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

FORM 10-K

☒ ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the year ended December 31, 2019

OR

☐ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from ____ to ____

Commission file number: 001-33071

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)

2625 AUGUSTINE DRIVE, SECOND FLOOR
SANTA CLARA, CA 95054
(Address of principal executive offices)

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

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

Title of each class	Trading Symbol	Name of each exchange on which registered
Common Stock, par value $0.001 per share	EHTH	The Nasdaq Stock Market LLC

Securities registered pursuant to Section 12(g) of the Act: **None**

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted 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 such files). Yes ☒ No ☐

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

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth Company	☐		

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

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

Based on the closing price of the registrant's common stock on the last business day of the registrant's most recently completed second fiscal quarter, which was June 30, 2019, the aggregate market value of its shares (based on a closing price of $86.10 per share) held by non-affiliates was $1.4 billion. Shares of the registrant's common stock held by each executive officer and director and by each entity or person that owned five percent or more of the registrant's outstanding common stock were excluded as such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of February 18, 2020 was 23,457,682 shares.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Definitive Proxy Statement for the 2020 Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2019, are incorporated by reference into Part III of this Annual Report on Form 10-K to the extent stated herein.

EHEALTH, INC.

FORM 10-K

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PART I

ITEM 1. BUSINESS

In addition to historical information, this Annual Report on Form 10-K 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. The words "expect," "anticipate," "believe," "estimate," "target," "goal," "project," "hope," "intend," "plan," "seek," "continue," "may," "could," "should," "might," "forecast," and variations of such words and similar expressions are intended to identify such forward-looking statements. These statements include, among other things, statements regarding our expectations relating to submitted and approved health insurance applications and estimated membership; our estimates regarding the constrained lifetime value of commissions; our expectations relating to revenue, operating costs and profitability; our expectations regarding our strategy and investments; our expectations regarding our Medicare business, including market opportunity, consumer demand and our competitive advantage; our expectations regarding our individual and family business, including anticipated trends and our ability to enroll individuals and families into qualified health plans; the impact of future and existing healthcare laws and regulations on our business; the expected impact of the COVID-19 on our financial targets and product development initiatives; our expectations regarding commission rates, payment rates, conversion rates, plan duration, membership retention rates and membership acquisition costs; our expectations relating to the seasonality of our business; expected competition from government-run health insurance exchanges and other sources; our expectations relating to marketing and advertising expense and expected contributions from our marketing channels; the timing of our receipt of commission and other payments; our critical accounting policies and related estimates; our estimates relating to the fair value of earnout liability; liquidity and capital needs; political, legislative, regulatory and legal challenges; the merits or potential impact of any lawsuits filed against us; the potential approval and adoption of an employee stock purchase plan and the potential number of shares of common stock reserved for issuance thereunder; as well as other statements regarding our future operations, financial condition, prospects and business strategies.

We have based these forward-looking statements on our current expectations about future events. These statements are not guarantees of future performance and involve risks, uncertainties and assumptions that are difficult to predict. Our actual results may differ materially from those suggested by these forward-looking statements for various reasons, including our ability to retain existing members and enroll new members during the annual healthcare open enrollment period and Medicare annual enrollment period; changes in laws and regulations, including in connection with healthcare reform or with respect to the marketing and sale of Medicare plans; competition, including competition from government-run health insurance exchanges; the seasonality of our business and the fluctuation of our operating results; our ability to accurately estimate membership and lifetime value of commissions; changes in product offerings among carriers on our ecommerce platform and the resulting impact on our commission revenue; our ability to execute on our growth strategy in the Medicare market; exposure to security risks and our ability to safeguard the security and privacy of confidential data; 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; changes in the market for private health insurance; consumer satisfaction of our service; changes in member conversion rates; changes in commission rates; our ability to sell qualified health insurance plans to subsidy-eligible individuals and to enroll subsidy-eligible individuals through government-run health insurance exchanges; our ability to maintain and enhance our brand identity; our ability to derive desired benefits from investments in our business, including membership growth initiatives; reliance on marketing partners; the impact of our direct-to-consumer email, telephone and television marketing efforts; timing of receipt and accuracy of commission reports; payment practices of health insurance carriers; our ability to successfully make and integrate acquisitions; dependence on our operations in China; the impact on our operations of public health crises in China and the United States, including the current coronavirus outbreak; the restrictions in our debt obligations; compliance with insurance and other laws and regulations; and the performance, reliability and availability of our ecommerce platform and underlying network infrastructure and those identified in Part I, Item 1A of this Annual Report on Form 10-K under the heading "Risk Factors." Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements. The forward-looking statements included in this report are made only as of the date hereof. Except as required by applicable law, we do not undertake, and specifically decline, any obligation to update any of these statements or to publicly announce the results of any revisions to any forward-looking statements, whether as a result of new information, future events, changes in assumptions or otherwise.

Overview

We are a leading health insurance marketplace with a technology and service platform that provides consumer engagement, education and health insurance enrollment solutions. Our mission is to connect every person with the highest quality, most affordable health insurance and Medicare plans for their life circumstance. Our platform integrates proprietary and third-party developed educational content regarding health insurance plans with decision support tools to aid consumers in what has traditionally been a confusing and opaque purchasing process and to help them obtain the health insurance product that meets their individual health and economic needs. Our omni-channel consumer engagement platform enables consumers to use our services online, through interactive chat, or by telephone with a licensed insurance agent. We have created a marketplace that offers consumers a broad choice of insurance products that includes thousands of Medicare Advantage, Medicare Supplement, Medicare Part D prescription drug, individual and family, small business and other ancillary health insurance products from over 180 health insurance carriers across all fifty states and the District of Columbia. We strive to be the most trusted partner to the consumer in their life's journey through the health insurance market. We were incorporated in Delaware in November 1997.

Over the last four years, we have increasingly shifted our business focus to marketing of Medicare-related health insurance products. This shift in focus has enabled our business to benefit from (1) strong demographic trends, with 10,000 people on average turning 65 every day over the next ten years, (2) the increasing proportion of the Medicare eligible population that is choosing commercial insurance solutions rather than obtaining healthcare through the original Medicare program, and (3) the growing consumer demand for online tools to compare and enroll in Medicare related health insurance plans. Our shift toward the health insurance market for Medicare eligible individuals has enabled us to mitigate the impact of the Patient Protection and Affordable Care Act, or Affordable Care Act, on our business, which among other things, established competing government exchanges that offer non-Medicare, Affordable Care Act-compliant individual and family health insurance plans.

We operate our business in two segments: (1) Medicare, and (2) Individual, Family and Small Business. Our Medicare segment represents the majority of our business and constituted approximately 88% of our revenue in 2019. We derive the majority of our revenues from commission payments paid to us by health insurance carriers related to insurance plans that have been purchased by members who used our services. Our platform and services are free to the consumer, and we are not responsible for the payment of consumer health insurance claims.

On January 22, 2018, we completed our acquisition of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. GoMedigap has built a leading consumer acquisition and engagement platform focused on meeting the Medicare Supplement insurance needs of its individual customers with a technology-enabled, consumer-centric approach that aligns with our mission and operations. This strategic acquisition significantly enhanced our presence in the Medicare Supplement market, put us in a stronger position with health insurance carriers and strategic partners and helped us to accelerate our Medicare plan enrollment growth.

On January 23, 2019, we entered into an underwriting agreement with RBC Capital Markets, LLC and Credit Suisse Securities (USA) LLC as representatives of the several underwriters to issue and sell 2,400,000 shares of our common stock par value $0.001 per share in a public offering, and also granted the underwriters a 30-day option to purchase up to an additional 360,000 shares of common stock, which they exercised, for a total of 2,760,000 shares of common stock. The offering closed on January 28, 2019, at a price of $48.50 per share, for total net proceeds of $126.2 million, after deducting underwriting discounts and commissions and estimated offering expenses. We intend to use the net proceeds of the offering for general corporate purposes, including working capital.

Available Information

We make available free of charge on the Investor Relations page of our web site (*ir.ehealthinsurance.com*) our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, proxy statements, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as soon as reasonably practicable after we file such material with, or furnish it to, the Securities and Exchange Commission, or the SEC. The SEC also maintains an Internet website (*www.sec.gov*) that contains reports, proxy and information statements, and other information regarding issuers that file electronically with the SEC. The information that can be accessed on or through our websites is not part of this Annual Report on Form 10-K.

Our Business Model

Our management evaluates our business performance and manages our operations in the following two segments:

Medicare Segment

Through a combination of demand generation strategies, we actively market, a large selection of Medicare-related health insurance plans, and to a lesser extent, ancillary products such as dental and vision insurance, to our Medicare-eligible customers. Our Medicare ecommerce platform, which can be accessed through our websites (*www.eHealthMedicare.com*, *www.Medicare.com*, *www.PlanPrescriber.com* and *www.GoMedigap.com*), 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 as a result of commissions we receive from health insurance carriers. In the first effective plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application, 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 amount that covers a full twelve-month period, regardless of the month the plan was effective. Beginning with and subsequent to the second plan year, we typically receive fixed, monthly commissions for Medicare Advantage plans and fixed, annual commissions for Medicare Part D prescription drug plans. We are paid commissions for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically until either the plan is cancelled or we otherwise do not remain the agent on the plan. Commission payments we receive for Medicare Supplement plans sold by us typically are a percentage of the premium on the plan and are paid to us monthly until either the plan is cancelled or we otherwise do not remain the agent on the plan. Medicare Advantage and Medicare Part D prescription drug plan pricing is 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.

Individual, Family and Small Business Segment

We actively market individual and family health insurance and small business health insurance plans through our ecommerce platform, which can be accessed through our websites (*www.eHealth.com* and *www.eHealthInsurance.com*), and generate revenue as a result of commissions we receive from health insurance carriers whose health insurance plans are purchased through us, as well as commission override payments we receive for achieving sales volume thresholds or other objectives. In addition, we market a variety of ancillary products, including but not limited to, short-term limited duration, dental and vision plans. These ancillary products are offered to our individual and family and small business customers and are also sold on a standalone basis. The commission payments we receive for individual and family, small business and ancillary health insurance plans are either a percentage of the premium our customers pay for those plans or a flat amount per member per month, and vary depending on the carrier that is offering the plan, the state where the plan was sold and the size of the small business. Commission payments are typically made to us on a monthly basis until either the plan is cancelled or we otherwise do not remain the agent on the plan. Health insurance pricing, which is set by the health insurance carrier and approved by state regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

Non-Commission Revenue Sources

Within our two operating segments, we earn commission revenue, as well as non-commission revenue, or other revenue, which includes online sponsorship and advertising, technology licensing and lead referral revenue.

Online Sponsorship and Advertising. We generate revenue from our sponsorship and advertising program that allows carriers to purchase advertising space for non-Medicare products on our website and Medicare plan related advertising on separate websites that we develop, host and maintain. In addition, in connection with our Medicare plan advertising program, we may use direct marketing channels including direct television and direct mail to generate leads for carriers participating in the program. In return for our services, we typically are paid either a flat amount, a monthly amount, or, in our individual and

family health insurance sponsorship advertising program, a performance-based fee based on metrics such as submitted health insurance applications.

Technology Licensing. We generate revenue from licensing the use of our health insurance ecommerce technology. Our technology platform enables health insurance carriers to market and distribute health insurance plans online. Health insurance carriers 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 the sale of Medicare-related and individual and family health insurance leads generated by our ecommerce platforms and our marketing activities.

Additional financial information about our company is included in Part II, Item 7, *Management Discussion and Analysis of Financial Condition and Results of Operations* and Item 8, *Financial Statements and Supplementary Data*, of this Annual Report on Form 10-K.

Industry Background

The purchase and sale of health insurance have historically been complex, time-consuming and paper-intensive processes. The complexity can make it difficult to make informed health insurance decisions. In addition, the human errors that arise from traditional paper-intensive distribution have historically resulted in a high number of incomplete and inaccurate applications being submitted to health insurance carriers. These incomplete and inaccurate paper applications often result in back-and-forth communications, delay and additional costs. The Internet's convenient, information-rich and interactive nature offers the opportunity to provide consumers with more organized information, a broader choice of plans and a more efficient process than have typically been available from traditional health insurance distribution channels. We believe that over time the Internet will become an increasingly important channel for researching and enrolling into health insurance plans, similar to other consumer-focused industries such as travel, financial services and shopping.

Medicare is a federal program that provides persons sixty-five years of age and over, and some persons under the age of sixty-five who meet certain conditions, with hospital and medical insurance benefits. Medicare beneficiaries choose between Medicare Fee-For-Service and Medicare Advantage plans. Medicare Fee-For-Service is a government plan where the consumer is responsible for select health care related payments with no limit on out-of-pocket expenses. To increase coverage, Medicare Fee-For-Service beneficiaries can purchase commercially offered Medicare Supplement plans. Medicare Advantage is an alternative to Medicare Fee-For-Service. CMS contracts with private health insurance carriers under the Medicare Advantage and Medicare Part D prescription drug programs. Under these programs, the government pays health insurance carriers a fixed amount of money each year per enrollee to cover health care expenses rather than making payments directly to providers under Medicare Fee-For-Service. Medicare Advantage plans are required to cover the same services as Medicare Fee-For-Service and usually cover a variety of other health care services and include a cap on out-of-pocket spending for the consumer.

Individual and family products are typically purchased by consumers under 65 years of age that do not have coverage through their employer. Small business group health insurance addresses the health insurance needs of businesses with 100 or fewer employees, although we have chosen to focus on employer groups of 20 or fewer employees. Individual, family and small business health insurance has historically been sold by independent insurance agents and, to a lesser degree, directly by insurance companies. Many of these agents are self-employed or part of small agencies, and they typically service only their local communities. In addition, many of these agents sell health insurance from a limited number of insurance carriers (in some cases only one), resulting in a reduced selection of plans for the consumer.

Our Growth Strategy

We believe our consumer engagement platform and approach to bringing value to consumers is unique in the health insurance market and creates significant opportunities for growth in our core Medicare business and in other areas of the health insurance market. We intend to pursue the following strategies to further advance our business.

Increase Medicare Membership and Commission Revenue

We intend to enroll additional Medicare Advantage, Medicare Supplement, and Medicare Part D prescription drug plan members for our commercial carrier partners. In addition to the expansion of the Medicare-eligible population, a significantly large number of Medicare-eligible individuals have insufficient coverage or a suboptimal plan for their circumstances. We believe that our platform of proprietary content, decision support tools and enrollment solutions and go-to-market strategies in direct-to-consumer and partner channels, can allow us to reach a large portion of this underserved market and grow our membership and revenue more rapidly than the overall Medicare market.

Enhance Post-Enrollment Consumer Engagement and Increase Customer Retention

We continually invest in our consumer engagement platform to add products and services. We are also enhancing our consumer experience, both online and telephonically, to simplify and encourage the use of our platform for future enrollments as consumer needs and plan selection evolves. Our goal is to, over time, increase the contribution from repeat customers to our total enrollments. We believe that increased consumer engagement and customer retention will have a positive impact on our revenue as well as lower our marketing, customer care and enrollment costs.

Increase Online Enrollment to Improve Margins and Enhance Operating Leverage

We view our consumer engagement platform as unique in the Medicare market and as attractive to the growing number of Medicare beneficiaries who prefer to research, compare and purchase health insurance online. The percentage of members who submit applications for Medicare Advantage and Medicare Supplement products online through our platform has substantially increased from 10% in 2017 to 16% in 2018 to 27% in 2019. Online submitted applications include applications submitted with and without assistance from call center agents prior to the final submission of an application. We are able to scale growth more rapidly and at an incrementally lower cost basis though our online platform, which significantly reduces our reliance on and financial and managerial resources associated with our call center operations.

Expand Our Strategic Relationships

The value of our consumer engagement and enrollment solution platform allows us to work closely with strategic partners in the health care market to leverage their relationships with consumers. We expect to increase the contribution to total Medicare enrollments from this effective demand generation channel which has shown a positive impact on customer engagement and increased customer retention. In 2019, we had strategic relationships with each of the top five retail pharmacies in the United States, a growing networks of leading hospital systems in the United States and with select financial and affinity marketing organizations to expand the availability of our platform to more consumers. Through greater data integration, co-branding and further investments to improve the customer experience with our platform, we believe that we can create significant value for each of our partners and further expand our partner relationships.

Acquire Capabilities that Leverage our Consumer Engagement Platform

We intend to pursue strategic relationships or acquisitions that expand our platform, provide additional capabilities or enable us to access adjacent markets within the broader health insurance and related customer facing segments of the healthcare industry. We acquired GoMedigap in January 2018 to help us expand our presence and engagement capabilities in the Medicare Supplement market.

Our Platforms and Technology

Our ecommerce platforms and consumer engagement solutions are built to provide market leading information, decision support and transactional services to health insurance customers across the country. Our ecommerce platforms organize and present voluminous and complex health insurance information in an objective format that empowers individuals, families and small businesses to research, analyze, compare and purchase a wide variety of health insurance plans.

Elements of our platforms include:

Plan Comparisons and Recommendations. We offer online comparison and recommendation tools that process and simplify voluminous health insurance information according to each customer's specific insurance need. Our ecommerce platform enables consumers to compare and personalize health insurance options based on plan characteristics such as price, plan type, coverage limits, deductible amount, co-payment amount, and in-network and out-of-network benefits. After entering relevant information on our website, our platforms allow consumers to instantly receive a list of applicable health insurance plans and rate and benefit information in an easy-to-understand format.

Online Application and Enrollment Forms. Health insurance applications vary widely by carrier and state. Our proprietary application tool allows us to capture each insurance application's unique business rules and build a corresponding online application in a XML format. Our online application process offers our consumers significant improvements over the traditional, paper-intensive application process. It employs dynamic business logic to help individuals and families complete the application and enrollment forms correctly in real-time. This reduces delay resulting from application rework, a significant problem with traditional health insurance distribution, where incomplete applications are mailed back and forth between the consumer, the traditional agent and the carrier. We further simplify the enrollment process by accepting electronic signature and electronic payment from our consumers.

