers, including major health insurance carriers, are exiting the individual and family health insurance market altogether or in a large number of states, and paying reduced or no commissions in the markets where they do plan to sell individual and family health insurance. During the current open enrollment period, we expect to see a meaningful reduction in our average commission rates compared to the last open enrollment period. As a result of these circumstances, and as a result of the FFM's decision to not allow us to use the process we used during the last open enrollment period to enroll individuals and families through the FFM, we expect to substantially reduce our marketing expenses in our individual and family health insurance business. We anticipate that this expense reduction will result in a reduction in our individual and family health insurance enrollment, including enrollment in qualified health plans through the FFM, which would harm our business, operating results and financial condition.

In order to sell qualified health plans to subsidy eligible individuals during the open enrollment period, we must establish and maintain relationships with government-run health insurance exchanges, particularly the FFM, and given that at least a part of the qualified health insurance plan enrollment process must occur through the health insurance exchanges, we must maintain our technology platform to be able to enroll consumers in qualified health plans through the FFM in a scalable manner. If we are not able to adopt and maintain solutions to integrate with government-run health insurance exchanges or if the health insurance exchange websites and other processes are not consumer friendly, efficient and compatible with the process we have developed for enrolling individuals and families into qualified health plans through the exchanges, we would not be successful in retaining and acquiring members, and our business, operating results and financial condition would be harmed. The Centers for Medicare and Medicaid Services, or CMS, has broad authority over the requirements that we must meet in order to enroll individuals into qualified health plans through the FFM, and in addition to issuing new requirements, has the authority to interpret existing requirements. For example, CMS directed us to alter our method of enrolling subsidy eligible individuals into qualified health insurance plans beginning in February 2016. The change required us to cease using the online process we developed for enrolling individuals into qualified health plans through the FFM and use a prescribed FFM process. As a result of the changes that we made to our online process in response to CMS requirements, we experienced a reduction in the rate at which individuals and families starting the application process for qualified health plan and subsidies became members. The FFM has not improved the process to a significant degree for the current open enrollment period, and while we made significant efforts to convince CMS to allow us to use the process we used during the last open enrollment period, CMS has declined our request to do so. As a result, we anticipate that we will not be able to enroll individuals and families in qualified health plans in an efficient and scalable manner during the upcoming annual open enrollment period and that our qualified health plan enrollments will decline significantly compared to the number of our qualified health plan enrollments during the prior open enrollment period, which would result in our loss of existing members and new potential members, a reduction in our individual and family health insurance plan membership and commission revenue and harm our business, operating results and financial condition. While we intend to continue to offer consumers the ability to purchase qualified health plans through the FFM on our ecommerce platform, we plan to significantly reduce our marketing expense compared to the prior open enrollment period, which would result in a reduction in our individual and family and ancillary health insurance product membership and harm our business, operating results and financial condition. In addition, to the extent that we do enroll individuals into qualified health plans through the FFM, the FFM website, systems and infrastructure must be operational and not suffer significant outages or technical problems as a result of the number of individuals attempting to enroll in qualified health plans or for other reasons. If the FFM experiences these problems, our business, operating results and financial condition would be harmed.

We have entered into agreements with CMS relating to our ability to enroll individuals in qualified health plans through the FFM. The agreements contain comprehensive privacy and security and other requirements. In order to be able to enroll individuals into qualified health plans, we also must satisfy several other regulatory requirements and comply with additional laws and regulations. There are risks and uncertainties relating to our ability to enroll individuals into qualified health plans online through the FFM. Among other things, we must maintain our agreements with the FFM which need to be renewed every year; satisfy the requirements contained in the relevant agreements as well as applicable laws and regulations; maintain a compliant Internet platform incorporating those requirements; maintain qualified health plan information from health insurance carriers and CMS and incorporate it into our web platform; maintain a privacy and security program to conform to the privacy and security requirements of our agreement with CMS as well as applicable laws and regulations; and adopt and maintain solutions to integrate with the FFM so that information may be passed to and from us relating to enrollment in qualified health plans and subsidy eligibility. If we do not comply with applicable laws, regulations and requirements, our ability to enroll individuals into qualified health plans through the FFM could be terminated and we may be required to pay significant monetary

penalties, which would harm our business operating results and financial condition. The laws, regulations and requirements applicable to enrolling individuals in qualified health plans through government-run health insurance exchanges are evolving. For example, we were required to translate significant portions of our website into Spanish for the current open enrollment period in order to be able to offer qualified health plans to individuals in states where greater than 10% of the state's population is Spanish speaking (currently Texas). If it is determined that the manner in which we translated our website, or the extent to which our website has been translated, is insufficient, we may not be allowed to offer qualified health plans in those states. Our ability to maintain compliance with the various requirements to enroll individuals through the FFM has presented, and could in the future present, significant challenges for us. If we are not successful in these regards, we will not be successful in enrolling individuals and families into qualified health plans, which would harm our business, operating results and financial condition. We also depend upon the Federal government for a number of things relating to our ability to enroll individuals online into qualified health plans through the FFM, including certain qualified health plan information that is required under the applicable regulations to be displayed on our website. In addition, the FFM may at any time cease allowing us to enroll individuals in qualified health plans or change the requirements for doing so and must allocate resources to ensuring, and otherwise ensure, that its technology platform functions properly to enroll individuals online with an adequate customer experience and that results in our receiving credit for enrollments so that we may be paid a commission. We also depend on the FFM to maintain and permit us to use certain access points to the FFM in order for us to be able to assist individuals in applying for subsidies and enrolling in qualified health plans online. If the FFM does not maintain or permit us to use these access points, if CMS requests further changes to our online process for enrolling individuals into qualified health plans, or if our technology and website or the FFM's technology or website do not function or work together properly to allow us to assist with subsidy applications and enroll large numbers of individuals into qualified health plans in a short period of time, our business, operating results and financial condition would be harmed. In addition, instability or changes to either the FFM website, particularly the portions used by consumers who are referred by agents and brokers, or other FFM operations relating to agent and broker assisted enrollment in qualified health plans, could negatively impact our ability to retain existing members and add new members and would harm our business, operating results and financial condition.

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

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

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

We compete with government-run health insurance exchanges, among others. The exchanges may elect whether or not we are able to enroll subsidy-eligible individuals in qualified health plans through them and determine the manner in which we may do so. The exchanges have websites where individuals and small businesses can shop for

and purchase health insurance, and they also have offline customer support and enrollment capabilities. Individuals who are eligible for government subsidies in the form of premium tax credits and cost sharing reductions must apply for their subsidy and purchase qualified health plans through a government exchange to receive their subsidy. In the aggregate, government exchanges have greater resources, larger marketing budgets and greater public outreach capability than we do. They may also impact the process we use to enroll individuals and families through them in a manner that results in a reduction of the individuals and families that we are able to enroll through exchanges. Government exchanges may invest heavily in paid search advertising to a degree that increases paid search advertising cost for health insurance related Internet search terms. In addition, individuals that utilize our platform and services to apply for subsidies and health insurance through government exchanges receive marketing and communications from the government exchanges after they do so. In the event our existing members purchase health insurance directly through health insurance exchanges without using us as their health insurance agent, as a result of their being eligible for a subsidy or otherwise, we will no longer receive commission revenue as a result of our sale of health insurance to them. The exchanges also compete with us for new members, and under regulations adopted as a part of health care reform, government-run health insurance exchanges are required to automatically re-enroll individuals and families into a qualified health insurance plan purchased through the exchange if the individuals or families do not take affirmative action, which may contribute to a reduction in our membership. Competitive pressure from government-run health insurance exchanges has resulted, and may in the future result, in our experiencing increased marketing costs, decreased traffic to our website, a reduction in our individual and family health insurance membership and revenue and may otherwise harm our business, operating results and financial condition.

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

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

Our revenue will be adversely impacted if consumers enroll in Medicare or individual and family health insurance plans that reduce our average commission revenue per member. Due in part to health care reform, major health insurance carriers and other health insurance carriers have exited or reduced individual and family health insurance selling efforts in a large number of states, leading to changes in the health insurance carrier composition of our commission revenue. Since our commission rates vary by carrier, a shift in the mix of products selected by our new members will have an impact on our average commission revenue per member. We do not plan to offer carriers' individual and family health insurance products for sale on our website if we do not receive commissions for the sale of those plans. Any reduction in the supply of the individual and family health insurance offered on our website may adversely impact demand for the individual and family health insurance we sell, and if individuals and families do not purchase health insurance through us as a result of these circumstances, our business, operating results and financial condition would be harmed. Recently, given the significant losses that carriers have sustained in connection with their sale of individual and family health insurance, several health insurance carriers with which we have a relationship, including large national health insurance carriers, made changes to the commissions they pay us, including reducing or eliminating our commissions for individual and family health insurance enrollments outside of the open enrollment period, reducing or eliminating our commissions for individual and family health insurance plans sold during the current open enrollment period and/or reducing our 2017 renewal commissions for individual and family health insurance plans we previously sold in prior years. As a result, we expect to see a meaningful reduction in our average commission rates for plans sold during the current open enrollment period compared to the last open enrollment period and for our aggregate individual and family health insurance plan membership in 2017 compared to 2016. While we do expect to see premium inflation offsetting some of the negative impact of lower commission rates, given that some of the carriers pay us based on percentage of premiums, the exact impact of these rate changes on our commission revenue will largely depend on the mix of individual and family health insurance products that we sell during the current open enrollment period as well as the mix of active individual and family health insurance plans held by our individual and family health insurance membership in 2017 and in future years. Additionally, to the extent an increase in the health insurance premiums consumers pay for the individual and family health insurance reduces demand for the individual and family health insurance that we sell or there is an overall deterioration in the commissions that we

receive for plans that we sell in the current open enrollment period compared to the last open enrollment period, our business, operating results and financial conditions would be harmed.