Customer and Carrier Data Interchange. Our digital data interface technology integrates our online application process with health insurance carriers' technology systems, enabling us to electronically deliver our consumers' applications to health insurance carriers. This expedites the loading of insurance product inventory in to our various shopping experiences and accelerates the application process by eliminating manual delivery. We also receive alerts and data from carriers, such as notification of approval or a request from a carrier for a consumer's medical records for underwriting purposes, which we then relay electronically to the consumer. These features of our service help prevent applications from becoming delayed or rejected through inactivity of the consumer or the carrier.

Call Center Technology Systems. Our proprietary agent-assist management systems enable us to provide a full range of customer service tasks in an efficient and personalized manner while complying with Medicare and health insurance regulatory requirements. Call center agents have script-on-screen tools that align to health insurance needs and leverage a common back office platform that powers our direct-to-consumer shopping experience. Data science driven algorithms are used to route and match call center agents with the right training and experience to certain customers. These systems also have customer relationship management tools that can track each consumer throughout the application process, obtain real-time updates from the carrier, generate automated emails specific to each consumer and access a cross-sell engine and dashboard to identify and track cross-sell opportunities. Our auto-email system is feature-rich with HTML capability, customizable merge tags, granular segmentation and tracking capability.

Customer Data Platform. We have developed proprietary recommendation algorithms that are carrier agnostic and are designed based on the several million customer assistance encounters we have facilitated.

Carrier Relationships

We have developed strategic relationships with leading health insurance carriers in the United States, enabling us to offer thousands of health insurance plans online. We have relationships with a large number of Medicare-related, individual and family, small business and ancillary health insurance plan carriers, including large national carriers and well-established regional carriers. Many of these major carriers have been selling their products through us for over ten years. In many cases, we have back-office integration with major carriers allowing us to submit customer applications efficiently and cost-effectively, which is an area of competitive differentiation for our business. 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. 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.

Revenue derived from Humana represented approximately 26%, 22% and 20% of our total revenue for the years ended December 31, 2019, 2018 and 2017, respectively. Revenue derived from carriers owned by UnitedHealthcare represented approximately 19%, 19% and 23% of our total revenue in 2019, 2018, and 2017, respectively. Revenue derived from carriers

owned by Aetna represented approximately 17%, 14% and 10% of our total revenue in each of the years ended December 31, 2019, 2018 and 2017, respectively.

Marketing

We focus on building brand awareness, increasing individual, family and small business customer visits to our websites, increasing Medicare customer visits to our websites and telephonic sales centers and converting these visitors into members. Our marketing initiatives are varied and numerous. They include:

Direct Marketing. Our direct member acquisition channel consists of consumers who call our call centers directly or access our website addresses (*www.eHealth.com*, *www.eHealthInsurance.com*, *www.Medicare.com*, *www.eHealthMedicare.com*, *www.PlanPrescriber.com* and *www.GoMedigap.com*) either directly or through algorithmic search listings on Internet search engines and directories. Our direct marketing programs include direct mail, email marketing, search engine optimization, and television, radio and print advertising.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our website or call centers through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, paid social platforms like Facebook, as well as various Internet marketing programs such as display advertising and retargeting campaigns. Our online advertising programs are delivered across all Internet-enabled devices, including desktop computers, tablet computers and smart phones.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our website and call centers through a network comprised of hundreds of partners that drive consumers to our ecommerce platform and call centers. These partners include health care industry participants, such as pharmacies, hospital networks and insurance carriers; financial and online services partners in industries such as banking, insurance and mortgage; affiliate organizations; online advertisers and content providers that are specialists in paid and unpaid (algorithmic) search, as well as specialists in other types of Internet marketing; and off-line lead generators who specialize in traditional direct marketing channels, such as direct mail and television advertising.

Technology and Content

We have a technology and content team that is responsible for ongoing enhancements to the features and functionality of our ecommerce platform, which we believe are critical to maintaining our technology leadership position in the industry. A large number of our technology and content employees are located in our subsidiary in Xiamen, China. There are many risks associated with having an operation and doing business in China. Information regarding risks involving our operations in China is included in Part I, Item 1A, *Risk Factors*, of this Annual Report on Form 10-K.

Government Regulation and Compliance

We distribute health insurance plans in all 50 states and in the District of Columbia. The health insurance industry is heavily regulated. Each of these jurisdictions has its own rules and regulations relating to the offer and sale of health insurance plans, typically administered by a department of insurance. State insurance departments have administrative powers relating to, among other things: regulating premium prices; granting and revoking licenses to transact insurance business; approving individuals and entities to which, and circumstances under which, commissions can be paid; regulating advertising, marketing and trade practices; monitoring broker and agent conduct; and imposing continuing education requirements. We are required to maintain valid life and/or health agency and/or agent licenses in each jurisdiction in which we transact health insurance business.

In addition to state regulations, we also are subject to federal laws, regulations and guidelines issued by CMS that place a number of requirements on health insurance carriers and agents and brokers in connection with the marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans. We are subject to similar requirements of state insurance departments with respect to our marketing and sale of Medicare Supplement plans. Medicare plans are not generally able to be purchased outside of an annual enrollment period that occurs in the fourth quarter of the year, subject to exception for

individuals aging into Medicare eligibility and for individuals who qualify for a special enrollment period as a result of certain qualifying events. CMS and state insurance department regulations and guidelines include a number of prohibitions regarding the ability to contact Medicare-eligible individuals and place many restrictions on the marketing of Medicare-related plans. For example, our health insurance carrier partners are required to file with CMS and state departments of insurance certain of our websites, our call center scripts and other marketing materials we use to market Medicare-related plans. In some instances, CMS or state departments of insurance must approve the material before we use it. In addition, the laws and regulations applicable to the marketing and sale of Medicare-related plans are ambiguous, complex and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently.

In March 2010, the Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. The Affordable Care Act has primarily impacted our business of selling individual, family, and small business insurance plans. Among several other provisions, these laws and the regulations implementing them included a mandate requiring individuals to maintain health insurance or face tax penalties, which was repealed effective in 2019; a mandate that certain employers offer and contribute to their employees' group health insurance coverage or face tax penalties if they do not do so; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; requirements for minimum individual and small business health insurance benefit levels, including prohibitions on lifetime coverage limits and limitations on annual coverage limits; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; Medicaid expansion so that a greater number of individuals will be insured under Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels.

The Affordable Care Act also established annual open enrollment periods for the purchase of individual and family health insurance. 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. Moreover, in order to be eligible for a subsidy, qualified individuals must purchase subsidy-qualifying health plans, known as qualified health plans, through a government-run health insurance exchange during the open enrollment period or a special enrollment period. 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 them. The Federally Facilitated Marketplace, or FFM, run by CMS operated some part of the health insurance exchange in 38 states during the last health care open enrollment period. Our enrollment of individuals and families into qualified health plans to date has generally occurred through the FFM.

We are subject to various federal and state privacy and security laws, regulations and requirements. These laws govern our collection, use, disclosure, protection and maintenance of the individually-identifiable information that we collect from consumers. For example, we are subject to the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA and regulations adopted pursuant to HIPPA require us to maintain the privacy of individually-identifiable health information that we collect on behalf of health insurance carriers, implement measures to safeguard such information and provide notification in the event of a breach in the privacy or confidentiality of such information. In addition, we have entered into contracts with health insurance carriers and others regarding the collection, maintenance, protection, use, transmission, disclosure or disposal of sensitive personal information. The use and disclosure of certain data that we collect from consumers is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act, or GLBA, and state statutes implementing GLBA, which generally require brokers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to "opt out" of certain disclosures before sharing such information with a third party, and which generally require safeguards for the protection of personal information. We regularly assess our compliance with privacy and security requirements. These requirements are evolving, and states are beginning to adopt additional requirements, such as the California Consumer Privacy Act, which went into effect January 1, 2020, which establishes, among other things, new privacy rights for California residents such as the right to know what personal information has been collected about them, how we use and disclose this information and the right to request deletion of that information. In addition to government action, health insurance carrier expectations relating to privacy and security protections are increasing and evolving. We have incurred significant costs to develop new processes and procedures and to adopt new technology in an effort to comply with privacy and security laws and regulations and carrier expectations and to protect against cyber security risks and security breaches. We expect to continue to do so in the future. Violations of federal and state privacy and security laws and other contractual

requirements may result in significant liability and expense, damage to our reputation or termination of relationship with government-run health insurance exchanges and our members, marketing partners and health insurance carriers.

Intellectual Property

We rely on a combination of trademark, copyright and trade secret laws in the United States and other jurisdictions, as well as confidentiality procedures and contractual provisions, to protect our proprietary technology and our brand. We also have filed patent applications that relate to certain of our technology and business processes.

Competition

The market for selling health insurance plans is highly competitive. Our competitors include government entities, including government-run health insurance exchanges established as a result of health care reform; health insurance carriers; other health insurance agents and brokers; and companies that use the Internet and other means to attract individuals interested in purchasing health insurance and generate revenue by referring these individuals to us or one of our competitors.

Government. In connection with our marketing of Medicare related health insurance plans, we compete with the federal government's original Medicare program. CMS also offers Medicare plan online enrollment, information and comparison tools and has established call centers for the sale of Medicare Advantage and Medicare Part D prescription drug plans. CMS has regulatory authority over the Medicare Advantage and Medicare Part D prescription drug program and can influence the competitiveness of Medicare Advantage and Medicare Part D prescription drug plans compared to the original Medicare program, as well as the compensation that health insurance carriers are allowed to pay us.

Insurance carriers. Many health insurance carriers directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers and, to a much lesser extent, to small businesses. Health insurance carriers have become more experienced in marketing their products directly to consumers, both over the Internet and through more traditional channels, which has resulted in increased competition.

Other agents and brokers. We compete with agents and brokers who offer and sell health insurance plans utilizing traditional offline distribution channels as well as the Internet. Our current competitors include the tens of thousands of local insurance agents across the United States who sell health insurance plans in their communities. A number of these agents operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. In addition, a number of online health insurance agents like us generate demand over the Internet and sell health insurance to individuals over the Internet and using call centers.

Internet marketers and other advertisers. There are many internet marketing companies and other advertisers that use the Internet and other means to find consumers interested in purchasing health insurance and are compensated for referring those consumers to agents and health insurance carriers. We compete with these companies for individuals who are looking to purchase health insurance.

Seasonality

The majority of our commission revenue is recognized in the fourth quarter of each calendar year under Accounting Standards Update 2014-09, *Revenue from Contracts with Customers (ASC 606)*, which we adopted using the full retrospective transition method on January 1, 2018. We have historically sold a significant portion of Medicare plans for the year in the 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. During 2019, 2018, and 2017, 63%, 61%, and 52%, respectively, of our Medicare plan-related applications were submitted during the fourth quarter. As a result, we generate a significant portion of our commission revenues related to new Medicare plan-related enrollments in the fourth quarter.

Beginning January 1, 2019, CMS revived the Medicare Advantage open enrollment period during which Medicare Advantage plan enrollees may enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to original Medicare. The Medicare Advantage open enrollment period is scheduled to occur between January 1 and March 31 of each year. As a result, we expect to generate higher commission revenue in the first quarter compared to the second and third quarters.

The annual open enrollment period for individual and family health insurance also takes place in the fourth quarter of the calendar year, resulting in seasonality of individual and family plan submitted applications volume. During 2019, 2018, and 2017, 57%, 64%, and 52%, respectively, of our individual and family plan-related applications were submitted during the fourth quarter. As a result, we generate a significant portion of our commission revenues related to individual and family plan-related enrollments in the fourth quarter.

Our marketing and advertising expenses are typically lower in each of our first through third quarters compared to the fourth quarter. We incur a significant portion of our marketing and advertising expenses in the fourth quarter as a result of the Medicare annual enrollment period and the open enrollment period under the Affordable Care Act. Our marketing and advertising increases in the fourth quarter as a result of increased amounts owed to our marketing partners in connection with lead referral arrangements as well as an increase in the number of health insurance applications submitted on our ecommerce platforms referred to us by our marketing partners. We also typically incur an increase in other marketing and advertising related expenses in the fourth quarter. We expect this seasonal trend in marketing and advertising expenses to continue in 2020.

In preparation for the Medicare annual enrollment period during 2019, 2018, and 2017, and to a lesser extent the open enrollment period for individual and family health insurance plans during the same periods, we began increasing our customer care center staff during the third and fourth quarters to handle the anticipated increased volume of health insurance transactions, which resulted in higher customer care and enrollment expenses in the third and fourth quarters. We expect this seasonal trend in customer care and enrollment expenses to continue in 2020.

Employees

As of December 31, 2019, we had approximately 1,500 full-time employees, of which 860 were in customer care and enrollment, 370 were in technology and content, 210 were in general and administrative, and 60 were in marketing and advertising.

None of our U.S. employees are represented by a labor union. As required under Chinese law, the employees in our Xiamen, China office established a labor union in January 2014. We have not experienced any work stoppages and consider our employee relations to be good.

ITEM 1A. RISK FACTORS

In addition to other information in this Annual Report on Form 10-K 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

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws and regulations, and non-compliance with 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 the Centers for Medicare and Medicaid Services, or 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. In addition, Medicare eligible individuals may 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, marketing and operations are not in compliance or give rise to too many complaints. The termination of or change in our relationship with health insurance carriers for this reason would reduce the products we are able to offer, could result in the loss of commissions for past and 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 these laws, regulations and guidelines. 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. CMS, state departments of insurance or health insurance carriers may determine to object to or not to approve aspects of our online platforms, sales function or marketing material and processes and may determine that certain existing aspects of our Medicare-related business are not in compliance. Changes to the laws, regulations and guidelines relating to the sale of Medicare plans, their interpretation or the manner in which they are enforced could impact the manner in which we conduct our Medicare business, our platforms or our sale of Medicare plans, 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.

If our ability to enroll individuals during enrollment periods is impeded, our business will be harmed.

It is 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 contract with outsourced call centers and hire 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 this period. We must ensure that our employee health insurance agents and the health insurance agent employees of outsourced call centers are timely licensed, trained and certified and have the appropriate authority to sell health insurance in a number of states and for a number of different health insurance carriers. We depend upon our own employees, state departments of insurance, government exchanges and health insurance carriers for licensing, certification and appointment. If our ability to market and sell Medicare-related health insurance and individual and family health insurance is constrained during an enrollment period for any reason, such as technology failures, reduced allocation of resources, any inability to timely employ, license, train, certify and retain our employees and our contractors and their health insurance agents to sell health insurance or interruptions in the operation of our website or systems, we could acquire fewer members, suffer a reduction in our membership and our business, operating results and financial condition could be harmed.

If investments we make in enrollment periods do not result in the returns we expected when making those investments, 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 under the Affordable Care Act, we may invest in areas of our business, including technology and content, customer care and enrollment, and marketing and advertising. We have in the past made investments in areas of our business in advance of enrollment periods that have not yielded the results we expected when making those investments. Any investment we make in any enrollment period may not result in a significant number of approved and paying members or may not be as cost-efficient as we anticipated. If it does not, or is not, our business, operating results and financial condition would be harmed.

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, with respect to our sale of Medicare-related and individual and family health insurance. The federal government operates a website where Medicare beneficiaries can purchase Medicare Advantage and Medicare Part D prescription drug plans or be referred to carriers to purchase Medicare Supplement plans. CMS has made improvements to the consumer experience on this website and proposals exist for it to continue to do so. Medicare beneficiaries can also obtain plan selection assistance from the federal government in connection with their purchase of a Medicare Advantage or Medicare Part D prescription drug plan. The exchanges in the individual and family health insurance market created by the Affordable Care Act 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 Affordable Care Act exchanges have websites where individuals and small businesses can 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. In the aggregate, government exchanges have greater resources and greater public outreach capability than we do and they or the government agencies that run them may in the future impact the process we use to enroll individuals and families in a manner that results in a reduction in revenue and our membership. In addition, individuals who utilize our platform and services to apply for subsidies and health insurance through Affordable Care Act exchanges receive marketing and communications from the 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 may no longer receive commission payments as a result of our sale of health insurance to them. 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 membership and revenue and may otherwise harm our business, operating results and financial condition.

Our operating results will be impacted by factors that impact our estimate of the constrained lifetime value (LTV) of commissions per approved member.

Effective January 1, 2018, we adopted Accounting Standards Update 2014-09, *Revenue from Contracts with Customers (ASC 606)* using the full retrospective method, which required us to revise our historical financial information by applying the new standard. The adoption had a material impact on our consolidated financial statements. The most significant impact of the standard was on our commission revenue. Since the adoption of ASC 606, we recognize revenue at the time of plan approval by applying the latest estimated constrained LTV for that product. We estimate commission revenue for each product by using a portfolio approach to a group of approved members by plan type and the effective month of the relevant plan, which we refer to as "cohorts". We estimate the cash commissions we expect to collect for each approved member cohort by evaluating various factors, including but not limited to, commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship. On a quarterly basis, we recompute LTV at a cohort level for all outstanding cohorts, review and monitor changes in the data used to estimate LTV as well as the cash received for each cohort as compared to our original estimates. The fluctuations of cash received for each cohort and LTV can be significant and may or may not be indicative of the need to adjust LTVs for prior period cohorts. Management analyzes these fluctuations and, to the extent we see changes in our estimates of the cash commission collections that we believe are indicative of an increase or decrease to prior period LTVs, we will adjust LTV for the affected cohorts at the time such determination is made. Changes in LTV may result in an increase or a decrease to revenue and a corresponding increase or decrease to commissions receivable, accordingly. We refer the net commission revenue from members approved in prior periods as "adjustment revenue" and our revenue can fluctuate significantly from period to period as a result of adjustment revenue.

Adjustment revenue can have a significant favorable or unfavorable impact on our revenue. During the fourth quarter of 2019, we incorporated statistical tools to increase the accuracy of LTV estimates with an emphasis on improving member retention forecasting. As a result, we recognized adjustment revenue of $50.8 million for Medicare Advantage plans during the fourth quarter of 2019, which increased our adjustment revenue for all Medicare products to $55.3 million for the year ended December 31, 2019.

As we continue to evaluate our LTV estimation models, we may in the future make further changes based on a number of factors and such changes could result in significant increases or decreases in our revenue. Constrained LTVs are estimates and are based on a number of assumptions, which include, but are not limited to, estimates of the conversion rates of approved members into paying members, forecasted average plan duration and forecasted commission rates we expect to receive per

approved member's plan. These assumptions are based on historical trends and require significant judgment by our management in interpreting those trends and in applying the constraints. Changes in our historical trends will result in changes to our constrained LTV estimates in future periods and therefore could adversely affect our revenue and financial results in those future periods. As a result, negative changes in the factors upon which we estimate constrained LTVs, such as reduced conversion of approved members to paying members, increased health insurance plan termination or a reduction in the lifetime commission amounts we expect to receive for selling the plan to a member or other changes could harm our business, operating results and financial condition. In addition, if we ultimately receive commission payments that are less than the amount we estimated when we recognized commission revenue, we would need to write off the remaining commission receivable balance, which would adversely impact our business, operating results, and financial condition.

The rate at which approved members become paying members is a significant factor in our estimation of constrained LTVs. For example, during the first open enrollment period under the Affordable Care Act, we experienced a decline in the rate at which members approved for individual and family health insurance turned into paying members, which harmed our operating results. To the extent we experience a similar decline in the rate at which approved members turn into our paying members, our business, operating results, and financial condition would be harmed.

The forecasted average plan duration is another important factor in our estimation of constrained LTV. We receive commissions from health insurance carriers for health insurance plans sold through us. 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 payment. Our forecasted average plan duration and health insurance plan termination rate are calculated based on our historical data by plan type. As a result, our inability to produce accurate forecasted average plan duration may adversely impact our business, operating results and financial condition.

Commission rates are also part of the significant factors in our estimation of constrained LTVs. 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 reductions in contractual commission rates, a change in the mix of carriers whose products we sell during a given period, and increased health insurance plan termination rates, 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. Given that Medicare-related and individual and family health insurance purchasing is concentrated during enrollment periods, we may experience a shift in the mix of Medicare-related and individual and family health insurance products selected by our members over a short period of time. Any reduction in our average commission revenue per member during the enrollment periods caused by such a shift or otherwise 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 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 the event we are not successful in gaining or maintaining the ability to sell Medicare, individual and family and ancillary 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 commissions, 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, quality and affordability of health insurance plans we offer, cause a loss of commission payments, cause a reduction in constrained LTVs and adversely impact our ability to recognize 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.

Health insurance carriers can unilaterally amend the commission rates that they pay to us. For example, given the significant losses that carriers sustained in connection with their sale of individual and family health insurance as a result of health care reform, many health insurance carriers with which we have a relationship, including large national health insurance carriers, reduced or eliminated our commissions for selling individual and family health insurance, and in a limited number of cases, our renewal commissions. As a result, we experienced a meaningful reduction in our average commission rates for our aggregate individual and family health insurance plan membership. In addition, the reduction in contractual commission rates and these carriers' desire to not sell individual and family health insurance reduced the number of plans that we are able to offer on our websites, which resulted in less consumer demand for the individual and family health insurance that we sell and a reduction in our membership. 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 to sell their own plans, determine not to sell their plans or otherwise limit or prohibit us from selling their plans. In addition to reducing commission rates, health insurance carriers may determine to exit 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 or determine not to pay for health insurance at all. If we lose these members, our business, operating results and financial condition could be harmed.

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.

We also may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carriers. The regulations applicable to the business of selling health insurance are complex and frequently change. We or the health insurance agents we employ have in the past, and may in the future, violate one or more of the many requirements imposed by CMS or state laws and regulations. A carrier may terminate our relationship for that or other reasons, or CMS may 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. CMS also may require the carrier to terminate its membership and allow its members to move to other plans. 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 or if the health insurance carrier loses its Medicare product membership, 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.

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

Our success is 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 executive officers and employees can terminate their employment at any time. The transition and the departure of members of our senior management could result in attrition in our senior management and key personnel and any significant change in leadership over a short period of time 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 designated writing agent with each insurance carrier. A small number of our employees act as writing agent and each employee that acts as writing agent does so for a number of carriers. Robert Hurley, who recently resigned as an executive officer and will remain a part-time employee for a transitionary period of an undetermined amount of time, is the writing agent on a large number of our carrier relationships. During Mr. Hurley's transitionary period, we need to replace Mr. Hurley as writing agent with another employee who has health insurance licenses. Due to our national reach and the large number of carriers whose plans are purchased by our members, this transition may be difficult and could require 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 business may be harmed if we are not successful in executing on our strategic investments and initiatives.

As part of our strategy, we have determined to invest in initiatives to accelerate growth in our Medicare product sales, including Medicare Advantage and Medicare Supplement plans. Pursuing and investing in these and other initiatives we develop will require significant investments in marketing and advertising, technology and product offerings, and customer care and enrollment, among others, and 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, potential changes in laws and regulations and other issues 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. Our cash flow from operations was negative in each of the years ended December 31, 2019, 2018 and 2017. As a result, our investment in these initiatives could result in our needing to raise additional capital. If we are not successful in executing on our business strategy, 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. 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 26%, 22% and 20% of our total revenue for the years ended December 31, 2019, 2018 and 2017, respectively. Revenue derived from carriers owned by UnitedHealthcare represented approximately 19%, 19% and 23% of our total revenue for the years ended December 31, 2019, 2018 and 2017, respectively. Revenue derived from Aetna represented approximately 17%, 14% and 10% of our total revenue for the years ended December 31, 2019, 2018 and 2017, 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.

Seasonality may cause fluctuations in our financial results.

Open enrollment periods drive the seasonality of our business. The Medicare annual enrollment period occurs from October 15 to December 7 each year and the individual and family health insurance open enrollment period typically runs from November 1 through December 15 each year. In addition, the Medicare open enrollment period, where Medicare-eligible individuals who enrolled in a Medicare Advantage plan can switch to the original Medicare program or switch to a different Medicare Advantage plan, runs from January 1st through March 31st of each year. We experience an increase in the number of submitted Medicare-related applications and approved members during the fourth quarter and, to a lesser extent, in the first quarter, and an increase in Medicare plan related expense during the third and fourth quarters in connection with the open enrollment periods. Our commission revenue is the highest in our fourth quarter and second-highest in our first quarter given the increase in submitted applications and approved members in those periods compared to the rest of the year. We have typically experienced increased customer care and enrollment experience in the third and fourth quarters as we increase the number of agents to assist consumers in the enrollment periods. A significant portion of our marketing and advertising expenses is driven by the number of health insurance applications submitted through us. Since our marketing and advertising costs are expensed and generally paid as incurred and commissions from approved members are paid to us over time, our operating cash flows could be adversely impacted by a substantial increase in marketing expense as a result of a higher volume of applications

submitted during a quarter or positively impacted by a substantial decline in marketing expense as a result of lower volume of applications submitted during a quarter.

The seasonality of our business could change in the future due to other factors, including as a result of changes in timing of the Medicare or individual and family health plan enrollment periods and changes in 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. If the timing of the enrollment periods for Medicare-related health insurance or individual and family health insurance changes, 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.

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

We receive commissions from health insurance carriers for health insurance plans sold through us. When one of these plans is canceled, or if we otherwise do not remain the agent on the plan, we no longer receive the related commission payment. Our members may choose to discontinue their health insurance plans for a variety of reasons. Consumers may also purchase individual and family and Medicare-related health insurance plans directly from other sources, such as government-run health insurance exchanges, and we would not remain the agent on the policy and receive the related commission. Medicare Advantage plan enrollees may enroll in another Medicare Advantage plan or disenroll from their Medicare Advantage plan and return to original Medicare during the Medicare Advantage open enrollment period that is scheduled to occur between January 1st and March 31st of each year. If the new members that we enroll during this Medicare Advantage open enrollment period do not offset any loss of existing Medicare Advantage members or if investments we make during this new Medicare Advantage open enrollment period do not result in a significant number of approved and paying Medicare Advantage members, our business, operating results and financial condition would be harmed. In addition, the open enrollment period could cause us to experience an increased Medicare Advantage plan termination rate, which could adversely impact our business, operating results and financial condition.

Health insurance carriers have in the past and may in the future terminate health insurance plans purchased and held by our members. Any decrease in the amount of time we retain our members on the health insurance plans that they purchased through us could adversely impact the estimated constrained LTV we use for purposes of recognizing revenue, which could harm our business, operating results and financial condition. Moreover, if we are not able to successfully retain existing members and limit health insurance plan termination, 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 plan if the plan is the first Medicare-related plan 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 to new plans, our business, operating results and financial condition would be harmed. If we experience higher health insurance plan termination rate than we estimated when we recognized commission revenue, we may not collect all of the related commission receivable, which could result in a write-off of commissions receivable, which would harm our business, operating results and financial condition.

Our business may be harmed if our websites, marketing materials or call center scripts are not timely approved or do not comply with legal requirements.

Health insurance carriers whose Medicare plans we sell approve our websites, much of our marketing material and our call center scripts. We must receive these approvals in order for us to be able to generate Medicare plan demand and sell Medicare plans to Medicare-eligible individuals as a health insurance agent. Many of these materials also must be filed with CMS. In the event that CMS or a health insurance carrier requires change to, disapproves, or delays approval of our websites, our marketing material or call center scripts, we could lose a significant source of Medicare plan demand and our ability to sell Medicare plans would be adversely impacted, which would harm our business, operating results and financial condition. The rules and regulations relating to the approval and submission of marketing material are ambiguous and complex and state department of insurance or CMS may determine that certain aspects of our marketing material and processes are not in compliance with legal requirements. The CMS rules and regulations also apply 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 all required marketing material with CMS, we could be prevented from implementing our Medicare marketing initiatives and our Medicare plan marketing could become less effective, which would harm our business, operating results and financial condition, particularly if the delay or non-compliance occurred during the Medicare annual or open

enrollment periods. If a marketing partner of ours does not consent to having its website or other marketing material filed with 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 referrals could be delayed and our business, operating results and financial condition would be harmed.

If we or our marketing partners substantively change our websites or call center scripts after they are filed with CMS, we may need to resubmit them to health insurance carriers and have them re-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 and time consuming 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, which could adversely impact our business, operating results and financial condition. In addition, if a change to scripts, our websites or other marketing material is required by CMS, a state department of insurance or health insurance carriers, we may be prevented from using the marketing material until the change is made and approved, which would harm our business, operating results and financial condition, particularly if it occurred during the annual enrollment period.

We have received, and may in the future receive, inquiries from CMS or state departments of insurance regarding our marketing and business practices and compliance with laws and regulations. We typically respond to these inquiries by explaining how we believe we are in compliance with relevant regulations, or may modify our practices in connection with the inquiry. CMS and certain state regulators notified us in advance of and during the 2018 Medicare annual enrollment period for 2019 enrollment of their opinion that certain marketing material that we were using relating to one of our websites was misleading and did not follow certain legal and regulatory requirements. While we have resolved the matter with the relevant regulators, we may be subject to additional inquiries and proceedings in the future related to these or other materials. Inquiries and proceedings initiated by the government could adversely impact our health insurance licenses, require us to pay fines, require us to modify marketing and business practices, result in litigation and otherwise harm our business, operating results or financial condition.

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 and, during the Medicare annual enrollment period, outsourced call 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 and employees of third-party call centers must 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 applicable state. Because a significant number of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we retain and train a significant number of additional employees and employees of third-party call centers in a limited period of time. We must also ensure that our health insurance agents 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 our employees, state departments of insurance and health insurance carriers for the licensing, certification and appointment of our health insurance agents. We may not be successful in timely hiring a sufficient number of additional licensed agents or other employees for the Medicare annual enrollment period. We also may not be successful in engaging outsourced call centers, and the outsourced call centers may not be successful in engaging a sufficient number of licensed health insurance agents. Even if we and our outsourced call centers are successful, these health insurance agents may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments. New health insurance agents also may not perform to the standard we expect of them, which could result in lower than expected conversion rates and revenue and higher costs of acquisition per member. If we and our outsourced call centers 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 agent depends upon maintenance of functioning information technology systems.

The success of our Medicare plan customer care center operations is dependent upon information technology systems. Many 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. These systems have failed temporarily in the past. 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 enrollment periods, and the failure or interruption of any of these systems and technology or any inability to handle increased volume 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 are outside of our control.

Our success in selling Medicare-related health insurance is dependent in part on the actions of federal and state governments. The adoption of laws, regulations or policies by federal and state governments has in the past and could in the future adversely impact our Medicare business. For example, we access information from CMS in our customer care centers to increase the efficiency of our customer care agents in interacting with Medicare beneficiaries. CMS has limited access to that information, and we will have to get the information in a different way or develop different processes. CMS also has in the past determined to reduce the payments it makes to health insurance carriers in connection with the sale of Medicare Advantage plans. Any similar reduction in the future could 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. CMS also has in the past adopted rules relating to the timing and nature of the compensation of agents in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans. The effect of these rules was to reduce our compensation as a health insurance agent in connection with the sale of these plans or had other adverse consequences. In addition, under the Affordable Care Act, health insurance carriers are required to pay a fee or tax on net premium revenue for certain types of health insurance. The health insurance tax applies to Medicare Advantage, Part D prescription drug, individual and family, and small group health insurance plans. This health insurance tax was suspended by the federal government in 2017 and 2019, but it is effective in 2020 and is expected to be suspended again in 2021. As a result of the health insurance tax, consumers could experience higher premiums, higher out of pocket costs and/or reduced benefits as health insurance carriers may pass the cost of the health insurance tax to the consumers. In the event the actions of the federal government, state governments or other circumstances decrease the demand for the Medicare related health insurance that we sell, or result in a reduction in the amount paid to us or have other adverse impacts, our business, operating results and financial condition could be harmed.

Our success in the Medicare plan market as a health insurance agent depends 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, including television advertising, online marketing and direct mail marketing, and in entering into and maintaining marketing partner relationships to drive Medicare-eligible individuals to our ecommerce platforms or customer care centers on a cost-effective basis;
- 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 and policies 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 enrollment periods 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 revenue, membership acquisition and expenses and the fact that much of the sales of Medicare plans occur during this period.

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 Internet advertising and "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, Internet advertising 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 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. CMS offers plan information and referral to health insurance carriers for Medicare Supplement plans. We compete with the Federally Facilitated Marketplace, or FFM, and state health insurance exchanges implemented as a result of health care reform in marketing individual and family health insurance products. Health care reform also has resulted in health insurance plan cost and benefit data being more readily accessible, which has facilitated 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 cost-effectively driving a substantial number of consumers interested in purchasing health insurance to our website and customer care centers, 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 and other aspects of their operations to comply with applicable laws, regulations and rules;
- 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 demand and loss of market share, or may otherwise harm our business, operating results and financial condition.

Changes in the market for private health insurance, including passage and implementation of a law reflecting any current proposal to create a single payor health insurance program, could harm our business and operating results.

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. The market for private health insurance in the United States is evolving and our future financial performance will depend in part on growth in this market. Changes and developments in the health insurance system in the United States could reduce demand for our services and harm our business. For example, there has been an ongoing national debate relating to the health care reimbursement system in the United States. Certain candidates for President of the United States as well as some members of Congress have introduced proposals to expand the Medicare program, ranging from proposals generally

known as Medicare-for-all that would create a new single payor national health insurance program for all United States residents, replacing virtually all other sources of public and private insurance, to more incremental approaches such as lowering the age of eligibility for the Medicare program or creating a new public health insurance plan option as a supplement to private sources of coverage. In the event that laws, regulations or rules that eliminate or reduce private sources of health insurance are adopted, the demand for our products could be adversely impacted and our business, operating results and financial condition would be harmed.

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

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. The implementation of health care reform has increased, and could further increase, our competition in the individual and family health insurance market and reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals and families that we sell; further decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause a further reduction in our membership and revenue; cause us to incur increased expense across our business and cause health insurance carriers to further reduce our commissions and other amounts they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. These and other impacts of health care reform caused a significant decline in our individual and family plan membership and other changes in the future could have a similar impact on our Medicare related health insurance business. In addition, various aspects of health care reform have caused and could continue to cause health insurance carriers 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 individual and family and small business health insurance plans in particular jurisdictions or altogether, 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.

Under the Affordable Care Act, health insurance carriers offering coverage in the individual or small business health insurance market must ensure that such coverage meets certain actuarial value standards, includes certain minimum health benefits and is not subject to lifetime or, for most health insurance benefits, annual dollar amount coverage limits. Moreover, health insurance carriers cannot deny individuals health insurance for health reasons. For these and other reasons, the cost of individual and family health insurance has generally increased and many health insurance carriers suffered financial losses in their individual and family health insurance businesses. As a result, many health insurance carriers exited the individual and family health insurance business in part or altogether. The number of individual and family health insurance plans offered on our website has been reduced, including states and many zip codes where we have no individual and family health insurance plans to offer. If these conditions persist, we anticipate that demand for the individual and family health insurance that we sell will continue to decrease and this would harm our business, operating results and financial condition.

The Trump administration and Republican leadership in Congress have attempted on several occasions to repeal or amend the Affordable Care Act, but their efforts at doing so have largely failed. The Affordable Care Act contains a mandate requiring individuals to maintain health insurance plans that comply with the Affordable Care Act or face a tax penalty. As a part of the tax reform law that came into effect in December 2017, the tax penalty for violating the mandate was set at zero effective in 2019, essentially repealing it. The essential repeal of the individual mandate could cause individuals to determine not to purchase or maintain individual and family health insurance and could cause carriers to increase premiums, reduce commissions or exit the business of selling individual and family health insurance, any of which would adversely impact our business, operating results and financial condition.