In addition, we are required to display or provide access to all qualified health insurance plans available through the FFM in our individual and family health insurance shopping process regardless of whether we receive commissions for the sale of those plans. If consumers choose health insurance products for which we receive lower or no commissions, our commission revenue per member could decline and our business, operating results and financial condition would be harmed.

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

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

We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers also may amend the terms of our agreements unilaterally on short notice. Carriers may be unwilling to allow us to sell their existing or new health insurance plans, or desire to amend our agreements with them, for a variety of reasons, including for competitive or regulatory reasons, dissatisfaction with the economics of the members that we place with them or because they do not want to be associated with our brand. We may also terminate our relationship with health insurance carriers. In addition, many aspects of health care reform have caused, and may in the future cause, carriers to modify their relationship with us given the substantial changes in the industry in which we operate. For instance, in addition to the medical loss ratio requirements, health care reform contains taxes and assessments on health insurance carriers that may make their businesses less profitable. Carriers may choose to exclude us from their most profitable or popular plans or may determine not to distribute health insurance plans in the Medicare, individual and family and small business markets in certain geographies or altogether. In the event we are not successful in gaining or maintaining the ability to sell Medicare, individual and family and qualified health insurance plans, if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans or if health insurance carriers change our relationship with them in other ways, we could lose a substantial number of existing and potential members and commission revenue, which would materially harm our business, operating results and financial condition. The termination of our relationship with a health insurance carrier by us or the health insurance carrier or the amendment of or change in our relationship with a carrier could reduce the variety of health insurance plans we offer, cause a loss of commission revenue or have other adverse impacts, which could harm our business, operating results and financial condition. It also could adversely impact, or cause the termination of, commissions for past and future sales, which would materially harm our business, operating results and financial condition. Our business could also be harmed if in the future we fail to develop new carrier relationships and are unable to offer consumers a variety of health insurance plans in each jurisdiction.

Given the significant losses that carriers have sustained in connection with their sale of individual and family health insurance, several health insurance carriers with which we have a relationship, including large national health insurance carriers, reduced or eliminated our commissions for individual and family health insurance enrollments outside of the open enrollment period. In addition, many health insurance carriers recently indicated that they will eliminate commissions or pay reduced commissions for individual and family health insurance plans that we sell in the current open enrollment period compared to the last open enrollment period and/or reduce our 2017 renewal commissions for individual and family health insurance plans we previously sold in prior years. As a result, we expect to see a meaningful reduction in our average commission rates for plans we sell in the current open enrollment period compared to the last open enrollment period and for our aggregate individual and family health insurance plan membership in 2017 compared to 2016. In addition, the reduction in contractual commission rates and these carriers' desire to not sell individual and family health insurance will reduce the plans that we are able to offer on our websites, which could result in less consumer demand for the individual and family health insurance that we sell, a reduction in our membership and harm our business operating results and financial condition. In the future and as a result of health care reform or for other reasons, an increasing number of health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels, including in-house agents and carrier websites, to sell their own plans, determine not sell individual and family health insurance or otherwise limit or prohibit us from selling their plans on their ecommerce platforms. In addition to reducing commission rates, health insurance carriers have ceased and may in the future cease selling qualified health plans or individual and family health insurance in certain

markets or altogether. They may also determine to exit the individual and family health insurance business in certain states or increase premiums to a significant degree, which could cause our members' health insurance to be terminated or our members to purchase new health insurance. If we lose these members, our business, operating results and financial condition could be harmed. In addition, a reduction in the individual and family health insurance products that we are able to offer as a result of carriers exiting the market in certain geographies or altogether, could adversely impact demand for our services and a reduction in our membership, which would harm our, business, operating results and financial results.

Changes in our management and key employees could affect our business and financial results.

Our success is dependent upon the performance of our executive officers and key personnel. Our executive officers and employees can terminate their employment at any time. We have recently experienced significant changes in our senior management. Our former chief executive officer Gary L. Lauer resigned in May 2016, and Scott N. Flanders, a member of our board of directors, was appointed as our chief executive officer. In June 2016, William T. Shaughnessy resigned from his positions as president, chief operating officer and a member of our board of directors. Our former chief financial officer, Stuart M. Huizinga, resigned in July 2016, and our new senior vice president and chief financial officer David K. Francis began his service with us in July 2016. In September 2016, we announced the appointment of David K. Francis as our chief financial officer and Jay W. Jennings as our principal accounting officer. In October 2016, we announced the appointment of Robert S. Hurley as president, Medicare products and Tom G. Tsao as President, small business, individual and family products. Mr. Hurley previously served as executive vice president of sales and operations, and Mr. Tsao previously served as executive vice president, chief technology and product officer. We also announced that Mr. Francis will add the responsibilities of chief operations officer to his current responsibilities as senior vice president, chief financial officer, and principal financial officer. This transition in senior management could adversely impact our business, operating results and financial condition as it will take time for our new chief executive officer and chief financial officer to integrate into our business. The transition and the departure of members of our senior management could result in further attrition in our senior management and key personnel, which could harm our business, operating results and financial condition.

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

Our business may be harmed if we are not successful in executing our strategic investments and initiatives.

We have conducted a strategic review of our business operations and examined potential areas of investment and strategic emphasis. As a result of this review, we have determined to invest in initiatives to accelerate growth in our Medicare product sales, including Medicare Advantage and Medicare Supplement plans. We also plan to invest resources in efforts to grow our small business group insurance business and pursue cross-selling and adjacent revenue opportunities in our Medicare and small business group business. Pursuing and investing in these initiatives will require significant investments in marketing and advertising, technology and product offerings, and customer care and enrollment, among others. Our pursuit of and investment in these initiatives involves risks and uncertainties described elsewhere in this Risk Factors section, including the initiatives resulting in insufficient revenue to offset any expenses associated with these new investments, inadequate return of capital on our investments, legal and regulatory compliance risks and issues not discovered in our strategic review that could cause us to fail to realize the anticipated benefits of our investments and incur unanticipated liabilities. Our pursuit of these strategic initiatives may not be successful. If we are not successful in executing our business strategy, our future profitability would be negatively impacted and our business, operating results and financial condition would be harmed.

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

The health insurance industry in the United States has experienced a substantial amount of consolidation, resulting in a decrease in the number of health insurance carriers. Significant additional consolidation may occur given the proposed acquisition of Humana by Aetna and the proposed acquisition of Cigna by Anthem. Consolidation in the health insurance industry could cause a loss of or changes in our relationship with carriers and reduction in our commission or other revenue, which could harm our business, operating results and financial condition. In the future, we may be forced to offer health insurance from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. Revenue derived from Humana represented approximately 19% and 9% of our total revenue in the three months ended September 30, 2015 and 2016, respectively, Revenue derived from Humana represented approximately 24% and 23% of our total revenue in the nine months ended September 30, 2015 and 2016, respectively. Revenue derived from carriers owned by UnitedHealthcare represented approximately 11% and 15% of our total revenue in the three months ended September 30, 2015 and 2016, respectively. Revenue derived from carriers owned by UnitedHealthcare represented approximately 10% and 12% of our total revenue in the nine months ended September 30, 2015 and 2016, respectively. Revenue derived from carriers owned by Aetna represented approximately 9% and 8% of our total revenue in the three months ended September 30, 2015 and 2016, respectively. Revenue derived from carriers owned by Aetna represented approximately 9% and 10% of our total revenue in the nine months ended September 30, 2015 and 2016, respectively. We have several agreements that govern our sale of health insurance plans with these health insurance carriers. They may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact or cause the termination of the commission payments that we receive from these health insurance carriers, including commissions on plans that we have already sold, which could materially harm our business, operating results and financial condition. Our revenue could be adversely impacted if we are unable to maintain currently-existing levels of business with any of our significant health insurance carriers if we are unable to offset any loss of business with alternative health insurance carriers. We expect that a small number of health insurance carriers will account for a significant portion of our revenue for the foreseeable future and any impairment of our relationship with, or the material financial impairment of, these health insurance carriers could adversely affect our business.

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

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

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

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

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

Seasonality may cause fluctuations in our financial results.