In addition to eliminating the penalty for violating the individual mandate, the Trump administration issued an executive order in October 2017 that directed the executive branch of the government to consider proposing regulations and revising guidance to expand access to association health plans, expand the availability of short-term health insurance and increase the usability of health reimbursement arrangements. As a result of the executive order, new regulations were adopted in July and August 2018, respectively, that would facilitate association-based health insurance plans and promote the sale of more short-term health insurance. The regulations relating to short-term health insurance plans extend the initial duration of short-term health insurance from three months to less than one year and allow for short-term health insurance plans to be renewed as long as the total duration of the plan does not exceed thirty-six months. However, states have authority to impose their own

laws and regulations over short-term health insurance plans sold in their markets and certain states have adopted or are contemplating laws and regulations that would ban the sale of short-term health insurance, limit their duration and renewability, apply certain aspects of the Affordable Care Act to short-term health insurance or impose stronger disclosure requirements than the federal regulation. The expansion of the availability of short-term health insurance in many states may cause individuals and families to purchase short-term health insurance instead of individual and family health insurance, which could adversely impact our business, operating results and financial condition if any reduction in our sales of individual and family health insurance is not offset by increased revenue from sales of short-term health insurance. The regulations relating to association health plans allow small businesses, including sole proprietors and other self-employed individuals, to join industry or geographically-based associations and collectively purchase large group health insurance plans. Large group health insurance is not subject to many of the provisions of the Affordable Care Act, including the requirement that health insurance plans cover all of the essential health benefits defined under the Affordable Care Act. The goal of the new regulation is to create a new health insurance option for small businesses, sole proprietors and other self-employed individuals and to reduce the cost of insurance for these purchasers if they are association members. While the regulation could present new business opportunities for us, it also may reduce the size of the individual, family and small business health insurance markets that we are able to address, which would harm our business, operating results and financial condition.

In December 2018, a federal district court in Texas in *Texas v. United States of America et al.*, determined that the individual mandate in the Affordable Care Act is unconstitutional, because it was not within Congress's tax power or interstate commerce power. It also determined that the remaining provisions of the Affordable Care Act were inseverable and therefore invalid. The court, however, did not rule that the operation of the Affordable Care Act be enjoined, so the law continues to operate until determined otherwise by the court or an appellate court. The Fifth Circuit Court of Appeals agreed with the district court that the mandate is unconstitutional, but remanded the case back to the district court to address whether the unconstitutionality of the mandate should impact the rest of the law. If the Affordable Care Act were finally determined to be unconstitutional and no longer operated, it is unclear what impact it or its replacement would have on our business. However, it or its replacement could adversely impact our business, operating results and financial condition.

Our business may be harmed if we do not enroll subsidy-eligible individuals through government-run health insurance exchanges efficiently.

In order to offer the qualified health plans that individuals and families must purchase to receive Affordable Care Act subsidies, agents and brokers must meet certain conditions, such as receiving permission to do so from the applicable government health insurance exchange, entering into an agreement with the health insurance exchange or a partner of the exchange, ensuring that the enrollment and subsidy application is completed through the health insurance exchange and complying with privacy, security and other standards. 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 requirements. To the extent we enroll individuals and families into qualified health plans, we do so through the Federally Facilitated Marketplace, or FFM, which runs all or part of the health insurance exchange in 38 states. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members, and in getting them enrolled through the FFM. 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, if we are not able to adopt or contract with and maintain solutions to integrate with government-run health insurance exchanges or if the health insurance exchange websites and other processes are unstable or not consumer friendly, efficient and compatible with the process we have adopted 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 FFM may at any time cease allowing us to enroll individuals in qualified health plans or change the requirements for doing so. If it does so or if the FFM platform does not function properly, our ability to retain existing members and add new members could be negatively impacted, which would harm our business, operating results and financial condition.

CMS has broad authority over the requirements that must be met in order to enroll individuals into qualified health plans through the FFM without visiting the FFM website. Beginning in the open enrollment period that occurred in the fourth quarter of 2018, CMS adopted a new enhanced direct enrollment pathway for CMS-approved partners to enroll individuals into qualified health plans and complete all steps in the eligibility and enrollment process on a single website. The enhanced direct enrollment process uses an application programming interface to transfer information relating to health plan and subsidy eligibility between the FFM and the approved partner's website. Before enhanced direct enrollment partners are approved,

extensive security and privacy reviews are conducted by an independent third-party auditor and CMS reviews the audit results to ensure the entity satisfies numerous additional privacy and security standards. We entered into an agreement to outsource certain aspects of the enrollment process for qualified health plans to a third party in light of the expense and burden associated with the additional requirements, and the entity was successful in passing the required audit to use this new process for the current open enrollment period that began on November 1, 2019. However, if we do not develop the ability to satisfy the requirements to use the improved qualified health plan enrollment process in the future, or if we are unsuccessful in entering into or maintaining a relationship with a third party who is approved to use the process, we could be required to use an alternative "double redirect" process that would require our customers to visit the FFM website in the middle of purchasing qualified health insurance plans to receive a subsidy eligibility determination. We have in the past used the "double redirect" process which resulted in a reduction in the rate at which individuals and families starting the application process for qualified health plans and subsidies became members and a reduction in our individual and family health insurance plan membership and revenue. If we are forced to use the "double redirect" process in the future, we could continue to experience loss of existing members and new potential members and a reduction in our individual and family health insurance plan membership and commission revenue, which would harm our business, operating results and financial condition. In addition, if any third party we contract with to perform certain aspects of the qualified health plan selection and enrollment process has a poor consumer experience or otherwise experiences technical or other difficulties, we could experience a reduction in our individual and family health insurance plan membership and revenue and our business, operating results and financial condition could be harmed.

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

The Affordable Care Act contains 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 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%. 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. Health insurance carriers may determine to reduce our Medicare Advantage plan, individual and family, or small group commissions as a result of the medical loss ratio requirements, which would 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 approved members in a given period. The rate at which consumers visiting our ecommerce platforms and customer care centers seeking to purchase health insurance are converted into approved members directly impacts our revenue. In addition, the rate at which consumers who are approved become paying members impacts the constrained LTV of our approved members, which impacts the revenue that we are able to recognize. A number of factors have influenced, and could in the future influence, these conversion rates for any given period, some of which are outside of our control. These factors include:

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers' ability or willingness to pay for health insurance, availability of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business, including health care reform;
- the quality of and changes to the consumer experience on our ecommerce platforms or with our customer care centers;
- regulatory requirements, including those that make the experience on our ecommerce platforms cumbersome or difficult to navigate or reduce the ability of consumers to purchase plans outside of enrollment periods;
- 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 effectiveness of health insurance agents in assisting consumers; and

- our ability to enroll subsidy-eligible individuals in qualified health plans through government-run health insurance exchanges and the efficacy of the process we are required to use to do so.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels. We may make changes to our ecommerce platforms 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 platforms or telephonically via our customer care centers and are converted into approved and paying members could cause an increase in our cost of acquiring members on a per member basis and impact our revenue in any given period. To the extent the rate at which we convert consumers visiting our ecommerce platforms or telephonically via our customer care centers into members suffers, our membership may decline, which would harm our business, operating results and financial condition.

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 platforms 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.

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. Among these factors, the assumptions underlying our estimates of commission revenue as required by ASC 606, may vary significantly over time. 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 initiatives we determined to pursue. 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.

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 facilities and our database and systems are vulnerable to damage or interruption from human error, 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, fire, severe weather conditions, including those brought about by climate change, and other natural disasters in the San Francisco Bay Area and elsewhere in Northern California as well as in other parts of the country and in China where we or our outsourced health insurance agents maintain offices.

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.

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 to attract consumers to our websites and otherwise generate demand for our services.

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 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 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 platforms. We typically pay a search engine for prominent placement of our 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. The competition has increased the cost of paid internet search advertising and has increased our marketing and advertising expenses. The competition increases substantially during the enrollment periods for Medicare related health insurance and for individual and family health insurance. If paid search advertising costs increase or become 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 strategic marketing partners, including hospitals and pharmacy chains that promote our Medicare platforms to their customers as well as pharmacy service providers. 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 with applicable laws, regulations and guidelines;
- the interest of the marketing partner’s customers in the health insurance plans that we offer ;
- 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 us;
- 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.

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.

Competition for referrals from our marketing partners has increased particularly during the 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 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. We also have relationships with hospital systems and pharmacy chains that utilize aspects of our platform and tools. Our relationships with these hospital systems and 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 hospital systems or 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.

If commission reports we receive from carriers are inaccurate or not sent to us in a timely manner, our business and operating results could be harmed and we may not recognize trends in our membership.

We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission rates per member, 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. 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. Our revenue recognition policy changed in the first quarter of 2018 as a result of our adoption of ASC 606. 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, our estimates of constrained LTV may be adversely impacted, which would harm our business, operating results and financial condition. In addition, any inaccuracies in the reports would adversely impact our commission revenue for future periods which is based on historical trends, including trends relating to contracted commission rates and expected health insurance plan cancellation.

We 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.

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 the significant increase in health insurance transaction volume, which could impair the accuracy of our membership estimates. 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. If our actual membership is different from our estimates, the constrained LTV component of our revenue recognition could also be inaccurate, including as a result of an inaccurate estimate of the average amount of time our members maintain their health insurance plans.

Our business is subject to security risks and, if we are subject to cyber attacks, security breaches or otherwise 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 and personally identifiable 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 protected health information such as information regarding the medical history of consumers. As a result, we are subject to various laws and regulations and contractual requirements regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We also hold a significant amount of information relating to our current and former employees. We cannot guarantee that our facilities and systems, and those of our third party service providers, will be free of security breaches, cyber-attacks, acts of vandalism, computer viruses, malware, misplaced or lost data, programming and/or human errors or other similar events. Compliance with privacy and security laws, requirements and regulations, particularly new state legislation such as the California Consumer Privacy Act, 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. In addition, in the event that additional 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 or require us to comply with privacy and security standards to do business with us at all. PCI compliance and compliance with other privacy and security standards are regularly assessed, and we may not always be compliant with the standards. If we are not in compliance, we may not be able to accept credit card information from consumers or conduct health insurance business, and our relationship with health insurance carriers could be adversely impacted or terminated, which would harm our business, operating results and financial condition.

There are many risks associated with our operations in China.

A portion of our operations is conducted by our subsidiary in China. Among other things, we use employees in China to maintain and update our ecommerce platform and perform certain tasks within our finance and customer care and enrollment functions. We rely on the Internet to communicate with our subsidiary in China. Our business would be harmed if our ability to communicate over the Internet with these employees failed, and we were prevented from promptly updating our software or implementing other changes to our database and systems, among other things. From time-to-time we receive inquiries from health insurance carriers relating to our operations in China and the security measures we have implemented to protect data that our employees in China may be able to access. As a part of these inquiries, we have implemented additional security measures relating to our operations in China. We may be required to implement further security measures to continue aspects of our operations in China or health insurance carriers may require us to bring aspects of our operations in China back to the United States, which could be time consuming and expensive and harm our operating results and financial condition. Health insurance carriers may also terminate our relationship due to concerns surrounding protection of data that our employees in China are able to access, which would harm our business, operating results and financial condition.

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. United States and Chinese trade laws may also impose restrictions on the importation of programming or technology to or from the United

States. We are also subject to anti-bribery and anti-corruption laws, privacy and data security laws, labor laws, tax laws, foreign exchange controls and cash repatriation restrictions in China. On June 1, 2017, a national cyber security law came into effect in China. The law, along with its implementation regulations, applies to the establishment, operation, maintenance and usage of networks within China and the supervision and management of cyber security. Under the law, network operators are required to comply with certain tiered security obligations based on the networks' relative impact on national security, social order, public interest and individuals' privacy rights. There remains considerable uncertainty as to how the cyber security law will be applied, and the regulatory environment continues to evolve with new draft regulations and standards published frequently. Such laws, regulations and standards are complex, ambiguous and subject to change or interpretation, which create uncertainty regarding compliance. Pursuant to the draft regulations, we may be required to perform self-assessments, obtain third party certifications, report cyber security incidents and make filings with public security authorities. We could also be subject to security inspections and evaluations by public security authorities and be restricted to use only network products and services that meet certain standards based on the level of risk applicable to us. Compliance with these laws and regulations could cause us to incur substantial costs or require us to change our business operations in China. Violation of applicable laws and regulations could adversely affect our brand, affect our relationship with our health insurance carriers, and could result in regulatory enforcement actions and the imposition of civil or criminal penalties and fines, which would harm our business, operating results and financial condition.

Our business may be adversely impacted by changes in China's economic or political condition. 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 China. 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. Moreover, any significant or prolonged deterioration in the relationship between United States and China could adversely affect our operations in China. Certain risks and uncertainties of doing business in China are solely within the control of the Chinese government, and Chinese law regulates the scope of our foreign investments and business conducted within China. The escalation of trade tensions initiated by the current administration has increased the risk associated with our operations in China. Either the United States or the Chinese government may sever our ability to communicate with our China operations or may take actions that force us to close our operations in China. We employ a large number of our technology and content employees in China, and we have other employees in China that support our business. Any sudden disruption of our operations in China would adversely impact our business. If we are required to move aspects of our operations from China to our offices in the United States as a result of political instability, changes in laws, inquiries from health insurance carriers or for other reasons, we could incur increased expenses, and our business, operating results and financial condition could be harmed.

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 or otherwise result in accusations that we are favoring certain plans over others. As a result, our business, operating results and financial condition could be harmed.

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

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

We believe that our intellectual property is an essential asset of our business and that our technology currently gives us a competitive advantage in the distribution of Medicare-related, 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. The efforts we have taken to protect our intellectual property may not be sufficient or effective, and our trademarks 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. 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 provide could harm our business and operating results.

We provide information on our website, through our customer care centers, in our marketing materials 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. We also 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. If the information we provide on our website, through our customer care centers, in our marketing materials 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 or impaired 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 or impact to our brand or reputation, we cannot guarantee that we will be able to do so in the future. Our sales of short-term health insurance plans that lack the same benefits as major medical health insurance plans may increase the risk that we receive complaints regarding our marketing and business practices due to the potential for consumer confusion between short-term health insurance and major medical health insurance. 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 also have become, and may in the future become, involved in litigation or claims in the ordinary course of our business, including with respect to employment-related claims such as workplace discrimination or harassment. We have, and may in the future, face claims of violations of other local, state, and federal labor or employment laws, laws and regulations relating to marketing and laws and regulations relating to the sale of insurance. 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 cause us to lose our commission revenue, and our business, operating results and financial condition would be materially harmed. In addition, if regulators believe our websites or marketing material are not compliant with applicable laws or regulations, we could be forced to stop using our websites, marketing material or certain aspects of them, which would harm our business, operating results and financial condition.

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

We acquired Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, in January 2018 and we may in the future acquire other 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, such as expenses related to the change in fair value of earnout liability;
- 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 departs or 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 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.

Our debt obligations contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.

We are party to a credit agreement with Royal Bank of Canada and other lenders that enable us to borrow up to $75 million pursuant to a revolving credit facility. This credit agreement imposes certain covenants and restrictions on our business and our ability to obtain additional financing. As of December 31, 2019, we had no outstanding debt under our revolving credit facility.

Among other things, the credit agreement requires the lender's consent, under certain circumstances, to:

- merge or consolidate;
- sell or transfer assets outside the ordinary course of business;
- make certain types of investments and restricted payments;
- incur additional indebtedness or guarantee indebtedness of others;
- pay dividends on our capital stock;
- enter into transactions with affiliates; and
- grant liens on our assets, subject to certain exceptions.

Our credit agreement also contains customary affirmative covenants, including covenants regarding the payment of taxes and other obligations, maintenance of insurance, reporting requirements and compliance with applicable laws and regulations. Further, the credit agreement contains a financial covenant requiring the Company to maintain a minimum level of excess availability at any time. The facility contains events of default, including, among others, non-payment defaults, inaccuracy of representations and warranties, covenant defaults, cross-defaults to other indebtedness, judgment defaults, collateral defaults, bankruptcy and insolvency defaults and a change of control default.

If we experience a decline in cash flow due to any of the factors described in this "Risk Factors" section or otherwise, we could have difficulty paying interest and principal amounts due on our indebtedness and meeting the financial covenants set forth in our loan facility. If we are unable to generate sufficient cash flow or otherwise obtain the funds necessary to make required payments under the credit facility, or if we fail to comply with the requirements of our indebtedness, we could default under our credit facility. Any default that is not cured or waived could result in the acceleration of the obligations under the credit facility, an increase in the applicable interest rate under the credit facility, and would permit our lender to exercise rights and remedies with respect to all of the collateral that is securing the credit facility, which includes substantially all of our assets. Any such default could materially adversely affect our liquidity and financial condition.

Even if we comply with all of the applicable covenants, the restrictions on the conduct of our business could materially adversely affect our business by, among other things, limiting our ability to take advantage of financings, mergers, acquisitions and other corporate opportunities that may be beneficial to the business. Even if the credit facility were terminated, additional debt we could incur in the future may subject us to similar or additional covenants, which could place restrictions on the operation of our business.

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 and changing accounting requirements. 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. 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 or changes in tax legislation 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, tax effects of stock-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.

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, or GAAP, relating to accounting for income taxes. In addition, we are subject to examinations of our income tax returns by the Internal Revenue Service, or IRS, 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.

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 most applicable state laws 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 adopted 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 to our business, or states may adopt new requirements that adversely impact our business, operating results and financial condition. For example, certain states have adopted or are contemplating rules and regulations that would either ban the sale of short-term health insurance, limit its duration and renewability, or apply certain aspects of the Affordable Care Act to short-term health insurance, such as the essential health benefits or requiring that short-term health insurance cover pre-existing conditions. Rules and regulations such as these could adversely impact our sale of short-term health insurance for several reasons, including because carriers may exit the market of selling short-term health insurance due to regulatory concerns, determine it is not profitable to sell the plans or increase plan premiums to a degree that reduces consumer demand for them. Moreover, our sales outside of the health care reform open enrollment period could decline, because many individuals and families choose to purchase short-term health insurance outside of the open enrollment period given the unavailability of major medical individual and family health insurance to them. States may also require stronger disclosure and marketing rules governing the sale of short-term health insurance which may impact our conversion rates on the sale of short-term health insurance. We received a letter from the Committee on Energy and

Commerce of the United States House of Representatives in March 2019 requesting information relating to our sale of short-term health insurance. The letter indicates that the committee is conducting oversight of short-term health insurance and companies that assist consumers enrollment in short-term health insurance plans in light of committee concerns, including its concern relating to the understanding of consumers who purchase short term health insurance coverage. Additionally, states and the federal government may adopt laws and regulations that further impact the types of health insurance coverage available to consumers, the product features and benefits, and the role and compensation of agents and brokers in the sale of health insurance.

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

We are required to maintain a valid license in each state in which we transact health insurance business and to adhere to sales, documentation and administration practices specific to that state. We must maintain our health insurance licenses to continue selling plans and to continue to receive commissions from health insurance carriers. 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, limit, suspend 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. 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. 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, required modification of our advertising and business practices, changes to our existing technology or platforms, the limitation, suspension and/or revocation of our licenses in a particular jurisdiction, termination of our relationship with health insurance carriers or loss of commissions and/or our inability to sell health insurance plans, which would 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, business 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.

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 contact our consumers or market the availability of our products through specific channels.

We use email and telephone, among other channels, 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 emails and telephone calls for marketing purposes continue to evolve, and changes in technology, the marketplace or consumer preferences may lead to the adoption of additional laws or regulations or changes in interpretation of existing laws or regulations. If new laws or regulations are adopted, or existing laws and regulations are interpreted or enforced, to impose additional restrictions on our ability to send email or telephone messages 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.

We use telephones to communicate with customers and prospective customers and some of these communications may be subject to the Telephone Consumer Protection Act, or TCPA, and other telemarketing laws. The TCPA and other laws, including state laws, relating to telemarketing restrict our ability to market using the telephone in certain respects. For instance, the TCPA prohibits us from using an automatic telephone dialing system to make certain telephone calls to consumers without prior express consent. We have policies in place to comply with the TCPA and other telemarketing laws. However, despite our legal compliance, we have in the past and may in the future become subject to claims that we have violated the TCPA. The TCPA provides for statutory damages of $500 for each violation and $1,500 for each willful violation. In the event that we were found to have violated the TCPA, our business, operating results and financial condition could be harmed. In addition, telephone carriers may block or put consumer warnings on calls originating from call centers. Consumers increasingly screen their incoming emails and telephone calls, including by using screening tools and warnings, and therefore our members or potential members may not reliably receive our emails or telephone messages. If we are unable to communicate effectively by email or telephone with our members and potential members as a result of legislation, blockage, screening technologies or otherwise, our business, operating results and financial condition would be harmed.

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

Consumers using our website and accessing our services depend upon Internet, online and other service providers for access to our website and services. 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 call centers or 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.

Public health crises, illness, epidemics or pandemics could adversely impact our business, operating results and financial condition.

In December 2019, a novel strain of coronavirus, COVID-19, was reported to have surfaced in Wuhan, China. In late January 2020, in response to intensifying Chinese government efforts to contain the spread of COVID-19, we temporarily closed our Xiamen, China office and requested that our employees in China work from home. While we do not expect the closure of our China office to have an impact on our ability to achieve our financial targets in 2020, it could have a negative impact on longer-term product development initiatives should the office closure persist. We have contingency plans relating to disruption of our operations in China and could accelerate implementation of them in the event of a longer-term business disruption as a result of COVID-19 in China. The extent to which the COVID-19 impacts our business will depend on future developments in China and the United States, which are highly uncertain and cannot be predicted, including new information which may emerge concerning the severity of the COVID-19 and the actions required to contain and treat COVID-19, among others. For example, in January 2020, COVID-19 spread to other countries, including the United States. The impact of COVID-19 in the United States has thus far not been as extensive as in China. We are in the process of developing contingency plans for our United States operations in the event COVID-19 were to proliferate in the United States or in particular geographies where we have facilities. We expect our contingency plans to incorporate the possibility that employees in some or

all of our facilities, including our call centers, may need to work from home, the shifting of call center resources between our sites and the sites of outsourced call center vendors with which we have a relationship and the possible acceleration of a larger implementation of a virtual desk-top solution we have used in a more limited fashion historically. COVID-19 and public health crises, illness, epidemics or pandemics, in general, and disruption to our call center and service operations, in particular, could materially impact our business, operations and financial condition.

We cannot predict the impact that changing climate conditions, including legal, regulatory and social responses thereto, may have on our business.

Global climate change has added, and will continue to add, to the unpredictability, frequency and severity of natural disasters, including but not limited to hurricanes, tornadoes, freezes, droughts, other storms and fires in certain parts of the world. In response, a number of legal and regulatory measures and social initiatives have been introduced in an effort to reduce greenhouse gas and other carbon emissions that are chief contributors to global climate change. We cannot predict the impact that changing climate conditions will have on our business. The legal, regulatory and social responses to climate change could also adversely affect our results of business, operating results and financial conditions.

Our ability to use net operating losses to offset future taxable income may be subject to certain limitations.

We have net operating loss carryforwards for federal and state income tax purposes to offset future taxable income. Our federal and state net operating loss carryforwards begin expiring in 2034 and 2021, respectively. A lack of future taxable income would adversely affect our ability to utilize these net operating loss carryforwards. In addition, utilization of the net operating loss carryforwards may be subject to a substantial annual limitation due to ownership changes that may have occurred, may occur in connection with this offering or that could occur in the future, as required by Section 382 of the Code and similar state provisions. These ownership change limitations may limit the amount of net operating loss carryforwards and other tax attributes that can be utilized annually to offset future taxable income and tax, respectively. In general, an “ownership change” as defined by Section 382 of the Code results from a transaction or series of transactions over a three-year period resulting in an ownership change of more than 50 percentage points (by value) of the outstanding stock of a company by certain stockholders. Our ability to use the remaining net operating loss carryforwards may be further limited if we experience a Section 382 ownership change as a result of future changes in our stock ownership.

Risks Related to Ownership of Our Common Stock

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. Among these factors, the assumptions underlying our estimates of commission revenue as required by ASC 606, may vary significantly over time. 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. Accordingly, our guidance is only an estimate of what management believes is realizable as of the date of release. Our actual results have, and may in the future, 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.

The price of our common stock has been and may continue to be volatile, and the value of your investment could decline.

The trading price of our common stock has been volatile and is likely to continue to fluctuate substantially. For the quarter ended December 31, 2019, the closing price of our common stock fluctuated from $53.12 to $98.29 per share. For the year ended December 31, 2019, the closing price of our common stock fluctuated from $36.19 to $110.32 per share. The trading price of our common stock depends on a number of factors, including those described in this “Risk Factors” section, many of which are beyond our control and may not be related to our operating performance. These fluctuations could cause you to lose all or part of your investment in our common stock since you might be unable to sell your shares at or above the price you paid. Factors that could cause fluctuations in the trading price of our common stock include the following:

- price and volume fluctuations in the overall stock market from time to time;
- volatility in the market prices and trading volumes of our competitors' shares, including high technology stocks, which have historically experienced high levels of volatility;
- new laws or regulations or new interpretations of existing laws or regulations applicable to our business, including developments relating to the health care industry, particularly health care reform legislation and the implementation of health care reform;
- actual or anticipated changes in our operating results or fluctuations in our operating results;
- changes in operating performance and stock market valuations of other technology companies generally, and of our competitors;
- failure of securities analysts to maintain coverage of us, changes in financial estimates by any securities analysts who follow our company, or our failure to meet these estimates or the expectations of investors;
- sales of shares of our common stock by us or our stockholders;
- announcements by us or our competitors of new products or services;
- the public reaction to our press releases, other public announcements, and filings with the SEC;
- rumors and market speculation involving us or other companies in our industry;
- actual or anticipated developments in our business, our competitors' businesses, or the competitive landscape generally;
- our ability to control costs, including our operating expenses;
- litigation involving us, our industry or both, or investigations by regulators into our operations or those of our competitors;
- developments or disputes concerning our intellectual property or other proprietary rights;
- announced or completed acquisitions of businesses or technologies by us or our competitors;
- changes in accounting standards, policies, guidelines, interpretations, or principles;
- any significant change in our management; and
- general economic conditions and slow or negative growth of our markets.

The effect of such factors on the trading market for our stock may be enhanced by the lack of a large and established trading market for our stock. In addition, the stock market in general, and the market for technology companies in particular, have experienced extreme price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of those companies. Broad market and industry factors may seriously affect the market price of our common stock, regardless of our actual operating performance. Additionally, as a public company, we face the risk of shareholder lawsuits, particularly if we experience declines in the price of our common stock. In the past, following periods of volatility in the overall market and the market prices of a particular company's securities, securities class action lawsuits have often been instituted against affected companies. We have been, and may in the future be, subject to such legal actions.

Anti-takeover provisions contained in our certificate of incorporation and bylaws, as well as provisions of Delaware law, could impair a takeover attempt.

Our certificate of incorporation, bylaws, and Delaware law contain provisions which could have the effect of rendering more difficult, delaying, or preventing an acquisition deemed undesirable by our board of directors. Our corporate governance documents include provisions:

- creating a classified board of directors whose members serve staggered three-year terms;
- authorizing undesignated preferred stock, which could be issued by our board of directors without stockholder approval and may contain voting, liquidation, dividend, and other rights superior to our common stock;
- limiting the liability of, and providing indemnification to, our directors and officers;
- limiting the ability of our stockholders to call and bring business before special meetings;
- requiring advance notice of stockholder proposals for business to be conducted at meetings of our stockholders and for nominations of candidates for election to our board of directors;
- controlling the procedures for the conduct and scheduling of board of directors and stockholder meetings; and
- providing our board of directors with the express power to postpone previously scheduled annual meetings and to cancel previously scheduled special meetings.

These provisions, alone or together, could delay or prevent hostile takeovers and changes in control or changes in our management.

As a Delaware corporation, we are also subject to provisions of Delaware law, including Section 203 of the Delaware General Corporation law, which prevents some stockholders holding more than 15% of our outstanding common stock from engaging in certain business combinations without approval of the holders of substantially all of our outstanding common stock.

Any provision of our certificate of incorporation, bylaws or Delaware law that has the effect of delaying or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our common stock, and could also affect the price that some investors are willing to pay for our common stock.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table sets forth the location, approximate square footage and primary use of each of the principal properties we occupied as of December 31, 2019:

Location	Approximate Square Footage	Primary Use
Santa Clara, California	32,492	Corporate headquarters, marketing and advertising, technology and content and general and administrative
Gold River, California	63,206	Customer care and enrollment, technology and content and general and administrative
South Jordan, Utah	41,813	Customer care and enrollment
Xiamen, China	53,758	Technology and content, customer care and enrollment, marketing and advertising and general and administrative
Austin, Texas	26,878	Technology and content, customer care and enrollment, marketing and advertising and general and administrative
Indianapolis, Indiana	56,276	Customer care and enrollment

ITEM 3. LEGAL PROCEEDINGS

On April 6, 2018, a former employee, Lupita Gonzalez, filed a complaint against us in the Superior Court of the State of California for the County of Sacramento (the “Gonzalez Complaint”). The Gonzalez Complaint is brought under the California Private Attorney General Act (“PAGA”) on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The claim alleges that we violated wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing compliant meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The Gonzalez Complaint seeks penalties and costs, expenses and attorneys’ fees.

On July 1, 2019, two other current or former employees, Michael Le’Vias and Ramona Meadows, filed a related complaint against us and eHealth Ins. Serv. Co., in the Superior Court of the State of California for the County of Santa Clara (the “Le’Vias Complaint”). A substantial overlap exists between the facts and circumstances alleged in the Gonzalez Complaint and the Le’Vias Complaint. Specifically, the Le’Vias Complaint is also brought under PAGA on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The claim alleges that we violated wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing compliant meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The Le’Vias Complaint seeks unpaid wages, penalties and costs, expenses and attorneys’ fees.

The parties have agreed to resolve both the Le’Vias and Gonzalez Complaints, which settlement will require court approval. In the interim, the parties have stipulated to vacate or, in the alternative, stay proceedings, including all discovery, with the exception of any deadlines or proceedings necessary to effectuate the settlement. The parties are seeking a court order vacating or, in the alternative, continuing the April 13, 2020 trial date for the Gonzalez matter.

In the ordinary course of our business, we have received and may continue to receive inquiries from state and federal 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 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Our common stock is traded on The Nasdaq Global Market under the symbol EHTH. As of February 18, 2020, there were 30 stockholders of record of our common stock (which does not include the number of stockholders holding shares of our common stock in “street name”) and the closing price of our common stock was $127.34 per share on February 18, 2020 as reported by The Nasdaq Global Market.

Dividend Policy

We have never declared or paid any cash dividend on our common stock. We currently do not expect to pay any dividends in the foreseeable future.

Unregistered Sales of Equity Securities

In February 2019, we issued 294,608 shares of our common stock and in January 2020 we issued another 294,608 shares of our common stock, each as a part of earnout payments in connection with our acquisition of GoMedigap, as described in *Item 8 – Financial Statements and Supplementary Data – Note 3 – Acquisition* of our *Notes to Consolidated Financial Statements* of this Annual Report on Form 10-K. These shares were issued in reliance on Section 4(a)(2) of the Securities Act of 1933, as amended, as transactions not involving any public offering.

Securities Authorized for Issuance under Equity Compensation Plans

Our compensation committee will consider recommending that our board of directors approve of a proposal to adopt an employee stock purchase plan, or ESPP, to be put forth for stockholder approval at our 2020 annual meeting of stockholders. We currently expect that if approved by our board of directors the proposal would include the reservation of approximately 500,000 shares of common stock for issuance under the ESPP. The ESPP would be a broad-based incentive plan that would give our employees and the employees of our designated subsidiaries the opportunity to acquire shares of our common stock through accumulated payroll or other permissible contributions of compensation. The ESPP would generally be qualified under Section 423 of the Internal Revenue Code of 1986, as amended, and may also have a component that does not qualify under Internal Revenue Code Section 423 that would permit employees located outside the United States to also participate in the plan on terms and conditions substantially similar to employees located in the United States but adjusted as desirable for applicable local laws and other requirements. This description of the ESPP is qualified in its entirety by the proposal to be included in the proxy statement that is presented for vote at the 2020 annual meeting of stockholders with any updates or adjustments to this description based on the ESPP that is actually put forth for approval by stockholders.

See also *Item 12 – Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters* for information regarding securities authorized for issuance.

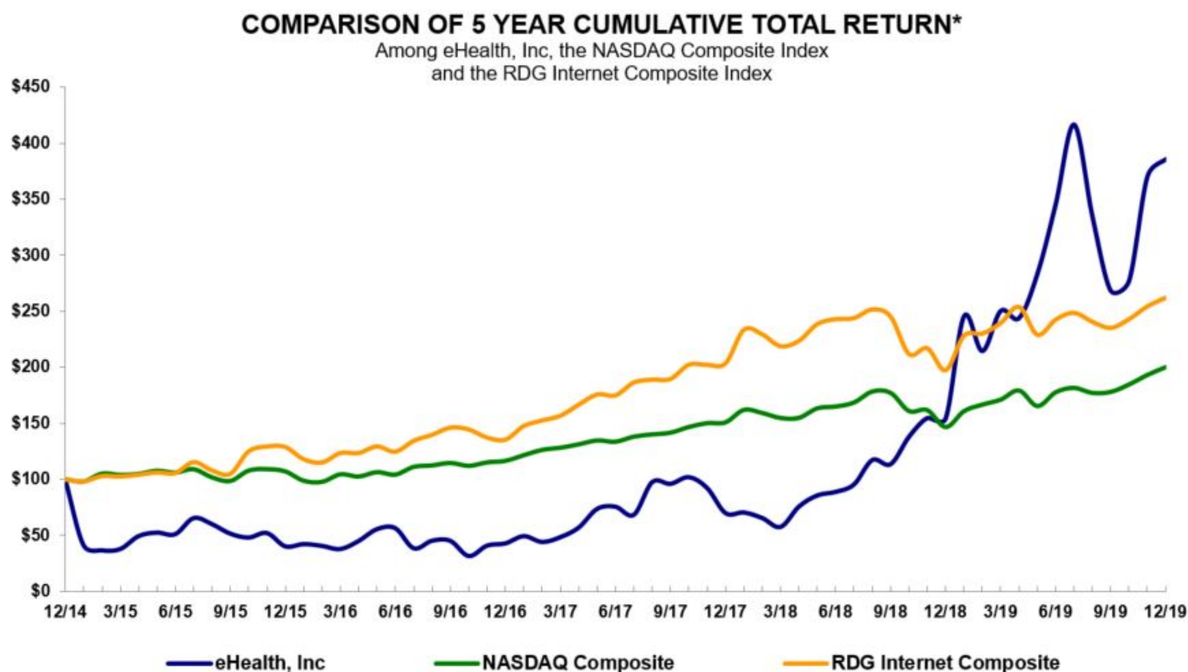
Issuer Purchases of Equity Securities

We did not repurchase any of our common stock during the year ended December 31, 2019.