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

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

Our estimated individual and family health insurance plan membership has declined substantially since the implementation of health care reform. Our revenue has been, and will continue to be, adversely impacted if our membership does not grow. We receive revenue from commissions health insurance carriers pay to us for health insurance plans sold through our ecommerce platform. When one of these plans is canceled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission revenue. Our members may also choose to discontinue their health insurance plans for a variety of reasons. For example, our members may replace a health insurance plan purchased through us with a health insurance policy provided by a new or existing employer or may determine that they can no longer afford health insurance. They may also determine that they do not like the benefits and physician network covered under the plan. In addition, our members may choose to purchase new plans through other sources or use a different agent, if, for example, they are not satisfied with our customer service or the health insurance plans that we offer. Our expense reduction measures have impacted the number of our employees dedicated to customer service in our individual and family health insurance business, which could cause a greater number of individuals to be dissatisfied with our customer service. Consumers may also purchase health insurance plans 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, and a significant number of our individual and family health insurance plan members will experience termination of their plans so that the plans are not effective in 2017. If we are not successful in transferring members covered under a terminated plan to another policy that we offer, we will lose these members and associated commission revenue. Our cost of acquiring a new member is substantially greater than the cost involved in maintaining our relationship with an existing member. If we are not able to successfully retain existing members and limit member turnover, our revenue and operating margins will be adversely impacted and our business, operating results and financial condition would be harmed. In addition, the Medicare-related commission rates that we receive may be higher in the first calendar year of a policy if the policy is the first Medicare-related policy issued to the member. The individual and family commission rates that we receive are typically higher in the first twelve months of a policy. After the first twelve months, they generally decline significantly. As a result, if we do not add a sufficient number of members on new plans, our revenue will be negatively impacted.

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

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

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

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

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

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

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

In 2010 we began to actively market the availability of Medicare-related health insurance plans using our ecommerce platforms, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We refer to these plans as Medicare plans. We market Medicare plans to Medicare-eligible individuals, who are predominately senior citizens over the age of 65. The sale of Medicare Advantage and Medicare Part D prescription drug plans are subject to an annual enrollment period during the fourth quarter of each year, when a substantial percentage of the annual sales of these plans occur. We sell Medicare plans as a health insurance agent using our websites and customer care centers.

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

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

termination of, the commission payments that we receive for selling their Medicare plans, including commissions on plans that we have already sold, which could materially harm our business operating results and financial condition.

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

Health insurance carriers whose Medicare plans we sell must approve our websites, our marketing material and call center scripts for us to be able to generate Medicare plan demand and sell Medicare plans to Medicare-eligible individuals as a health insurance agent. These materials also must be filed with CMS. In addition, we use Medicare plan cost and benefit data collected and made publicly available by CMS. In the event that CMS or a health insurance carrier requires changes to, disapproves, or delays approval, of our websites, our marketing material or call center scripts, or if CMS does not timely release Medicare plan cost and benefit data for the following year's Medicare plans prior to the annual enrollment period, we could lose a significant source of Medicare plan demand and our ability to sell Medicare plans would be adversely impacted, each of which would harm our business, operating results and financial condition. CMS broadened its interpretation of rules and regulations relating to Medicare plan-related marketing material so that they apply to websites that we did not previously need to submit to health insurance carriers for approval and file with CMS. This broadened interpretation also applies the same approval and filing process to marketing material of our marketing partners. If we are not successful in timely submitting these marketing materials to health insurance carriers for approval, in gaining that approval and in filing the marketing material with CMS, our Medicare plan marketing could become less effective, which would harm our business, operating results and financial condition. Further, if a marketing partner of ours does not consent to having its website or other marketing material filed with the CMS, does not make changes required by carriers or CMS or does not comply with the CMS marketing guidelines or other Medicare program related laws, rules and regulations, we may lose the ability to receive referrals of individuals interested in purchasing Medicare plans from that marketing partner or our ability to receive referral could be delayed and our business, operating results and financial condition would be harmed. In addition, each time we or our marketing partners substantively change our websites or call center scripts after they are filed with CMS, we need to resubmit them to our health insurance carriers and have them filed with CMS. We are not permitted to make CMS filings ourselves. Given the review cycles our scripts, websites and other marketing material undergo, it is very difficult to make changes to them, and our inability to timely make changes to these marketing materials, whether to comply with new rules and regulations or otherwise could adversely impact our ability to sell Medicare plans during the Medicare annual enrollment period or otherwise, which could impact our business, operating results and financial condition. In addition, if a change to scripts or websites is required by CMS or health insurance carriers, we may be prevented from selling Medicare plans during this period of review, which could harm our business, operating results, and financial condition, particularly if it occurred during the annual enrollment period.

Our Medicare plan-related revenue is dependent upon the number of paying Medicare plan insurance members we are successful in retaining and acquiring during the Medicare annual enrollment period. If we are not successful in retaining and acquiring Medicare plan members during the annual enrollment period for any reason, our business, operating results and financial condition would be harmed.

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

In addition to our websites, we rely upon our customer care centers to sell Medicare plans. The success of our customer care center operations is largely dependent on licensed health insurance agents and other employees. In order to sell Medicare-related health insurance plans, our health insurance agent employees must first be licensed by the states in which they are selling plans and certified and appointed with the health insurance carrier that offers the plans in each state that the Medicare-related health insurance product is being sold by the agent. Because a significant number of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we hire and train a significant number of additional employees on a temporary or seasonal basis in a limited period of time. It may be difficult for the health insurance agents we employ and our systems and processes to handle the increased volume of health insurance transactions that occur in a short period of time during the Medicare annual enrollment period. We must also ensure that our health insurance agent employees are timely licensed in a significant number of states and certified and appointed with the health insurance carriers whose products we sell. We depend upon state departments of insurance and health insurance carriers for the licensing, certification and appointment of our health insurance agent employees. We may not be successful in timely hiring a sufficient number of additional licensed agents or other employees for the Medicare annual enrollment period, and even if we are successful, these employees may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments with our health insurance carrier partners. If we and our health insurance agent employees are not

successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the annual enrollment period, which would harm our business, operating results and financial condition.

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

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

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

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

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

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

- our ability to continue to adapt our ecommerce platforms to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the effective modification of our user experience;
- our success in marketing to Medicare-eligible individuals and in entering into marketing partner relationships to drive Medicare-eligible individuals to our ecommerce platforms;
- our effectiveness in entering into and maintaining relationships with marketing partners that refer Medicare-eligible individuals to us;

- our ability to hire and retain additional employees with experience in Medicare, including our ability to timely implement Medicare sales expertise into our customer care centers;
- our ability to implement and maintain an effective information technology infrastructure for the sale of Medicare plans, including the infrastructure and systems that support our websites, call centers and call recording;
- our ability to leverage technology in order to sell, and otherwise become more efficient at selling, Medicare-related plans over the telephone;
- our ability to comply with the numerous, complex and changing laws and regulations and CMS guidelines relating to the marketing and sale of Medicare plans, including continuing to conform our online and offline sales processes to those laws and regulations; and
- the effectiveness with which our competitors market the availability of Medicare plans from sources other than our ecommerce platforms.

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

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

The marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. The marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans are principally regulated by CMS. The marketing and sale of Medicare Supplement plans are principally regulated on a state-by-state basis by state departments of insurance. The laws and regulations applicable to the marketing and sale of Medicare plans are numerous, ambiguous and complex, and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently. The telephone calls on which we enroll individuals into Medicare Advantage and Medicare Part D prescription drug plans are required to be recorded. Health insurance carriers audit these recordings for compliance and listen to them in connection with their investigation of complaints pursuant to CMS rules and regulations. In addition, Medicare eligible individuals often receive a special election period and the ability to change Medicare Advantage and Part D prescription drug plans outside the Medicare annual enrollment period in the event the sale of the plan was not in accordance with CMS rules and guidelines. Given CMS's scrutiny of Medicare product health insurance carriers and the responsibility of the health insurance carriers for actions that we take, health insurance carriers may terminate our relationship with them or take other corrective action if our Medicare product sales and marketing is not in compliance or gives rise to too many complaints. The termination of our relationship with health insurance carriers for this reason would reduce the products we are able to offer, result in the loss of commissions for past and loss of future sales and would otherwise harm our business, operating results and financial condition.