STOCK PERFORMANCE GRAPH

The following information relating to the price performance of our common stock shall not be deemed "filed" with the Securities and Exchange Commission or "soliciting material" under the Securities Exchange Act of 1934, as amended, or subject to Regulation 14A or 14C, or to liabilities under Section 18 of the Exchange Act, except to the extent that we specifically request that such information be treated as soliciting material or to the extent that we specifically incorporate this information by reference.

The graph below matches our cumulative total stockholder return on our common stock with the cumulative 5-year total returns on the Nasdaq Composite index and the Research Data Group, or RDG Internet Composite index. The graph tracks the performance of a $100 investment in our common stock and in each index (with the reinvestment of all dividends) from December 31, 2014 to December 31, 2019.



* $100 invested on December 31, 2014 in stock or index, including reinvestment of dividends. Fiscal year ending December 31.

	12/31/2014	12/31/2015	12/31/2016	12/31/2017	12/31/2018	12/31/2019
eHealth, Inc.	$ 100.00	$ 40.05	$ 42.74	$ 69.70	$ 154.17	$ 385.55
Nasdaq Composite	$ 100.00	$ 106.96	$ 116.45	$ 150.96	$ 146.67	$ 200.49
RDG Internet Composite	$ 100.00	$ 128.89	$ 135.45	$ 203.48	$ 197.34	$ 262.03

ITEM 6. SELECTED CONSOLIDATED FINANCIAL DATA

The following selected consolidated financial data should be read in conjunction with "Management's Discussion and Analysis of Financial Condition and Results of Operations" and with our consolidated financial statements and accompanying notes included in this Annual Report on Form 10-K.

Consolidated Statements of Operations Data
(in thousands, except per share amounts):

	Year Ended December 31,				
	2019	2018	2017	2016	2015
Revenue					
Commission	$ 466,676	$ 227,211	$ 176,883	$ 177,234	$ 184,933
Other	39,525	24,184	13,823	16,090	18,414
Total revenue	506,201	251,395	190,706	193,324	203,347
Operating costs and expenses					
Cost of revenue	2,738	1,228	582	862	1,947
Marketing and advertising *	150,249	82,939	65,874	72,213	75,571
Customer care and enrollment *	134,304	70,547	59,183	48,718	43,159
Technology and content *	47,085	31,970	32,889	32,749	36,351
General and administrative *	64,150	45,828	39,969	35,216	30,239
Change in fair value of earnout liability	24,079	12,300	—	—	—
Amortization of intangible assets	2,187	2,091	1,040	1,040	1,153
Restructuring *	—	1,865	—	(297)	4,541
Acquisition costs	—	76	621	—	—
Total operating costs and expenses	424,792	248,844	200,158	190,501	192,961
Income (loss) from operations	81,409	2,551	(9,452)	2,823	10,386
Other income (expense), net	2,090	755	1,182	1,149	1,285
Income (loss) before provision (benefit) for income taxes	83,499	3,306	(8,270)	3,972	11,671
Provision (benefit) for income taxes	16,612	3,065	(33,696)	3,668	7,707
Net income	$ 66,887	$ 241	$ 25,426	$ 304	$ 3,964
Net income per share:					
Basic	$ 2.90	$ 0.01	$ 1.37	$ 0.02	$ 0.22
Diluted	$ 2.73	$ 0.01	$ 1.33	$ 0.02	$ 0.22
Weighted average number of shares used in calculation:					
Basic	23,075	19,294	18,512	18,272	18,008
Diluted	24,539	20,409	19,047	18,314	18,086

* Includes stock-based compensation as follows:

	Year Ended December 31,				
	2019	2018	2017	2016	2015
Marketing and advertising	$ 4,230	$ 1,974	$ 1,033	$ 1,237	$ 1,950
Customer care and enrollment	1,451	816	418	497	477
Technology and content	3,611	1,675	1,410	1,836	1,728
General and administrative	13,278	7,824	6,833	3,696	2,734
Restructuring charges	—	251	—	—	113
Total stock-based compensation expense	$ 22,570	$ 12,540	$ 9,694	$ 7,266	$ 7,002

Consolidated Balance Sheet Data

(in thousands)	As of December 31,				
	2019	2018	2017	2016	2015
Cash and cash equivalents	$ 23,466	$ 13,089	$ 40,293	$ 61,781	$ 62,710
Working capital	95,161	95,549	130,294	146,794	148,509
Total assets	741,634	439,278	359,118	357,674	353,545
Debt	—	5,000	—	—	—
Earnout liability - non-current	—	19,270	—	—	—
Deferred taxes	64,130	47,901	45,089	75,403	80,491
Other non-current liabilities	3,050	3,339	1,920	4,253	6,257
Retained earnings	271,852	204,965	204,724	179,298	169,252
Total stockholders' equity	$ 527,164	$ 303,149	$ 286,664	$ 252,280	$ 236,178

Revenue By Segment Data

(in thousands)	Year Ended December 31,		
	2019	2018	2017
Commission revenue			
Medicare	$ 411,208	$ 192,259	$ 135,010
Individual, Family and Small Business	55,468	34,952	41,873
Total commission revenue	466,676	227,211	176,883
Other revenue			
Medicare	35,753	18,312	7,438
Individual, Family and Small Business	3,772	5,872	6,385
Total other revenue	39,525	24,184	13,823
Total revenue	$ 506,201	$ 251,395	$ 190,706

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

Please read the following discussion and analysis of our financial condition and results of operations together with our consolidated financial statements and related notes included under Part II, Item 8 of this Annual Report on Form 10-K.

Overview

We provide a leading health insurance marketplace for Medicare, individuals, families and small businesses through our ecommerce platforms and customer care centers where consumers can get quotes from leading health insurance carriers, compare plans, 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. This simplifies and streamlines the traditionally paper-intensive and complex health insurance sales and purchasing process. We have invested heavily in technology and resources for our ecommerce platforms and to obtain licenses and necessary regulatory approvals enabling us to sell health insurance in all 50 states and the District of Columbia and offer thousands of health insurance plans online.

Summary of Selected Metrics

We rely upon certain metrics to estimate and recognize commission revenue, evaluate our business performance and facilitate strategic planning. Our commission revenue is influenced by a number of factors including but not limited to:

- the number of individuals on applications for Medicare-related, individual and family, small business and ancillary health insurance plans we submit to and are approved by the relevant health insurance carriers, and
- the constrained lifetime value of approved members for Medicare-related, individual and family and ancillary health insurance plans we sell as well as the estimated annual value of approved members for small business plans we sell.

Submitted Applications

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.

The following table shows submitted applications by product for the periods presented:

	Year Ended December 31,		
	2019	**2018**	**2017**
Medicare [1]			
Medicare Advantage	299,415	159,753	125,989
Medicare Supplement	54,328	40,252	21,401
Medicare Part D	117,835	64,898	42,805
Total Medicare	471,578	264,903	190,195
Individual and Family [2]			
Non-Qualified Health Plans	18,325	18,580	40,274
Qualified Health Plans	9,310	11,118	27,154
Total Individual and Family	27,635	29,698	67,428
Ancillary [3]			
Short-term	55,077	102,608	93,445
Dental	38,650	46,073	70,452
Vision	18,301	22,399	29,468
Other	23,468	42,415	34,788
Total Ancillary	135,496	213,495	228,153
Small Business [4]	8,095	8,693	6,458
Total	642,804	516,789	492,234

(1) Medicare-related health insurance applications submitted on our website or through our customer care center during the period, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans.

(2) Major medical individual and family plan ("IFP") health insurance applications submitted on our website during the period. 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.

(3) Ancillaries consists primarily of short-term, dental and vision insurance plans submitted on our website during the period.

(4) Applications for small business health insurance 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.

2019 compared to 2018 – Submitted applications grew 24% in 2019 compared to 2018, primarily driven by a 78% increase in Medicare submitted applications. The increased number of submitted applications resulted from our strong execution and significant investment in Medicare-related sales and marketing initiatives. The Medicare submitted applications were primarily driven by an 87% growth in Medicare Advantage submitted applications and an 82% growth in Medicare Part D submitted applications in 2019 as compared to 2018. Approximately 27% of all Medicare Advantage and Medicare Supplement applications were submitted online, which is a combination of agent unassisted and partially agent assisted online applications, in 2019, compared to 16% in 2018.

Individual and family plan submitted applications decreased by 7% in 2019 compared to 2018, primarily due to a 16% decrease in submitted applications for qualified plans. Ancillary plan submitted applications decreased by 37% in 2019 compared to 2018, primarily due to a 46% decline in short-term plans submitted applications. Small business submitted applications declined 7% in 2019 compared to 2018. The decline in submitted applications for individual, family, ancillary and small business products was due to the shift of our sales resources to our Medicare business.

2018 compared to 2017 – Medicare submitted applications grew 39% in 2018 compared to 2017. The increase was primarily due to direct-to consumer marketing initiatives, our flexible call center capabilities, an improved online experience and our acquisition of GoMedigap. Individual and family plan submitted applications declined 56% in 2018 compared to 2017, due to the state of the individual and family plan market as a result of the Affordable Care Act and our continued focus on the Medicare market in 2018. Approximately 16% of all Medicare Advantage and Medicare Supplement applications were submitted online, which is a combination of agent unassisted and partially agent assisted online applications, in 2018, compared to 10% in 2017.

The decline in individual and family plan submitted applications has limited our ability to cross-sell ancillary plans, resulting in a decline of 6% in submitted applications for all ancillary products combined in 2018 compared to 2017. Small business submitted applications grew 35% in 2018 compared to in 2017, due to the progress in implementing a focused marketing strategy for this market, technology enhancements and increased conversion rate.

Approved Members

Approved Members represents the number of individuals on submitted applications that were approved by the relevant insurance carrier for the identified product during the current period. The applications may be submitted in either the current period or prior periods. Approved members may not pay for their plan and become paying members.

The following table shows approved members by product for the period presented:

	Year Ended December 31,		
	2019	**2018**	**2017**
Medicare			
Medicare Advantage	279,561	148,478	118,055
Medicare Supplement	42,688	29,837	15,992
Medicare Part D	112,677	61,373	41,618
Total Medicare	434,926	239,688	175,665
Individual and Family			
Non-Qualified Health Plans	20,187	23,075	50,111
Qualified Health Plans	11,999	19,575	28,442
Total Individual and Family	32,186	42,650	78,553
Ancillary			
Short-term	58,687	107,846	85,106
Dental	43,640	47,343	67,924
Vision	21,391	24,638	31,360
Other	22,980	33,500	26,485
Total Ancillary	146,698	213,327	210,875
Small Business	16,685	19,550	15,302
Total	630,495	515,215	480,395

2019 compared to 2018 – Medicare approved members grew 81% in 2019 compared to 2018. The growth was primarily due to our strong execution and significant investment in Medicare-related sales and marketing initiatives, which resulted in an 88% growth in Medicare Advantage submitted applications and an 84% growth in Medicare Part D submitted applications. Individual and Family Plan approved members declined 25% in 2019 compared to 2018, due primarily to market conditions in the individual and family plan market and our decision to shift our marketing investments towards our Medicare business. Approved members for all ancillary products combined declined 31% in 2019 compared to 2018, due primarily to a 46% decline in short-term plan submitted applications. Small business approved members decreased 15% in 2019 compared to 2018, due primarily to a decrease in the number of members per application and in the percentage of approved applications.

2018 compared to 2017 – Medicare approved members grew 36% in 2018 compared to 2017. The increase was primarily due to 39% growth in Medicare submitted applications mainly driven by our investment in Medicare-related marketing initiatives, call center capabilities and an improved online experience and our acquisition of GoMedigap. Individual and Family Plan approved members declined 46% in 2018 compared to 2017, due to the state of the individual and family health insurance plan market. Approved members for all ancillary products combined 2018 increased 1% compared to 2017, despite a decrease in submitted applications of 6%, due to improved conversion rates year-over-year. Small business approved members grew 28% in 2018 compared to 2017, due to improved focus on key partnerships, technology enhancements and increased conversion rates.

Constrained Lifetime Value of Commissions Per Approved Member

The following table shows our estimated constrained lifetime value, or LTV, of commissions per approved member by product for the years presented below:

	Year Ended December 31,		
	2019	2018	2017
Medicare			
Medicare Advantage [1]	$ 1,013	$ 964	$ 903
Medicare Supplement [1]	$ 979	$ 1,047	$ 965
Medicare Part D [1]	$ 238	$ 243	$ 266
Individual and Family			
Non-Qualified Health Plans [1]	$ 213	$ 151	$ 136
Qualified Health Plans [1]	$ 217	$ 141	$ 131
Ancillary			
Short-term [1]	$ 101	$ 56	$ 65
Dental [1]	$ 70	$ 77	$ 68
Vision [1]	$ 56	$ 55	$ 51
Small Business [2]	$ 159	$ 168	$ 169

(1) Constrained LTV of commissions per approved member represents commissions estimated to be collected over the estimated life of an approved member's policy after applying constraints in accordance with our revenue recognition policy. The estimate is driven by multiple factors, including but not limited to, commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship. These factors may result in varying values from period to period. For additional information on constrained LTV, see Critical Accounting Policies and Estimates.

(2) For small business, the amount represents the estimated commissions we expect to collect from the plan over the following twelve months. The estimate is driven by multiple factors, including but not limited to, contracted commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship and applied constraints. These factors may result in varying values from period to period.

2019 compared to 2018 – The constrained LTV of commissions per approved member for Medicare Advantage plans increased by 5% in 2019 compared to 2018, primarily due to improved member attrition and higher commission rates.

The constrained LTV for Medicare Supplement approved members declined by 6% primarily as a result of a decrease in the average plan duration, and the constrained LTV of commissions per Medicare Part D approved member declined by 2% primarily as a result of carrier mix.

Constrained LTV of commissions per qualified and non-qualified health plan for approved members increased by 54% and 41%, in 2019 compared to 2018, respectively, mostly due to improved plan duration. Constrained LTV of commissions per short-term approved member increased 80% in 2019 compared to 2018, primarily driven by an increase in average plan duration.

2018 compared to 2017 – The constrained LTV improved 7% and 8% for Medicare Advantage and Medicare Supplement plans, respectively, in 2018 compared to 2017. The improvement in constrained Medicare Advantage plan LTV was driven by increased commission rates and member retention, and the improvement in constrained Medicare Supplement plan LTV was driven by increased commission rates and our acquisition of GoMedigap in January 2018. The constrained LTV of commissions for non-qualified health plans and Qualified Health Plans increased 11% and 8%, respectively, mostly driven by improved plan duration, in 2018 compared to 2017. The constrained LTV for Medicare Part D prescription drug, short term and small business plans decreased 9%, 14% and 1%, respectively, in 2018 compared to 2017. The decrease in Medicare Part D prescription drug plan LTV was due to higher plan turnover rate year-over-year. The decrease in short term constrained LTV was mainly driven by a regulatory change in April 2017 that reduced the maximum length of a short-term policy from one year to 90 days. The change year-over-year in small business plan LTV was relatively flat.

Estimated Membership

The following table shows estimated membership by product as of the periods presented below:

	As of December 31,		
	2019	2018	2017
Medicare [1]			
Medicare Advantage	404,694	276,357	236,857
Medicare Supplement	93,477	70,426	33,635
Medicare Part D	212,478	139,907	114,362
Total Medicare	710,649	486,690	384,854
Individual and Family [2]	128,487	151,904	224,396
Ancillary [3]			
Short-term	27,862	24,192	16,771
Dental	127,083	138,916	170,078
Vision	71,277	73,987	80,738
Other	38,119	38,136	28,356
Total Ancillary	264,341	275,231	295,943
Small Business [4]	42,638	39,101	31,702
Total Estimated Membership	1,146,115	952,926	936,895

(1) To estimate the number of members on Medicare-related health insurance plans, we take the sum of (i) the number of members for whom we have received or applied a commission payment for a month that may be up to three months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the period being estimated); and (ii) the number of approved members over that period (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 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.

(2) To estimate the number of members on Individual and Family health insurance plans (“IFP”), we take the sum of (i) the number of IFP members for whom we have received or applied a commission payment for a month that may be up to three months prior to the date of estimation after reducing that number using historical experience for assumed member cancellations over the period being estimated; and (ii) the number of approved members over that period (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 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.

(3) To estimate the number of members on ancillary health insurance plans (such as short-term, dental and vision insurance), we take the sum of (i) the number of members for whom we have received or applied a commission payment for a month that may be up to three months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the period being estimated); and (ii) the number of approved members over that period (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 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.

(4) To estimate the number of members on small business health insurance plans, we use the number of initial members at the time the group was approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier. 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 or group size changes to us. We often are made aware of policy cancellations and group size changes at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

Health insurance carriers bill and collect insurance premiums paid by our members. The carriers do not report to us the number of members that we have as of a given date. The majority of our members who terminate their plans do so by discontinuing their premium payments to the carrier and do not inform us of the cancellation. Also, some of our 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.

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. 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 on our membership retention. Various circumstances 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. 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.

2019 compared to 2018 – Medicare estimated membership grew 46% as of December 31, 2019 compared to December 31, 2018 primarily driven by a 46% and 52% increase in Medicare Advantage and Medicare Part D prescription drug plan estimated membership, respectively. Individual and family plan estimated membership declined by 15% as of December 31, 2019 compared to December 31, 2018 primarily due to market conditions in the individual and family plan market and our decision to shift our marketing investments towards our Medicare business. Ancillary plan estimated membership declined 4% as of December 31, 2019 compared to December 31, 2018, primarily due to a 9% decline in dental plan estimated membership. Small business estimated membership grew 9% as of December 31, 2019 compared to December 31, 2018, primarily driven by our focus on key partnerships and technology enhancements.