As a result of the laws, regulations and guidelines relating to the sale of Medicare plans, we have altered, and likely will have to continue to alter, our websites and sales process to comply with several requirements that are not applicable to our sale of non-Medicare-related health insurance plans. For instance, many aspects of our online platforms and our marketing material and processes, as well as changes to these platforms, materials and processes, including call center scripts, must be filed on a regular basis with CMS and reviewed and approved by health insurance carriers in light of CMS requirements. In addition, certain aspects of our Medicare plan marketing partner relationships have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. Changes to the laws, regulations and guidelines relating to Medicare plans, their interpretation or the manner in which they are enforced could be incompatible with these relationships, our platforms or our sale of Medicare plans. For instance, we recently experienced a reduction in lead volume from certain business development partners as a result of CMS rule related changes to their advertising. In addition, a change in sales and marketing guidelines issued by CMS. The change in sales and marketing guidelines resulted in our making changes to our Medicare product sales

and marketing processes during the third quarter of 2016, which impacted the effectiveness of our call center agents in converting leads into submitted applications during the third quarter of 2016. In February 2015 CMS issued guidance indicating that third party websites and marketing material must be filed for approval with CMS. Health insurance carriers have interpreted this guidance to mean that websites and marketing material of our marketing partners must go through the process of CMS filing and review and approval by health insurance carriers. Our marketing partners may not consent to having their websites or other marketing material filed with CMS. In addition, we have a number of marketing partners who refer leads to us for Medicare-related health insurance products. Given the resources and review required of us and health insurance carriers prior to CMS filing, it is unlikely that we will be able to have all of our marketing partner websites and material filed and approved by CMS, which could harm our business, operating results and financial condition. Even for our marketing partner websites and marketing material that are filed with CMS, they may not make it through the review process in time for the Medicare annual enrollment period. Moreover, under CMS guidance, websites and marketing material must be refiled with CMS if changed, which also will make it difficult to adapt and optimize marketing partner websites and marketing material in a short amount of time. Given these circumstances, the CMS guidance relating to third party websites could harm our business, operating results and financial condition.

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

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

CMS has in the past proposed changing the rules relating to compensation of agents in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans to reduce our compensation as a health insurance agent in connection with the sale of these plans. In the event CMS adopts regulations that have the effect of reducing the compensation that we receive in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans, our business, operating results and financial condition would be harmed. CMS adopted regulations that changed the definition of a plan year from being twelve months from the effective date of a policy to January 1 through December 31 of each year, causing all Medicare Advantage and Medicare Part D prescription drug policies to renew on January 1 of each year. As a result, we record all Medicare Advantage and Medicare Part D prescription drug plan renewal commission revenue in the first quarter of each year. This plan year change resulted in our recognition of minimal renewal commission revenue outside of the first quarter of each year beginning 2015, and we expect similar results in the future. During 2015 and 2016, for certain categories of enrollments that occur outside of the annual enrollment period, CMS allowed carriers to either prorate the commission payment for the number of months remaining in the calendar year or pay the broker a full year of commissions up-front. A number of carriers for which we sell Medicare products recently changed from paying us a full-year of commissions up-front to pro-rating their payments based on the number of months remaining in the calendar year, which negatively impacted our Medicare commission revenue in the third quarter of 2016 compared to the third quarter of 2015. In addition, CMS also issued a regulation prohibiting carriers from paying commissions during the fourth quarter on Medicare Advantage and Medicare Part D prescription drug policies sold during the fourth quarter with an effective date in the following year, which negatively impacts our operating cash flows in the fourth quarter of the year. This regulation also makes it more difficult for us to recognize revenue relating to our sale of Medicare Advantage and Medicare Part D prescription drug plans in the fourth quarter of the year, given that our revenue recognition policy requires us to receive either a cash payment or commission statement in the period we recognize revenue, provided we receive the second corroborating communication shortly following the period of recognition. If health insurance carriers do not send at least one of these communications during the fourth quarter, our recognition of revenue relating to our sale of these policies in the fourth quarter will be delayed until we receive the first communication, which would adversely impact our financial results in the fourth quarter. In the event health care reform, the actions of the federal government

or other circumstances decrease the demand for Medicare Advantage plans or other alternatives to original Medicare, or result in a reduction in the amount paid to us or impact the timing of our revenue recognition in connection with the sale of these plans, our business, operating results and financial condition could be harmed.

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

The market for selling health insurance plans is highly competitive. We compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our competitors include local insurance agents across the United States who sell health insurance plans in their communities. There also are a number of companies that operate websites, provide an online shopping experience for consumers interested in purchasing health insurance and act as a health insurance agent in connection with that purchase. Some local agents also use "lead aggregator" services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to health insurance agents or carriers. Many health insurance carriers also directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. CMS also offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans. We compete with the FFM and state health insurance exchanges implemented as a result of health care reform. Health care reform also has resulted in health insurance plan cost and benefit data being more readily accessible, which could facilitate additional competition. To remain competitive against our current and future competitors, we will need to market our services effectively and continue to improve the online shopping experience and functionalities of our website and other platforms that our current and future customers may access to purchase health insurance products from us. If we cannot predict, develop and deliver the right shopping experience and functionality in a timely and cost-effective manner, or if we are not effective in driving a substantial number of consumers interested in purchasing health insurance to our website in a cost-effective manner, we may not be able to compete successfully against our current or future competitors and our business, operating results and financial condition may be adversely affected.

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

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

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

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

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

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers' ability or willingness to pay for health insurance, availability of unemployment

benefits or proposed or enacted legislative or regulatory changes impacting our business, including health care reform;

- the quality of and changes to the consumer experience on our ecommerce 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, the amount of time a carrier takes to make a decision on that application and the percentage of submitted applications approved by health insurance carriers;
- the percentage of our members who did not accept their approved policies and from whom we do not receive commission payments; and
- our ability to enroll subsidy-eligible individuals in qualified health plans through government-run health insurance exchanges.

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

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

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

The demand for health insurance marketed through our ecommerce platforms is impacted by, among other

things, the variety, quality and price of the health insurance plans we offer. Many health insurance carriers, including major national health insurance carriers, have exited a large number of state insurance markets where we have historically represented their insurance plans or determined to pay reduced or no commissions for the sale of their plans and we may determine not to work with or otherwise be unable to offer health insurance plans from other health insurance carriers. If our ability to sell a variety of high-quality, affordable health insurance plans in the Medicare, individual and family, small business and ancillary product markets is impaired, or our health insurance plan offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform or otherwise, our sales or average commission rate per member may decrease and our business, operating results and financial condition could be harmed. For example, the cost of health insurance has increased substantially in many states as a result of health care reform implementation and many health insurance carriers have exited the individual and family health insurance business altogether or in a large number of states. Moreover, as a result of several carriers not desiring to sell individual and family health insurance, commission rate reduction and our decision not to sell plans where we would not receive a commissions a result of their reductions in our commissions for those sales, we are not able to sell individual and family health insurance plans that we have historically sold. This reduction in the supply we are able to offer consumers may adversely impact demand for the individual and family health insurance we sell, and if individuals and families do not purchase health insurance through us as a result of these circumstances, our business, operating results and financial condition would be harmed.

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

Our commission rates, and the commission override payments we receive from health insurance carriers for achieving sales volume thresholds or other objectives, are either set by each carrier or negotiated between us and each carrier. Carriers have altered, and may in the future alter, the contractual relationships we have with them on short notice, either by renegotiation or unilateral action. If these contractual changes result in reduced commissions, our business may suffer and our operating results and financial condition would be harmed. For example, several health insurance carriers with which we have a relationship, including large national health insurance carriers, made changes to the commissions they pay us, including reducing or eliminating our commissions for individual and family health insurance enrollments outside of the open enrollment period, reducing or eliminating our commissions for individual and family health insurance plans sold during the current open enrollment period and/or reducing our 2017 renewal commissions for individual and family health insurance plans we previously sold in prior years. As a result, we expect to see a meaningful reduction in our average commission rates for plans sold during the current open enrollment period compared to the last open enrollment period and for our aggregate individual and family health insurance plan membership in 2017 compared to 2016. While we do expect to see premium inflation offsetting some of the negative impact of lower commission rates, given that some of the carriers pay us based on percentage of premiums, the exact impact of these rate changes on our commission revenue will largely depend on the mix of individual and family health insurance products that we sell during the current open enrollment period as well as the mix of active individual and family health insurance plans held by our individual and family health insurance membership in 2017 and in future years. Additionally, to the extent an increase in the health insurance premiums consumers pay for the individual and family health insurance reduces demand for the individual and family health insurance that we sell or there is an overall deterioration in the commissions that we receive for plans that we sell in the current open enrollment period compared to the last open enrollment period, our business, operating results and financial conditions 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 platforms and system infrastructure, system failures and interruptions may occur if we are unsuccessful in these efforts, if we are unable to accurately project the rate or timing of increases in our website traffic or for other reasons, some of which are completely outside our control. Although we have experienced only minor system failures and interruptions to date, we could experience significant failures and interruptions in the future, which would harm our business, operating results and financial condition. If these failures or interruptions occurred during the Medicare annual enrollment period or during the open enrollment period under health care reform, the negative impact on us would be particularly pronounced.

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

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

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

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

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

If we are not successful in these regards, and if consumers and health insurance carriers determine that other sources for health insurance and health insurance applications are superior, our business will not grow and our operating results and financial condition would be harmed.

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

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

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

We purchase paid advertisements on search engines in order to attract consumers to our website. We typically pay a search engine for prominent placement of our name and website when particular health insurance-related terms are searched for on the search engine, regardless of the algorithmic search result listings. The prominence of the placement of our advertisement is determined by a combination of factors, including the amount we are willing to pay and algorithms designed to determine the relevance of our paid advertisement to a particular search term. As with algorithmic search result listings, search engines may revise the algorithms relevant to paid advertisements and websites other than our ecommerce 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, government health insurance exchanges and some of our marketing partners for both algorithmic search result listings and for paid advertisements. This competition has increased the cost of paid internet search advertising and has increased our marketing and advertising expenses. This competition has increased substantially during the open enrollment periods for individual and family health insurance and Medicare-related health insurance and may increase further if these open enrollment periods occur over the same period of time. If paid search advertising costs increase or becomes cost prohibitive, whether as a results of competition, algorithm changes or otherwise, our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which would harm our business, operating results and financial condition.

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

In addition to marketing through Internet search engines, we frequently enter into contractual marketing relationships with other online and offline businesses that promote us. These marketing partners include financial and online service companies, affiliate programs and online advertisers and content providers. We also have relationships with marketing partners, including pharmacy chains, that promote our Medicare platforms to their customers. We compensate many of our marketing partners for their referrals on a submitted health insurance application basis and, if they are licensed to sell health insurance, may share a percentage of the commission we earn from the health insurance carrier for each member referred by the marketing partner.

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

- the continued positive market presence, reputation and growth of the marketing partner;
- the effectiveness of the marketing partner in marketing our website and services, including whether the marketing partner is successful in maintaining the prominence of its website in algorithmic search result listings and paid Internet advertisements;
- 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. While we have relationships with a large number of marketing partners, we depend upon referrals from a limited number of marketing partners for a significant portion of the submitted applications we receive from our marketing partner customer acquisition channel. Moreover, a significant portion of our referrals for the purchase of Medicare plans comes from a single marketing partner.

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

- if we are unable to maintain successful relationships with our existing marketing partners, particularly marketing partners responsible for a significant number of our submitted applications;
- if we fail to establish successful relationships with new marketing partners;
- if we experience competition in our receipt of referrals from our high volume marketing partners; and
- if we are required to pay increased amounts to our marketing partners.

To the extent that health care reform makes it less profitable or desirable for marketing partners to promote us to their customers, we may lose relationships with existing marketing partners or those marketing partners may refer fewer individuals to us. We may also have difficulty entering into relationships with new marketing partners. We may also need to reduce the compensation that we pay to marketing partners to the extent that health care reform has the effect of reducing commissions for individual and family health insurance or causes our members to stay on their health insurance policies for a shorter period of time. 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 these factors. If we are not able to do so, our business, operating results and financial condition could be harmed. Competition for referrals from our marketing partners has increased particularly during the open enrollment periods for Medicare-related health insurance and individual and family health insurance. We may lose marketing partner referrals if our competitors pay marketing partners more than we do or be forced to pay increased fees to our marketing partners, which could harm our business, operating results and financial condition. If we lose marketing partner referrals during the Medicare or individual and family health insurance annual open enrollment periods, the adverse impact on our business would be particularly pronounced. In addition, the promulgation of laws, regulations or guidelines, or the interpretation of existing laws, regulations and guidelines, by state departments of insurance or by CMS, could cause our relationships with our marketing partners to be in non-compliance with those laws, regulations and guidelines. For instance, CMS issued guidance that health insurance carriers have interpreted to mean that websites and marketing material of our Medicare-related marketing partners must be filed with CMS before use. Before filing with CMS, these websites and marketing materials will need to undergo a review by health insurance carriers for whom we market Medicare products. Our marketing partners may not consent to having their websites or other marketing material filed with CMS, and we and health insurance carriers may not be able to dedicate the resources necessary to have the websites and marketing material reviewed. If we are not able to do so, our business, operating results and financial condition could be harmed. In addition, as a result of our acquisition of PlanPrescriber, we have marketing partner relationships with pharmacy chains that utilize aspects of our platform and tools. Our relationships with these pharmacy chains result in the referral of a significant number of individuals to us who are interested in purchasing Medicare-related health insurance plans. If CMS or state departments of insurance were to change existing laws, regulations or guidelines, or interpret existing laws, regulations or guidelines, to prohibit these arrangements, or if pharmacy partners otherwise decided to no longer utilize aspects of our platform and tools, we could experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and customer care centers, which would harm our business, operating results and financial condition and could result in a write-down of the value of intangible assets acquired in our PlanPrescriber acquisition.

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

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

We also depend on health insurance carriers and others for data related to our membership. For instance, with respect to health insurance plans other than small business health insurance, health insurance carriers do not directly report member cancellations to us, resulting in the need for us to determine cancellations using payment data that carriers provide. We infer cancellations from this payment data by analyzing whether payments from members have ceased for a period of time, and we may not learn of a cancellation for several months. With respect to our small

business membership, many groups notify the carrier directly with respect to increases or decreases in group size and policy cancellations. Our insurance carrier partners often do not communicate this information to us, and it often takes a significant amount of time for us to learn about small business group cancellations and changes in our membership within the group itself. We often are not made aware of policy cancellations until the time of the group's annual renewal.

A substantial number of our existing members may become eligible for health care reform subsidies in connection with their purchase of health insurance. In addition, the open enrollment periods applicable in connection with the sale of both individual and family health insurance and Medicare-related health insurance condenses purchasing activity over a limited period of time. The increased amount of health insurance purchasing activity and member movement as a result of health care reform over a limited period of time as well as any member turnover that we experience may make it difficult for health insurance carriers to accurately report commission information to us in a timely manner, which would also make it difficult or impossible for us to accurately report and estimate our membership at any given point in time. Delays in accurate reporting of commissions may result in delays in recognition of commission revenue compared to historical patterns and our business, operating results and financial condition could be harmed. In addition, if we experience a disruption in our ability to accurately estimate our membership it could result in a decrease in our stock price as a result of uncertainty relating to our membership base.

After we have estimated membership for a period, we may receive information from health insurance carriers that would have impacted the estimate if we had received the information prior to the date of estimation. We may receive commission payments or other information that indicates that a member who was not included in our estimates for a prior period was in fact an active member at that time, or that a member who was included in our estimates was in fact not an active member of ours. We also reconcile information health insurance carriers provide to us and may determine that we were not historically paid commissions owed to us, which would cause us to have underestimated our membership. As a result of open enrollment periods, we may not receive information from our carriers on as timely a basis due to significant spikes in volume, which could impair the accuracy of our estimates of the number of members we have for a period of time. Additionally, health insurance carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be different from our estimates, perhaps materially. Total revenue per estimated member for the period would also change if our estimated membership changed. Our estimate regarding the average amount of time our members maintain their health insurance plans also could be inaccurate as it depends on the accuracy of our membership estimates.

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

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

We believe that demand for the health insurance and services we offer are impacted by prevailing economic conditions. We cannot be certain of the future impact that economic conditions will have on our business. A softening of demand for health insurance and services offered by us, whether caused by changes in customer preferences or a weak U.S. economy, including as a result of disruptions in the global financial markets or a decrease in general consumer confidence, could adversely impact our operating results. Consumers may attempt to reduce expenses by 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.

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 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 generally determined not to spend on individual and family health insurance advertising through our sponsorship and advertising program as a result of the impact of health care reform on the profitability of their individual and family health insurance businesses. 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. Since much of our sponsorship revenue depends upon the number of applications we submit to health insurance carriers, a reduction in demand for the carrier's product (such as outside open enrollment periods) would reduce our sponsorship revenue and our business, operating results and financial condition could be harmed. The success of our sponsorship and advertising program depends on a number of other factors, including the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer and health insurance carrier adoption of the Internet and our ecommerce 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 successful in licensing the use of our ecommerce technology to health insurance carriers and other third parties.

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

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

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

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.

We may experience difficulties as a result of our implemented cost reduction plan.

In March 2015, we implemented an organizational restructuring and cost reduction plan. As part of the plan, we eliminated approximately 160 full-time positions in the United States, representing approximately 15% of our workforce primarily in our technology and content and customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. The majority of the restructuring activities comprising the plan were substantially completed in the first quarter of 2015, and we also eliminated certain positions in our China operation in that quarter. As a part of the reduction-in-force, we significantly reduced headcount in our customer care and enrollment and technology and content groups. These reductions could impair our ability to assist consumers seeking to purchase health insurance. They also constrain our ability to enhance our technology platforms as well as adapt our technology platforms and service to changes in the health insurance industry brought about by changes to the implementation of health care reform or for other reasons. The reductions also may impact our ability to enter new business areas and develop and enhance our existing products and services. In the aggregate, the reduction-in-force could harm our business, operating results and financial condition.