2018 compared to 2017 – Medicare estimated membership grew 26% as of December 31, 2018 compared to December 31, 2017 primarily due to our continued investment in Medicare-related marketing activities, call center capabilities and an improved online experience and our acquisition of GoMedigap. Individual and family plan estimated membership declined 32% as of December 31, 2018 compared to December 31, 2017 due to the state of the individual and family plan market as a result of health care reform and our continued shift in focus on the Medicare market. Ancillary plan estimated membership declined 7% as of December 31, 2018 compared to December 31, 2017 as a result of the decline in our ability to cross-sell dental and vision plans as a result of the decline in individual and family plan membership. Small business plan estimated membership grew 23% as of December 31, 2018 compared to December 31, 2017 due to technology enhancements and an increased conversion rate.

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. In addition, we incur customer care and enrollment expenses in assisting applicants during the enrollment process.

The following table shows the variable marketing cost per approved member and the customer care and enrollment expense per approved member metrics for the years presented below:

	Year Ended December 31,		
	2019	2018	2017
Medicare variable cost per approved member			
Medicare variable marketing cost per approved Medicare Advantage ("MA")-equivalent member [1]	$ 330	$ 297	$ 337
Medicare CC&E expense per approved MA-equivalent member [2]	$ 355	$ 315	$ 330
Total Medicare cost per approved member	$ 685	$ 612	$ 667
Individual and Family Plan ("IFP") variable cost per approved member			
IFP variable marketing cost per approved IFP-equivalent member [3]	$ 67	$ 59	$ 50
IFP CC&E expense per approved IFP-equivalent member [4]	$ 102	$ 61	$ 74
Total IFP cost per approved member	$ 169	$ 120	$ 124

(1) Variable marketing cost per approved MA-equivalent member represents direct costs incurred in member acquisition for Medicare Advantage, Medicare Supplement and Medicare Part D plans from our direct, marketing partners and online advertising channels divided by MA-equivalent approved members in a given period. MA-equivalent members is a derived metric and is equal to the sum of (i) the number of Medicare Part D approved members divided by 4, (ii) the number of Medicare Advantage approved members and (iii) the number of Medicare Supplement approved members in the given period.

(2) Medicare CC&E expense per approved MA-equivalent member is equal to the CC&E expense of our Medicare business included in our operating costs and reported in our Consolidated Statements of Comprehensive Income divided by MA-equivalent approved members in a given period. MA-equivalent approved members is a derived metric and is equal to the sum of (i) the number of Medicare Part D approved members divided by 4, (ii) the number of Medicare Advantage approved members and (iii) the number of Medicare Supplement approved members in the given period.

(3) Variable marketing cost per approved IFP-equivalent member represents direct costs incurred in member acquisition for IFP plans from our direct, marketing partners and online advertising channels divided by IFP-equivalent approved members in a given period. IFP-equivalent approved members is a derived metric and is equal to the sum of (i) the number of short-term approved members divided by 3 and (ii) the IFP approved members in the given period.

(4) IFP CC&E expense per approved IFP-equivalent member is equal to the CC&E expense of our IFP business included in our operating costs and reported in our consolidated statement of comprehensive income divided by IFP-equivalent approved members in a given period. IFP-equivalent approved members is a derived metric and is equal to the sum of (i) the number of short-term approved members divided by 3 and (ii) the IFP approved members in the given period.

2019 compared to 2018 – Variable marketing costs per approved MA-equivalent member increased by 11% in 2019 compared to 2018, due to an increase in online advertising costs and higher variable marketing costs for select initiatives within the direct and partner channels. As we increased our spending on digital advertising channel for accelerated enrollment growth and market share expansion, the average costs were higher per member. Variable CC&E costs per approved MA-equivalent member increased 13% in 2019 compared to 2018, due to our decision to have more customer care agents during the lower volume quarters, and a significant increase in overtime costs and average call length during the peak volume period in the fourth quarter.

Variable marketing cost per approved IFP-equivalent member increased by 14% in 2019 compared to 2018 primarily driven by a decline in the number of approved members for non-qualified health plans, qualified health plans, and short-term products. Variable CC&E cost per approved IFP-equivalent member increased 67% in 2019 compared to 2018, also primarily driven by decline in the number of approved members for non-qualified health plans, qualified health plans, and short-term products as well as increase in investments of IFP-dedicated customer care agents.

2018 compared to 2017 – Medicare CC&E expense per approved MA-equivalent member decreased 5% in 2018 compared to 2017 due to the scalability of a flexible agent staffing model we adopted. Variable marketing cost per approved MA-equivalent member decreased 12% in 2018 compared to 2017 due to an increase in demand generated from direct channels, including direct mail, television, search engine optimization, and paid search advertising and a reduction in the purchases of customer leads from third-party lead generation sources.

Variable marketing cost per approved IFP-equivalent member increased 18% in 2018 compared to 2017 due to a decline in the number of approved members for short-term products. IFP CC&E expense per approved IFP-equivalent member decreased 18% in 2018 compared to 2017 due to our cost saving efforts.

The constraints applied to the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application in order to derive the constrained lifetime value of commissions for approved members recognized in the period are as follows:

	Year Ended December 31,		
	2019	**2018**	**2017**
Medicare			
Medicare Advantage	7%	7%	7%
Medicare Supplement	5%	5%	5%
Medicare Part D	5%	5%	5%
Individual and Family			
Non-Qualified Health Plans	15%	15%	15%
Qualified Health Plans	20%	20%	20%
Ancillary	10%	10%	10%
Small Business	—%	—%	—%

Results of Operations

The following table sets forth our operating results and related percentage of total revenues for the years presented below (dollars in thousands):

	Year Ended December 31,					
	2019		2018		2017	
Revenue						
Commission	$ 466,676	92%	$ 227,211	90%	$ 176,883	93 %
Other	39,525	8%	24,184	10%	13,823	7 %
Total revenue	506,201	100%	251,395	100%	190,706	100 %
Operating costs and expenses [1]						
Cost of revenue	2,738	1%	1,228	—%	582	— %
Marketing and advertising	150,249	30%	82,939	33%	65,874	35 %
Customer care and enrollment	134,304	27%	70,547	28%	59,183	31 %
Technology and content	47,085	9%	31,970	13%	32,889	17 %
General and administrative	64,150	13%	45,828	18%	39,969	21 %
Change in fair value of earnout liability	24,079	4%	12,300	5%	—	— %
Amortization of intangible assets	2,187	—%	2,091	1%	1,040	1 %
Restructuring charges	—	—%	1,865	1%	—	— %
Acquisition costs	—	—%	76	—%	621	— %
Total operating costs and expenses	424,792	84%	248,844	99%	200,158	105 %
Income (loss) from operations	81,409	16%	2,551	1%	(9,452)	(5)%
Other income, net	2,090	—%	755	—%	1,182	1 %
Income (loss) before provision (benefit) for income taxes	83,499	16%	3,306	1%	(8,270)	(4)%
Provision (benefit) for income taxes	16,612	3%	3,065	1%	(33,696)	(18)%
Net income	$ 66,887	13%	$ 241	—%	$ 25,426	13 %

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

	Year Ended December 31,		
	2019	2018	2017
Marketing and advertising	$ 4,230	$ 1,974	$ 1,033
Customer care and enrollment	1,451	816	418
Technology and content	3,611	1,675	1,410
General and administrative	13,278	7,824	6,833
Restructuring charges	—	251	—
Total stock-based compensation expense	$ 22,570	$ 12,540	$ 9,694

Revenue

Our commission revenue, other revenue and total revenue are summarized as follows for the years presented below (dollars in thousands):

		Change			Change		
	2019	**$**	**%**	**2018**	**$**	**%**	**2017**
Commission	$ 466,676	$ 239,465	105%	$ 227,211	$ 50,328	28%	$ 176,883
Percentage of total revenue	92%			90%			93%
Other	39,525	15,341	63%	24,184	10,361	75%	13,823
Percentage of total revenue	8%			10%			7%
Total revenue	$ 506,201	$ 254,806	101%	$ 251,395	60,689	32%	$ 190,706

2019 compared to 2018 – Total revenue increased by $254.8 million or 101% in 2019 compared to 2018 driven by the growth in both commission and other revenues. Commission revenue increased by $239.5 million or 105% in 2019 compared to 2018, primarily driven by a $217.8 million increase in Medicare commission revenue and a $12.2 million increase in commission revenue for individual and family plans. The increase in Medicare commission revenue was attributable to an 81% increase in Medicare approved members, higher LTVs for Medicare Advantage plans, and an increase in adjustment revenue from Medicare Advantage plans approved in prior periods. Of the adjustment revenue of $55.3 million for the year ended December 31, 2019, $42.3 million is related to a change in estimate of expected cash commission collections for Medicare Advantage plans since we began selling such products through the third quarter of 2019. See *Note 2 – Revenue* in our *Notes to the Consolidated Financial Statements* for details. The increase in individual and family commission revenue was primarily driven by an increase in LTVs for IFP plans and an increase in adjustment revenue from IFP plans approved in prior periods as we continued to observe longer member duration than initially anticipated at the time of enrollment for these plans.

Other revenue increased $15.3 million, or 63%, in 2019 compared to 2018, primarily driven by a $17.4 million growth in Medicare advertising revenue, partially offset by a $2.1 million decline in revenue from our individual and family health insurance sponsorship advertising program.

2018 compared to 2017 – Commission revenue increased $50.3 million, or 28%, in 2018, due to an increase of $57.2 million, or 42%, in Medicare commission revenue, partially offset by a $5.0 million decrease in Individual, Family and Small Business commission revenue. The increase in Medicare commission revenue was due to an increase in approved members of 36%, as well as increases in the LTVs for Medicare Supplement and Medicare Advantage plans for the year ended December 31, 2018 compared to December 31, 2017. The decrease in Individual, Family and Small Business commission revenue was primarily due to a 46% decline in individual and family health insurance approved members as of December 31, 2018 compared to December 31, 2017 due to the state of the individual and family health insurance plan market as a result of health care reform.

Other revenue increased $10.4 million, or 75% in 2018 compared to 2017 due primarily to increases of $7.7 million in sponsorship and advertising revenue and $4.6 million in lead generation revenue, offset partially by a decrease of $1.9 million in licensing revenue.

Cost of Revenue

Included in cost of revenue are payments related to health insurance plans 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 plans. 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.

The following table presents our cost of revenue for the years presented below (dollars in thousands):

	2019	Change $	Change %	2018	Change $	Change %	2017
Cost of revenue	$ 2,738	$ 1,510	123%	$ 1,228	$ 646	111%	582
% of total revenue	1%			—%			—%

2019 compared to 2018 – Cost of revenue increased $1.5 million in 2019, compared to $1.2 million in 2018, primarily due to an increased amount of payments to marketing partners with whom we have revenue sharing arrangements.

2018 compared to 2017 – Cost of revenue increased $0.6 million in 2018 compared to 2017, due primarily to an increased amount of payments to our marketing partners.

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. We recognize expenses in our direct member acquisition channel in the period in which they are incurred. We generally compensate our marketing partners for referrals based on the consumer submitting a health insurance application on our platform, regardless of whether the consumer's application is approved by the health insurance carrier, or for the referral of a Medicare-related lead to us by the marketing partner. Some of our partners such as pharmacies and hospital networks are not compensated for referrals to us as a result of legal requirements. These organizations have relationships with us to provide their customers and patients with our consumer experience and to help them find the plan that best meets their needs. Some of our marketing partners have tiered arrangements where the amount we pay the marketing partner per submitted application increases as the volume of submitted applications we receive from the marketing partner increases. We recognize these expenditures in the period when a marketing partner’s referral results in the submission of a health insurance application. In our Medicare business, our current emphasis is on reducing the contribution from the lead aggregator marketing channel that is characterized by high acquisition costs and emphasizing strategic partnerships including relationships with health care industry participants, such as pharmacies and hospital networks, and with affiliate organizations where our acquisition costs may be significantly lower.

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 or retargeting campaigns. We recognize expenses in our online advertising member acquisition channels in the period in which the consumer clicks on the advertisement. 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.

The following table presents our marketing and advertising expenses for the years presented below (dollars in thousands):

	2019	Change $	Change %	2018	Change $	Change %	2017
Marketing and advertising	$ 150,249	$ 67,310	81%	$ 82,939	$ 17,065	26%	$ 65,874
% of total revenue	30%			33%			35%

2019 compared to 2018 – Marketing and advertising expenses increased by $67.3 million or 81% in 2019, compared to 2018, primarily driven by a $59.3 million increase in Medicare plan related variable advertising costs and a $4.4 million increase in personnel costs due to higher headcount as we continued to invest in our marketing initiatives in Medicare-related products.

2018 compared 2017 – Marketing and advertising expenses increased $17.1 million, or 26%, in 2018, primarily due to our investment in Medicare-related marketing initiatives partially offset by a decline in IFP-related marketing costs. The higher expenses were due to $9.5 million increase in variable advertising costs, $5.7 million increase in personnel costs due to additional headcount, and $1.2 million higher in stock-based compensation expenses.

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.

The following table presents our customer care and enrollment expenses for the years presented below (dollars in thousands):

		Change			Change		
	2019	$	%	**2018**	$	%	**2017**
Customer care and enrollment	$ 134,304	$ 63,757	90%	$ 70,547	$ 11,364	19%	$ 59,183
% of total revenue	27%			28%			31%

2019 compared to 2018 – Customer care and enrollment expenses increased by $63.8 million, or 90%, in 2019 compared to 2018. This increase was primarily due to a $28.4 million increase in personnel costs and a $24.3 million increase for the external agents hired for the annual enrollment period in the fourth quarter. The increase in personnel costs resulted from higher headcount in the lower application volume quarters compared to the prior year as we started to hire and train agents earlier in 2019 in preparation for the annual enrollment period in the fourth quarter, a significant increase in overtime costs and average call length during the peak volume period in the fourth quarter, as well as the expenses incurred related to the opening of the new customer care center in Indianapolis.

2018 compared to 2017 – Customer care and enrollment expenses increased $11.4 million, or 19%, in 2018 compared to 2017, primarily due to growth in our Medicare and small group businesses, which resulted in increases of $6.3 million in personnel costs, $4.3 million in consulting costs, and $0.4 million in stock-based compensation expense, partially offset by a decrease of $0.4 million in facilities and other operating costs.

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 portion 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.

The following table presents our technology and content expenses for the years presented below (dollars in thousands):

		Change			Change		
	2019	$	%	**2018**	$	%	**2017**
Technology and content	$ 47,085	$ 15,115	47%	$ 31,970	$ (919)	(3)%	$ 32,889
% of total revenue	9%			13%			17%

2019 compared to 2018 – Technology and content expenses increased $15.1 million, or 47%, in 2019 compared to 2018, primarily driven by increases of $5.3 million in personnel and compensation costs, $3.3 million in consulting expenses, and $2.6 million in facilities and other operating costs.

2018 compared 2017 – Technology and content expenses decreased $0.9 million, or 3% in 2018 compared to 2017 as a result of a $2.8 million decrease in personnel costs, $0.4 million in depreciation and amortization expense, and $0.1 million in other professional fees, partially offset by increases of $1.0 million in consulting expenses, $0.4 million in facilities and other operating costs, and $0.3 million in stock-based compensation expense.

General and Administrative

General and administrative expenses include compensation and benefits costs for personnel 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.

The following table presents our general and administrative expenses for the years presented below (dollars in thousands):

		Change			Change		
	2019	**$**	**%**	**2018**	**$**	**%**	**2017**
General and administrative	$ 64,150	$ 18,322	40%	$ 45,828	$ 5,859	15%	$ 39,969
% of total revenue	13%			18%			21%

2019 compared to 2018 – General and administrative expenses increased by $18.3 million, or 40%, in 2019 compared to 2018, primarily driven by increases of $7.5 million in compensation and personnel costs, $5.4 million in stock-based compensation expense and $2.5 million in legal and professional fees.

2018 compared to 2017 – General and administrative expenses increased $5.9 million, or 15%, in 2018 compared to 2017, primarily due to increases of $3.2 million in personnel costs, $1.0 million in stock-based compensation expense, $1.1 million in legal and other professional fees, and $0.5 million in facilities and other operating costs.

Acquisition Costs

During 2017, we incurred $0.6 million of costs associated with our acquisition of Wealth, Health and Life Advisors, LLC, which was completed on January 22, 2018. Acquisition costs incurred in the year ended December 31, 2018 were immaterial. We did not incur any acquisition costs in the year ended December 31, 2019.

Change in Fair Value of Earnout Liability

During the year ended December 31, 2019, we recorded a $24.1 million increase in the fair value of earnout liability. During the year ended December 31, 2018, we recorded a $12.3 million increase in the fair value of earnout liability. The adjustments to fair value of earnout liability in both periods were due to an increase in the value of our common stock since our acquisition of GoMedigap in January 2018.

Restructuring Charges

In February 2018, our Board of Directors approved a plan to close our sales call center in Massachusetts and to terminate the employment of certain employees in certain other locations. As part of the plan, we eliminated approximately 110 full-time positions in the United States, representing approximately 10% of our workforce primarily in our customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. We incurred $1.9 million for employee termination benefits and related costs in the year ended December 31, 2018. The restructuring activities comprising the plan were completed during the year ended December 31, 2018. During the year ended December 31, 2019, we did not incur any restructuring costs.

The following table presents our restructuring charge for the years presented below (dollars in thousands):

		Change			Change		
	2019	**$**	**%**	**2018**	**$**	**%**	**2017**
Restructuring charge	$ —	$ (1,865)	(100)%	$ 1,865	$ 1,865	100%	$ —
% of total revenue	—%			1%			—%

Amortization of Intangible Assets

The following table presents our intangible asset amortization expense for the years presented below (dollars in thousands):

		Change			Change		
	2019	$	%	2018	$	%	2017
Amortization of intangible assets	$ 2,187	$ 96	5%	$ 2,091	$ 1,051	101%	$ 1,040
% of total revenue	—%			1%			1%

2019 compared to 2018 – Amortization expense was primarily related to intangible assets purchased through our acquisitions of PlanPrescriber and GoMedigap. Amortization expense in 2019 remained flat compared to 2018.