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

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

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

and other intangible assets, or may cause adverse tax consequences, substantial depreciation or deferred compensation charges;

- an acquisition undertaken for strategic business purposes may negatively impact our results of operations;
- we may encounter difficulties in assimilating and integrating the business, technologies, products, personnel or operations of companies that we acquire, particularly if key personnel of the acquired company decide not to work for us;
- an acquisition may disrupt our ongoing business, divert resources, increase our expenses and distract our management;
- we may be required to implement or improve internal controls, procedures and policies appropriate for a public company at a business that prior to the acquisition lacked these controls, procedures and policies;
- the acquired businesses, products or technologies may not generate sufficient revenue to offset acquisition costs or to maintain our financial results;
- we may have to issue equity securities to complete an acquisition, which would dilute our stockholders' ownership and could adversely affect the market price of our common stock; and
- acquisitions may involve the entry into geographic or business markets in which we have little or no prior experience.

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

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

We have a complex business organization. Ensuring that we have adequate internal financial and accounting controls and procedures in place to help ensure that we can produce accurate financial statements on a timely basis is a costly and time-consuming effort that needs to be re-evaluated frequently and is complicated by the expansion of our business operations. Our management, including our chief executive officer and chief financial officer, does not expect that our internal control over financial reporting will prevent all errors or all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time, controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. As a result, we cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations, or result in material misstatements in our financial statements. Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002 and the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

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

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections, changes in the valuation of our deferred tax assets and liabilities, expiration of or lapses in the research and development tax credit laws, tax effects of share-based compensation, outcomes as a result of tax examinations or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. The related domestic deferred tax assets remain available for use in future periods and will reduce the Company's tax provision if taxable income is generated. To the extent that our provision for income taxes is subject to volatility or adverse outcomes as a result of tax examinations, our operating results could be harmed.

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

Risks Related to State Insurance Regulation

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

The laws and regulations governing the offer, sale and purchase of health insurance are subject to change, and future changes may be adverse to our business. For example, a long standing provision in each state's law that we believe is advantageous to our business is that once health insurance premiums are set by the carrier and approved by state regulators, they are fixed and not generally subject to negotiation or discounting by insurance companies or agents. Additionally, state regulations generally prohibit carriers, agents and brokers from providing financial incentives, such as rebates, to their members in connection with the sale of health insurance. As a result, we do not currently compete with carriers or other agents and brokers on the price of the health insurance plans offered on our website. If these regulations change, we could be forced to reduce prices or provide rebates or other incentives for the health insurance plans sold through our ecommerce 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 and to government. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers. As a result, we are subject to various laws and regulations regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We cannot guarantee that our facilities and systems, and those of our third party service providers, will be free of security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with privacy and security laws, requirements and regulations may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by us or third party service providers, and enforcement actions. We may be required to expend significant amounts and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, techniques used to obtain unauthorized access or to sabotage systems change frequently.

As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures. Additionally, our third party service providers may cause security breaches for which we are responsible.

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

Government regulation of the Internet could adversely affect our business.

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

Our business could be harmed if we are unable to correspond with our consumers or market the availability of our ecommerce 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 and the implementation of health care reform. Other factors that could cause fluctuations in the trading price of our common stock include, but are not limited to, the following:

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

These factors, as well as general economic and political conditions and the announcement of proposed and completed acquisitions or other significant transactions, or any difficulties associated with such transactions, by us or our strategic partners, customers or our current competitors, may materially adversely affect the market price of our common stock in the future. In the past, following periods of volatility in the market price of a company's securities, securities class action litigation has often been instituted against that company. Such litigation could result in substantial cost and a diversion of management's attention and resources. In addition, volatility, lack of positive performance in our stock price or changes to our overall compensation program, including our equity incentive program, may adversely affect our ability to retain key employees.

Our actual operating results may differ significantly from our guidance.

From time to time, we have released, and may continue to release guidance in earnings conference calls, earnings releases, or otherwise, regarding our future performance that represents our management's estimates as of the date of release. This guidance, which includes forward-looking statements, has been and will be based on projections prepared by our

management. These projections are not prepared with a view toward compliance with published guidelines of the American Institute of Certified Public Accountants, and neither our registered public accountants nor any other independent expert or outside party compiles or examines the projections. Accordingly, no such person expresses any opinion or any other form of assurance with respect to the projections.

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

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

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

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

A small number of stockholders and their affiliated entities beneficially owned more than 50% percent of our outstanding common stock as of September 30, 2016. These stockholders, if they act together, could exert substantial influence over matters requiring approval by our stockholders, including the election of directors, the amendment of our certificate of incorporation and bylaws and the approval of mergers or other business combination transactions. This concentration of ownership may discourage, delay or prevent a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their stock as part of a sale of our company and might reduce our stock price. These actions may be taken even if they are opposed by other stockholders.

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

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

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;
- cumulative voting in the election of directors is prohibited, which limits the ability of minority stockholders to elect director candidates;
- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or the resignation, death or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors;
- 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 on Form 10-Q.

			Incorporation by Reference Herein	
Exhibit Number		**Description of Exhibit**	**Form**	**Date**
10.1		Ninth Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) dated August 17, 2016	Form 8-K	August 22, 2016
10.2		Subordination, Non-Disturbance and Attornment Agreement dated as September 14, 2016 by and among Deutsche Bank, AG, SLC Lake Pointe Equities LLC and eHealthInsurance Services, Inc.		
10.3	*	Transition Agreement and Release, dated July 11, 2016, between Stuart Huizinga and eHealth, Inc.	Form 10-Q	August 8, 2016
10.4	*	Employment Agreement, dated July 11 2016, between David Francis and eHealth, Inc.	Form 10-Q	August 8, 2016
10.5	*	2016 Chief Executive Officer Bonus Plan	Form 10-Q	August 8, 2016
10.6	*	Form of Notice of Stock Option Grant and Stock Option Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of eHealth, Inc.	Form 10-Q	August 8, 2016
10.7	*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of eHealth, Inc.	Form 10-Q	August 8, 2016
10.8	*	Notice of Stock Option Grant and Stock Option Agreement (Performance-Based Vesting) granted to Scott N. Flanders on June 3, 2016	Form 10-Q	August 8, 2016
10.9	*	Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) granted to Scott N. Flanders on June 3, 2016	Form 10-Q	August 8, 2016
10.10	*	Form of Severance Letter	Form 10-Q	August 8, 2016
31.1	†	Certification of Scott N. Flanders, 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 David K. Francis, 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 Scott N. Flanders, 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 David K. Francis, 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 management contract or compensatory plan or arrangement.
** Pursuant to applicable securities laws and regulations, these interactive data files are deemed furnished and not filed or part of a registration statement or prospectus for purposes of Sections 11 or 12 of the Securities Act, are deemed furnished and not filed for purposes of Section 18 of the Exchange Act and otherwise are not subject to liability under these sections.

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 November 8, 2016.

eHealth, Inc.

/s/ Scott N. Flanders
Scott N. Flanders
Chief Executive Officer
(Duly Authorized Officer on Behalf of the Registrant)

/s/ David K. Francis
David K. Francis
Chief Financial Officer

EXHIBIT INDEX

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This **SUBORDINATION, NON-DISTURBANCE, AND ATTORNMENT AGREEMENT** (the "***Agreement***") is dated as of September 14, 2016 and is by and among **DEUTSCHE BANK AG, NEW YORK BRANCH,** a branch of Deutsche Bank AG, a German Bank, authorized by the New York Department of Financial Services, having an address at 60 Wall Street, 10th Floor, New York, New York 10005 (together with its successors and assigns, "***Lender***"), SLC Lake Pointe Equities LLC, a Delaware limited liability company, having an office at 520 SW 6th Avenue, Suite 610, Portland, Oregon 97204 ("***Landlord***"), and eHealthInsurance Services, Inc., a Delaware corporation, having an office at Lake Pointe Corporate Centre – Building Three ("***Tenant***").

WHEREAS, Lender has made or intends to make a loan to Landlord (the "***Loan***"), which Loan shall be evidenced by one or more promissory notes (as the same may be amended, modified, restated, severed, consolidated, renewed, replaced, or supplemented from time to time, the "***Promissory Note***") and secured by, among other things, that certain Mortgage or Deed of Trust, Assignment of Leases and Rents and Security Agreement (as the same may be amended, restated, replaced, severed, split, supplemented or otherwise modified from time to time, the "***Mortgage***") encumbering the real property located in Lake Pointe Corporate Centre – Building Three more particularly described on **Exhibit A** annexed hereto and made a part hereof (the "***Property***");

WHEREAS, by a lease agreement (the "***Lease***") dated May 7, 2012, between Landlord (or Landlord's predecessor in title) and Tenant, Landlord leased to Tenant a portion of the Property, as said portion is more particularly described in the Lease (such portion of the Property hereinafter referred to as the "***Premises***");

WHEREAS, Tenant acknowledges that Lender will rely on this Agreement in making the Loan to Landlord; and

WHEREAS, Lender and Tenant desire to evidence their understanding with respect to the Mortgage and the Lease as hereinafter provided.

NOW, THEREFORE, in consideration of the mutual agreements hereinafter set forth, the parties hereto hereby agree as follows:

1. Tenant covenants, stipulates and agrees that the Lease and all of Tenant's right, title and interest in and to the Property thereunder (including but not limited to any option to purchase, right of first refusal to purchase or right of first offer to purchase the Property (or any portion thereof)) is hereby, and shall at all times continue to be, subordinated and made secondary and inferior in each and every respect to the Mortgage and the lien thereof, to all of the terms, conditions and provisions thereof and to any and all advances made or to be made thereunder, so that at all times the Mortgage shall be and remain a lien on the Property prior to and superior to the Lease for all purposes, subject to the provisions set forth herein. Subordination is to have the same force and effect as if the Mortgage and such renewals, modifications, consolidations, replacements and extensions had been executed, acknowledged, delivered and recorded prior to the Lease, any amendments or modifications thereof and any notice thereof. Tenant hereby acknowledges and agrees that any option to purchase, right of first refusal to purchase or right of

first offer to purchase the Property (or any portion thereof) in the Lease, shall not be exercisable in connection with any exercise of remedies pursuant to the Mortgage or any mezzanine loan secured by the membership interests in Landlord, including: (i) a purchase of the Property (or any portion thereof) at a foreclosure sale, (ii) a transfer of the Property (or any portion thereof) to Lender or its designee pursuant to a deed-in-lieu of foreclosure, (iii) a transfer of the membership interests in Landlord pursuant to a foreclosure of any such mezzanine loan, or (iv) any subsequent sale of the Property (or any portion thereof) by Lender or its designee after such foreclosure or deed-in-lieu of foreclosure or by any mezzanine lender or its designee after such foreclosure of such mezzanine loan. The holder of any such mezzanine loan shall be a third party beneficiary of the foregoing sentence.

2. Lender agrees that if Lender exercises any of its rights under the Mortgage, including entry or foreclosure of the Mortgage or exercise of a power of sale under the Mortgage, Lender will not disturb Tenant's right to use, occupy and possess the Premises under the terms of the Lease so long as Tenant is not in default beyond any applicable grace period under any term, covenant or condition of the Lease.

3. If, at any time Lender (or any person, or such person's successors or assigns, who acquires the interest of Landlord under the Lease through foreclosure of the Mortgage or otherwise) shall succeed to the rights of Landlord under the Lease as a result of a default or event of default under the Mortgage, Tenant shall attorn to and recognize such person so succeeding to the rights of Landlord under the Lease (herein sometimes called "***Successor Landlord***") as Tenant's landlord under the Lease, said attornment to be effective and self-operative without the execution of any further instruments. Although said attornment shall be self-operative, Tenant agrees to execute and deliver to Lender or to any Successor Landlord, such other instrument or instruments as Lender or such other person shall from time to time request in order to confirm said attornment.

4. Landlord authorizes and directs Tenant to honor any written demand or notice from Lender instructing Tenant to pay rent or other sums to Lender rather than Landlord (a "***Payment Demand***"), regardless of any other or contrary notice or instruction which Tenant may receive from Landlord before or after Tenant's receipt of such Payment Demand. Tenant may rely upon any notice, instruction, Payment Demand, certificate, consent or other document from, and signed by, Lender and shall have no duty to Landlord to investigate the same or the circumstances under which the same was given. Any payment made by Tenant to Lender or in response to a Payment Demand shall be deemed proper payment by Tenant of such sum pursuant to the Lease.

5. If Lender shall become the owner of the Property or the Property shall be sold by reason of foreclosure or other proceedings brought to enforce the Mortgage or if the Property shall be transferred by deed in lieu of foreclosure, then:

(a) Notwithstanding anything to the contrary in Section 22.7 of the Lease or elsewhere, Landlord shall, on or after such sale or transfer, remain fully responsible, liable and obligated for all of Landlord's obligations and liabilities under, arising from or relating to this Lease, including but not limited to any and all obligations and liabilities described under Section 5(b), below; and

(b) Lender or any Successor Landlord shall not be:

i. liable for any act or omission of any prior landlord (including Landlord) or bound by any obligation to make any payment to Tenant which was required to be made prior to the time Lender succeeded to any prior landlord (including Landlord); or

ii. obligated to cure any defaults of any prior landlord (including Landlord) which occurred, or to make any payment to Tenant which was required to be paid by any prior landlord (including Landlord), prior to the time that Lender or any Successor Landlord succeeded to the interest of such landlord under the Lease; or

iii. obligated to perform any construction obligations of any prior landlord (including Landlord) under the Lease or liable for any defects (latent, patent or otherwise) in the design, workmanship, materials, construction or otherwise with respect to improvements and buildings constructed on the Property; or

iv. subject to any offsets, defenses or counterclaims which Tenant may be entitled to assert against any prior landlord (including Landlord); or

v. bound by any payment of rent or additional rent by Tenant to any prior landlord (including Landlord) for more than one month in advance; or

vi. bound by any amendment, modification, termination or surrender of the Lease made without the written consent of Lender; or

vii. liable or responsible for or with respect to the retention, application and/or return to Tenant of any security deposit paid to any prior landlord (including Landlord), whether or not still held by such prior landlord, unless and until Lender or any Successor Landlord has actually received said deposit for its own account as the landlord under the Lease as security for the performance of Tenant's obligation under the Lease (which deposit shall, nonetheless, be held subject to the provisions of the Lease).

6. Tenant hereby represents, warrants, covenants and agrees to and with Lender:

(a) to deliver to Lender, by certified mail, return receipt requested, a duplicate of each notice of default delivered by Tenant to Landlord at the same time as such notice is given to Landlord and no such notice of default shall be deemed given by Tenant under the Lease unless and until a copy of such notice shall have been so delivered to Lender. Lender shall have the right (but shall not be obligated) to cure such default. Tenant shall accept performance by Lender of any term, covenant, condition or agreement to be performed by Landlord under the Lease with the same force and effect as though performed by Landlord. Tenant further agrees to afford Lender a period of thirty (30) days beyond any period afforded to Landlord for the curing of such default during which period Lender may elect (but shall not be obligated) to seek to cure such default, or, if such default cannot be cured within that time, then such additional time as may be necessary to cure such

default (including but not limited to commencement of foreclosure proceedings) during which period Lender may elect (but shall not be obligated) to seek to cure such default, prior to taking any action to terminate the Lease;

(b) that Tenant is the sole owner of the leasehold estate created by the Lease; and

(c) to promptly certify in writing to Lender, in connection with any proposed assignment of the Mortgage, whether or not any default on the part of Landlord then exists under the Lease and to deliver to Lender any tenant estoppel certificates required under the Lease.

7. Tenant acknowledges that the interest of Landlord under the Lease is assigned to Lender solely as security for the Promissory Note, and Lender shall have no duty, liability or obligation under the Lease or any extension or renewal thereof, unless Lender shall specifically undertake such liability in writing or Lender becomes and then only with respect to periods in which Lender becomes, the fee owner of the Property.

8. This Agreement shall be governed by and construed in accordance with the laws of the State in which the Premises is located (excluding the choice of law rules thereof).

9. This Agreement and each and every covenant, agreement and other provisions hereof shall be binding upon and shall inure to the benefit of the parties hereto and their respective successors and assigns (including, without limitation, any successor holder of the Promissory Note) and may be amended, supplemented, waived or modified only by an instrument in writing executed by the party against which enforcement of the termination, amendment, supplement, waiver or modification is sought.

10. All notices to be given under this Agreement shall be in writing and shall be deemed served upon receipt by the addressee if served personally or, if mailed, upon the first to occur of receipt or the refusal of delivery as shown on a return receipt, after deposit in the United States Postal Service certified mail, postage prepaid, addressed to the address of Landlord, Tenant or Lender appearing below. Such addresses may be changed by notice given in the same manner. If any party consists of multiple individuals or entities, then notice to any one of same shall be deemed notice to such party.

Lender's Address: Deutsche Bank AG, New York Branch
60 Wall Street, 10th Floor
New York, New York 10005
Attn: Transaction Management

with a copy to: Cadwalader, Wickersham & Taft LLP
227 West Trade Street, Suite 2400
Charlotte, North Carolina 28202
Attention: James P. Carroll, Esq.

Tenant's Address:	eHealthInsurance Services, Inc. Attn: Rena Lane, VP Human Resources 2875 South Decker Lake Drive, Suite 400 Salt Lake City, UT 84119
With a copy to:	eHealthInsurance Services, Inc. 340 East Middlefield Road Mountain View, CA 94024 Attn: General Counsel
Landlord's Address:	SLC Lake Pointe Equities LLC c/o Felton Properties Inc 520 SW 6th Avenue, Suite 610 Portland, OR 97204
With a copy to:	Brix Law LLP 75 SE Yamhill Street, Suite 202 Portland, OR 97214 Attention: Brad Miller, Partner

11. If this Agreement conflicts with the Lease, then this Agreement shall govern as between the parties and any Successor Landlord, including upon any attornment pursuant to this Agreement. This Agreement supersedes, and constitutes full compliance with, any provisions in the Lease that provide for subordination of the Lease to, or for delivery of nondisturbance agreements by the holder of, the Mortgage.

12. In the event Lender shall acquire Landlord's interest in the Premises, Tenant shall look only to the estate and interest, if any, of Lender in the Property for the satisfaction of Tenant's remedies for the collection of a judgment (or other judicial process) requiring the payment of money in the event of any default by Lender as a Successor Landlord under the Lease or under this Agreement, and no other property or assets of Lender shall be subject to levy, execution or other enforcement procedure for the satisfaction of Tenant's remedies under or with respect to the Lease, the relationship of the landlord and tenant under the Lease or Tenant's use or occupancy of the Premises or any claim arising under this Agreement.

13. If any provision of this Agreement is held to be invalid or unenforceable by a court of competent jurisdiction, such provision shall be deemed modified to the extent necessary to be enforceable, or if such modification is not practicable, such provision shall be deemed deleted from this Agreement, and the other provisions of this Agreement shall remain in full force and effect, and shall be liberally construed in favor of Lender.

14. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

[*Remainder of Page Intentionally Left Blank*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the date first above written.

TENANT:

EHEALTHINSURANCESERVICES, INC.

By: _____ 9/19/16
Name: Scott N. Flanders
Title: CFO

LANDLORD:

SLC LAKE POINTE EQUITIES LLC,
a Delaware limited liability company

By: SLC LAKE POINTE SPE LLC,
A Delaware limited liability company,
its Sole Member

By: SLC LAKE POINTE HOLDINGS LLC,
A Delaware limited liability company,
its Managing Member

By: _____
Name: Matthew Felton
Title: Managing Member

LENDER:

DEUTSCHE BANK AG, NEW YORK BRANCH

By: _____
Name:
Title:

By: _____
Name:
Title:

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed as of the date first above written.

TENANT:

ADP, LLC

By: _____
Name:
Title:

LANDLORD:

SLC LAKE POINTE EQUITIES LLC,
a Delaware limited liability company

By: SLC LAKE POINTE SPE LLC,
A Delaware limited liability company,
its Sole Member

By: SLC LAKE POINTE HOLDINGS LLC,
A Delaware limited liability company,
its Managing Member

By: _____
Name: Matthew Felton
Title: Managing Member

LENDER:

DEUTSCHE BANK AG, NEW YORK BRANCH

By: _____
Name: KEVIN PIVNICK
Title: MANAGING DIRECTOR

By: _____
Name: David Bush
Title: Vice President

LENDER'S ACKNOWLEDGEMENT

STATE OF)
) SS.
COUNTY OF _____)

I, _____, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that _____, personally known to me to be the _____ of [_____], whose name is subscribed to the within instrument, appeared before me this day in person and acknowledged that, in such capacity, (s)he signed and delivered the said Instrument of writing as _____ of said _____, as his/her free and voluntary act and as the free and voluntary act and deed of said entity for the uses and purposes therein set forth.

GIVEN under my hand and Notarial Seal this _____ day of _____, 2___.

_____
Notary Public

My Commission expires: _____

TENANT'S ACKNOWLEDGEMENT

STATE OF California)
) SS.
COUNTY OF Santa Clara)

I, Laura Louise Henrikson, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that Scott N. Flanders, personally known to me to be the CEO of eHealthInsurance Services, Inc. a Delaware Corporation, whose name is subscribed to the within instrument, appeared before me this day in person and acknowledged that, in such capacity, (s)he signed and delivered the said Instrument of writing as his/her free and voluntary act and as the free and voluntary act and deed of said entity, for the uses and purposes therein set forth.

GIVEN under my hand and Notarial Seal this 19 day of September, 2016

Laura L Henriksen
Notary Public

My Commission expires: March 26, 2017

LAURA LOUISE HENRIKSON
Commission # 2011932
Notary Public - California
Santa Clara County
My Comm. Expires Mar 26, 2017

LANDLORD'S ACKNOWLEDGEMENT

STATE OF OREGON_____)
) SS.
COUNTY OF MULTNOMAH___)

I, Marianne Majors, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that Matthew Felton, personally known to me to be the Manager of **SLC Lake Pointe Equities LLC**, a Delaware limited liability company, whose name is subscribed to the within instrument, appeared before me this day in person and acknowledged that, in such capacity, (s)he signed and delivered the said Instrument of writing as his/her free and voluntary act and as the free and voluntary act and deed of said entity for the uses and purposes therein set forth.

GIVEN under my hand and Notarial Seal this 26 day of September, 2016

Marianne L Majors
Notary Public

My Commission expires: 3/4/19

OFFICIAL STAMP
MARIANNE LOUISE MAJORS
NOTARY PUBLIC - OREGON
COMMISSION NO. 936910
MY COMMISSION EXPIRES MARCH 04, 2019

LENDER'S ACKNOWLEDGEMENT

STATE OF New York)
COUNTY OF New York) SS.

I, Theresa Eliel, a Notary Public in and for said County, in the State aforesaid, DO HEREBY CERTIFY that David Bush, personally known to me to be the Vice President of DB AG NY whose name is subscribed to the within instrument, appeared before me this day in person and acknowledged that, in such capacity, (s)he signed and delivered the said Instrument of writing as Vice President of said DB AG NY, as his/her free and voluntary act and as the free and voluntary act and deed of said entity for the uses and purposes therein set forth.

GIVEN under my hand and Notarial Seal this 20th day of September, 2016.

Notary Public

Theresa Eliel
Notary Public - State of New York
No. 01EL6276003
Qualified in Queens County
My Commission Expires 2/4/2017

My Commission expires: _____

For internal use only

Exhibit A

Legal Description of Property

(Attached)

Exhibit _____

Legal Description

Real property in Salt Lake County, State of Utah, described as follows:

PARCEL 1:

BEGINNING AT A POINT SOUTH 0°02'15" EAST ALONG THE NORTH-SOUTH CENTER SECTION LINE 17.00 FEET AND SOUTH 89°57'30" WEST ALONG THE CENTERLINE OF 2700 SOUTH STREET 693.00 FEET AND SOUTH 00°02'02" EAST 913.79 FEET FROM THE NORTH ONE QUARTER CORNER OF SECTION 27, TOWNSHIP 1 SOUTH, RANGE 1 WEST, SALT LAKE BASE AND MERIDIAN, AND RUNNING THENCE SOUTH 00°02'02" EAST 258.16 FEET; THENCE SOUTH 348.36 FEET; THENCE SOUTH 73°19'48" WEST 155.49 FEET; THENCE NORTH 45°00'00" WEST 350.00 FEET; THENCE SOUTH 59°44'20" WEST 236.18 FEET; THENCE NORTH 45°00'00" WEST 70.48 FEET TO A POINT OF A 425.00 FOOT RADIUS CURVE TO THE RIGHT; THENCE NORTHWESTERLY ALONG THE ARC OF SAID CURVE 242.10 FEET; THENCE WEST 15.34 FEET; THENCE NORTH 8°01'21" WEST 73.93 FEET TO A POINT OF A 215.00 FOOT RADIUS CURVE TO THE LEFT; THENCE NORTHWESTERLY ALONG THE ARC OF SAID CURVE 136.30 FEET TO A POINT ON THE EASTERLY LINE OF WIDENED DECKER LAKE DRIVE (1935 WEST STREET) BY THAT CERTAIN SPECIAL WARRANTY DEED RECORDED JULY 19, 2010 AS DOCUMENT NO. 10992767 IN BOOK 9841 PAGE 6226 OF OFFICIAL RECORDS, AND TO A POINT IN A NONTANGENT 1407.33-FOOT RADIUS CURVE TO THE LEFT; THENCE NORTHEASTERLY 174.51 FEET ALONG THE ARC OF SAID CURVE THROUGH A CENTRAL ANGLE OF 7°06'17", CHORD TO SAID CURVE BEARS NORTH 35°38'20" EAST FOR A DISTANCE OF 174.40 FEET; THENCE SOUTH 55°53'10" EAST 60.86 FEET; THENCE SOUTH 45°00'00" EAST 210.00 FEET; THENCE NORTH 45°00'00" EAST 154.21 FEET; THENCE NORTH 89°47'17" EAST 440.00 FEET TO THE POINT OF BEGINNING.

(FOR INFORMATIONAL PURPOSES ONLY: KNOWN AS TAX PARCEL NO.'S 15-27-126-091-0000 & 15-27-126-092-0000)

Exhibit 31.1

CERTIFICATION

I, Scott N. Flanders, 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: November 8, 2016

/s/ SCOTT N. FLANDERS

Scott N. Flanders

Chief Executive Officer

Exhibit 31.2

CERTIFICATION

I, David K. Francis, 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: November 8, 2016

/s/ DAVID K. FRANCIS

David K. Francis

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 September 30, 2016, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Scott N. Flanders, 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/ SCOTT N. FLANDERS

Scott N. Flanders
Chief Executive Officer
November 8, 2016

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 September 30, 2016, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, David K. Francis, 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/ DAVID K. FRANCIS

David K. Francis
Chief Financial Officer
November 8, 2016

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.