2018 compared to 2017 – Amortization expense for the year ended December 31, 2018 increased year over year due to the amortization of intangible assets from our acquisition of GoMedigap acquisition completed on January 2018.

Other Income, Net

The following table presents our other income, net for the years presented below (dollars in thousands):

		Change			Change		
	2019	$	%	2018	$	%	2017
Other income, net	$ 2,090	$ 1,335	177%	$ 755	$ (427)	(36)%	$ 1,182
% of total revenue	—%			—%			1%

Other income, net, primarily consisted of margin earned on commissions received from Medicare plan members transferred to us in 2010 through 2012 by a broker partner, whereby we became the broker of record on the underlying policies. In addition, other income, net included interest income earned on our invested cash, cash equivalents and marketable securities balances, offset by administrative bank fees, investment management fees and interest expense on capital lease obligations and our debt facility.

2019 compared to 2018 – Other income, net, increased by $1.3 million or 177% in 2019 compared to 2018 primarily driven by an increase in interest income and an increase in margin earned on from members previously transferred from a broker partner, partially offset by the accretion of debt related costs incurred from the debt facility that we entered into in 2018 and amended in 2019.

2018 compared to 2017 – Other income, net, decreased by $0.4 million in 2018, primarily due to an increase in interest expense as a result of the debt facility the we entered into in 2018 and realized losses.

Provision (Benefit) for Income Taxes

The following table presents our provision (benefit) for income taxes for the years presented below (dollars in thousands):

		Change			Change		
	2019	$	%	2018	$	%	2017
Provision (benefit) for income taxes	$ 16,612	$ 13,547	442%	$ 3,065	$ 36,761	(109)%	$ (33,696)
Effective tax rate	19.9%			92.7%			407.6%

2019 compared to 2018 – For the year ended December 31, 2019, we recorded a provision for income taxes of $16.6 million representing an effective tax rate of 19.9%, which is lower than the statutory federal rate primarily due to stock-based compensation windfalls and research and development tax credits, offset by state taxes and lobbying and other non-deductible expenses.

2018 compared to 2017 – For the year ended December 31, 2018, we recorded a provision for income taxes of $3.1 million, representing an effective tax rate of 92.7%, which was higher than the statutory federal rate due primarily to a one-time increase of $2.4 million in the valuation allowance on deferred tax assets related to certain state net operating loss carryforwards that are expected to expire unutilized. The remaining $0.7 million of provision for income taxes was impacted by lobbying and other non-deductible expenses, partially offset by research and development tax credits and stock-based compensation windfalls.

Segment Information

We report segment information based on how our chief executive officer, who is our chief operating decision maker, or CODM, regularly reviews our operating results, allocates resources, and makes decisions regarding our business operations. The performance measures of our operating segments include revenues and profit and loss. Our business structure is comprised of two operating segments:

- Medicare; and
- Individual, Family and Small Business.

Our CODM does not separately evaluate assets by segment, and therefore assets by segment are not presented.

The revenue in our Medicare segment consists primarily of commissions earned from our sale of Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans, and to a lesser extent, ancillary products sold to our Medicare-eligible customers, including but not limited to, dental and vision insurance, as well as our advertising program that allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us and our delivery and sale to third parties of Medicare-related health insurance leads generated by our ecommerce platforms and our marketing activities. In addition, in connection with our Medicare plan advertising program, we may use direct marketing channels including direct television and direct mail to generate leads for carriers participating in the program. In return for our services, we typically are paid either a flat amount, a monthly amount, or, in our individual and family health insurance sponsorship advertising program, a performance-based fee based on metrics such as submitted health insurance applications.

The revenue in our Individual, Family and Small Business segment consists primarily of commissions earned from our sale of individual and family and small business health insurance plans and ancillary products sold to our non-Medicare-eligible customers, including but not limited to, short-term, dental, vision, life, short-term disability and long-term disability insurance. To a lesser extent, the Individual, Family and Small Business segment consists of amounts earned from our online sponsorship program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website, our licensing to third parties the use of our health insurance ecommerce technology and our delivery and sale to third parties of individual and family health insurance leads generated by our ecommerce platforms and our marketing activities.

Marketing and advertising, customer care and enrollment, technology and content and general and administrative operating expenses that are directly attributable to a segment are reported within the applicable segment. Indirect marketing and advertising, customer care and enrollment and technology and content operating expenses are allocated to each segment based on usage. Other indirect general and administrative operating expenses are managed in a corporate shared services environment and, since they are not the responsibility of segment operating management, are not allocated to the operating segments and instead reported within Corporate.

Segment profit is calculated as total revenue for the applicable segment less direct and allocated marketing and advertising, customer care and enrollment, technology and content and general and administrative operating expenses, excluding stock-based compensation, depreciation and amortization expense and amortization of intangible assets.

The following table presents summary results of our operating segments for the years presented below (in thousands):

	2019	Change $	Change %	2018	Change $	Change %	2017
Revenue							
Medicare	$ 446,961	$ 236,391	112 %	$ 210,570	$ 68,122	48 %	$ 142,448
Individual, Family and Small Business	59,240	18,415	45 %	40,825	(7,433)	(15)%	48,258
Total revenue	$ 506,201	254,806	101 %	$ 251,395	60,689	32 %	$ 190,706
Segment profit							
Medicare segment profit	$ 155,234	94,390	155 %	$ 60,844	38,707	175 %	$ 22,137
Individual, Family and Small Business segment profit	23,368	17,565	303 %	5,803	(3,770)	(39)%	9,573
Total segment profit	178,602	111,955	168 %	66,647	34,937	110 %	31,710
Corporate	(45,374)	(12,378)	38 %	(32,996)	(6,026)	22 %	(26,970)
Stock-based compensation expense	(22,570)	(10,281)	84 %	(12,289)	(2,595)	27 %	(9,694)
Depreciation and amortization	(2,983)	(504)	20 %	(2,479)	358	(13)%	(2,837)
Change in fair value of earnout liability	(24,079)	(11,779)	96 %	(12,300)	(12,300)	100 %	—
Restructuring charge	—	1,865	(100)%	(1,865)	(1,865)	100 %	—
Acquisition costs	—	76	(100)%	(76)	545	(88)%	(621)
Amortization of intangible assets	(2,187)	(96)	5 %	(2,091)	(1,051)	101 %	(1,040)
Other income, net	2,090	1,335	177 %	755	(427)	(36)%	1,182
Income (loss) before income taxes	$ 83,499	$ 80,193	2,426 %	$ 3,306	$ 11,576	(140)%	$ (8,270)

2019 compared to 2018

Revenue **–** Medicare segment revenue grew $236.4 million or 112% in 2019 compared to 2018, primarily attributable to an increase in Medicare Advantage plan related commission revenue of $196.4 million. This was driven by 88% increase in approved Medicare Advantage applications in 2019 compared to 2018 and an increase in adjustment revenue for Medicare Advantage plans approved in prior periods. See *Note 2 – Revenue* in our *Notes to the Consolidated Financial Statements* for details.

Individual, Family and Small Business segment revenue grew $18.4 million or 45% in 2019 compared to 2018, primarily attributable to $11.1 million increase in non-qualified health plans commission revenue and $7.0 million increase in ancillary commission revenue. Most of these increases were contributed by the adjustment revenue.

Segment Profit **–** Our Medicare segment profit was $155.2 million in 2019, an increase of $94.4 million or 155%, compared to 2018. This was primarily driven by a $236.4 million increase in revenue, partially offset by a $142.0 million increase in operating expenses. The increase in operating expenses was mostly attributable to increased variable marketing costs and customer care and enrollment costs.

Individual, Family and Small Business segment profit was $23.4 million in 2019, an increase of $17.6 million or 303% compared to 2018. The increase was primarily driven by an $18.4 million increase in revenue and a $0.9 million increase in operating expenses.

2018 compared to 2017

Revenue **–** Medicare segment revenue increased $68.1 million, or 48%, in 2018 compared to 2017 primarily due to a $57.3 million increase in Medicare plan-related commission revenue and a $10.9 million increase in other revenue. The increase in Medicare commission revenue was primarily attributable to a 36% increase in Medicare approved applications in 2018 compared to 2017 and an increase in lifetime value of commissions per Medicare Supplement and Medicare Advantage approved applications. The increase in other Medicare revenue was driven primarily by carrier advertising programs and our sale of Medicare leads.

Our Individual, Family and Small Business segment revenue decreased $7.4 million, or 15%, in 2018 compared to 2017, primarily attributable to a $6.9 million decrease in commission revenue and a $0.5 million decrease in other revenue. The decrease in Individual, Family and Small Business segment commission revenue was primarily due to a 46% decline in individual and family health insurance approved applications in 2018 compared to 2017. The decrease in other revenue resulted from a decrease in individual and family health insurance applications submission during 2018 compared to 2017.

Segment Profit **–** Our Medicare segment profit was $60.8 million in 2018, a $38.7 million, or 175%, improvement compared to profit of $22.1 million in 2017. The improvement in profit from the Medicare segment in 2018 was primarily due to a $68.1 million increase in revenue, of which $57.3 million related to Medicare commission revenue and $10.9 million related to other revenue, partially offset by a $29.4 million increase in operating expenses. The increase in revenue from 2017 to 2018 was mostly due to an increase in approved applications. The increase in operating expenses was primarily attributable to an increase in personnel costs associated with higher headcount, an increase in variable advertising and customer care and enrollment expenses associated with the increase in applications and an increase in the number of licensed sales agents.

Individual, Family and Small Business segment profit was $5.8 million in 2018, a $3.8 million, or 39%, decrease compared to profit of $9.6 million from the Individual, Family and Small Business segment in 2017. The decrease in profit from the Individual, Family and Small Business segment in 2018 was primarily due to a $7.4 million decrease in revenue, of which $5.0 million related to a decrease in individual and family health plan revenue and $3.5 million related to ancillary plan revenue, partially offset by a $1.1 million increase in Small Business revenue. The decrease in Individual, Family and Small Business segment revenue from 2017 to 2018 was mainly due to a decline in individual and family health insurance approved members.

Liquidity and Capital Resources

We believe our current cash and cash equivalents, credit facility and expected cash collections will be sufficient to fund our operations for at least twelve months after the filing date of this Annual Report on Form 10-K. Our future capital requirements will depend on many factors, including our expected membership and retention rates, our level of investment in technology, marketing and advertising and our customer care initiatives. In addition, our cash position could be impacted by further acquisitions and investments we make to pursue our growth strategy. To the extent that available funds are insufficient to fund our future activities or to execute our financial strategy, we may raise additional capital through bank debt, or public or private equity or debt financing to the extent such funding sources are available.

As of December 31, 2019 and 2018, our cash and cash equivalents totaled $23.5 and $13.1 million, respectively. Cash equivalents, which are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, primarily consist of money market funds.

As of December 31, 2019 and 2018, we had 1.0 million and 0.8 million treasury shares, respectively, that were previously surrendered by employees to satisfy tax withholdings in connection with the vesting of certain restricted stock units. As of December 31, 2019 and 2018, we had a total of 11.6 million and 11.4 million shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the years presented below (in thousands):

	Year Ended December 31,		
	2019	2018	2017
Net cash used in operating activities	$ (71,492)	$ (3,230)	$ (15,541)
Net cash used in investing activities	$ (16,944)	$ (25,757)	$ (5,078)
Net cash provided by (used in) financing activities	$ 102,141	$ 1,860	$ (870)

The increase in cash and cash equivalents reflects $102.1 million cash provided by financing activities, partially offset by $71.5 million cash used in operating activities and $16.9 million cash used investing activities. As of December 31, 2019, we had a restricted cash balance of $3.4 million.

Operating Activities

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

Collection of commissions receivable depends upon the timing of our receipt of commission payments and associated commission reports from health insurance carriers. If we were to experience a delay in receiving a commission payment from a health insurance carrier within a quarter, our operating cash flows for that quarter could be adversely impacted.

A significant portion of our marketing and advertising expenses is driven by the number of health insurance applications submitted on our ecommerce platform. Since our marketing and advertising costs are expensed and generally paid as incurred and since commission revenue is recognized upon approval of a member but commission payments are paid to us over time, our operating cash flows could be adversely impacted by a substantial decrease in the volume of applications submitted during a quarter or negatively impacted by a substantial increase in attrition during a quarter. During the Medicare annual enrollment period, we experience an increase in the number of submitted Medicare-related health insurance applications and marketing and advertising expenses compared to outside of Medicare annual enrollment periods. Similarly, during the open enrollment periods for individual and family health insurance plans, we experience an increase in the number of submitted individual and family plan health insurance applications and marketing and advertising expenses compared to outside of open enrollment periods. The timing of enrollment periods impacts our cash flows typically during the third quarter as we increase the number of enrollment agents to get ready for the open enrollment in the fourth quarter.

Year Ended December 31, 2019 – Cash used in operating activities was $71.5 million in 2019, consisted of net income of $66.9 million and adjustments for non-cash items totaling $71.1 million, offset by cash used for working capital needs and other activities of $209.5 million. Adjustments for non-cash items primarily consisted of $24.1 million change in fair value of earnout liabilities, $22.6 million of stock-based compensation expense, $16.2 million increase in deferred income taxes, $3.8 million of amortization of internally-developed software, $3.0 million of depreciation and amortization and $2.2 million of amortization of intangible assets. The cash decrease resulting from changes in working capital in 2019 primarily consisted of $243.4 million increase in commissions receivable, partially offset by increases of $19.7 million in accounts payable, $8.8 million in accrued compensation and benefits, $1.9 million in accrued expenses and other liabilities, $1.7 million in deferred revenue and $1.0 million in accrued marketing expenses.

Year Ended December 31, 2018 – Cash used in operating activities was $3.2 million during 2018, consisted of net income of $0.2 million, offset by cash used for working capital needs and other activities of $38.6 million and adjustments for non-cash items of $35.1 million. Adjustments for non-cash items primarily consisted of $12.5 million of stock-based compensation expense, $12.3 million change in fair value of earnout liability, $2.8 million decrease in deferred income taxes, $2.5 million of depreciation and amortization, $2.2 million of amortization of internally-developed software and $2.1 million of amortization of intangible assets. The cash decrease resulting from changes in working capital during the year ended December 31, 2018 primarily consisted of an increase of $51.0 million in commissions receivable and a $2.1 million increase in trade receivables, partially offset by increases of $6.3 million in accrued marketing expenses, $5.1 million in accrued compensation and benefits, $1.4 million in accounts payable, $0.9 million in other current liabilities, $0.5 million in deferred revenue, and $0.2 million in prepaid expenses.

Year Ended December 31, 2017 – Cash used in operating activities was $15.5 million during 2017, consisted of a net income of $25.4 million, offset by cash used for working capital needs and other activities of $25.6 million and adjustments for non-cash items of $15.4 million. Adjustments for non-cash items primarily consisted of $9.7 million of stock-based compensation expense, $2.5 million of amortization of intangible assets and internally-developed software and $2.8 million of depreciation and amortization and $30.3 million decrease in deferred income taxes. The cash decrease resulting from changes in working capital during the year ended December 31, 2017 primarily consisted of decreases of $1.3 million in other liabilities, $3.4 million in accrued marketing expenses, $1.9 million in accounts payable and $0.5 million in deferred revenue and increases of $21.6 million in commissions receivable and $1.9 million in prepaid expenses and other current assets, partially offset by a $4.6 million increase in accrued compensation and benefits and a $0.5 million decrease in accounts receivable.

Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software to enhance our website and customer care operations, leasehold improvements related to facilities expansion, internal-use software and the purchase of certain intangible assets.

Year Ended December 31, 2019 – Net cash used in investing activities of $16.9 million during 2019 mainly consisted of $10.2 million of in capitalized internal-use software and website development costs and $6.6 million used to purchase property and equipment and other assets.

Year Ended December 31, 2018 – Net cash used in investing activities of $25.8 million during 2018 was due to $14.9 million of net cash used to acquire GoMedigap, $6.3 million of capitalized internal-use software and website development costs, and $4.5 million used to purchase property and equipment and other assets.

Year Ended December 31, 2017 – Net cash used in investing activities of $5.1 million during 2017 was due to $3.2 million in capitalized internal-use software and website development costs and $1.9 million used to purchase property and equipment and other assets.

Financing Activities

Year Ended December 31, 2019 – Net cash provided by financing activities of $102.1 million during 2019 was primarily attributable to $126.1 million proceeds from issuance of common stock, net of issuance costs and $5.5 million net proceeds from exercise of common stock options, partially offset by $14.3 million cash used to net-share settle the tax obligation related to vesting equity awards, $9.5 million acquisition-related contingent payments, and $5.0 million repayment of debt.

Year Ended December 31, 2018 – Net cash provided by financing activities of $1.9 million during 2018 was primarily due to $5.0 million proceeds from drawing on our line of credit, $2.7 million net proceeds from exercises of common stock options, partially offset by $4.5 million used to net-share settle the tax obligation related to vesting equity awards, $1.2 million of debt issuance costs, and $0.1 million for principal payments in connection with capital leases.

Year Ended December 31, 2017 – Net cash used in financing activities of $0.9 million during 2017 was primarily due to $1.0 million proceeds from the exercise of stock options and $1.8 million used to net-share settle the tax obligation related to vesting equity awards.

Acquisition

On January 22, 2018, we completed our acquisition of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. The acquisition price paid at closing of the transaction consisted of cash of $15.0 million, less $0.1 million cash acquired, and approximately 294,637 shares of our common stock. In addition, we are obligated to pay an additional $20.0 million in cash and 589,275 shares of our common stock, subject to the terms of the acquisition agreement and upon final determination of the achievement of certain milestones in 2018 and 2019. See *Note 5 – Fair Value Measurements* of our *Notes to Consolidated Financial Statements* for the discussion on the milestone payments.

Credit Agreement

We entered into a credit agreement with Royal Bank of Canada, or RBC, as administrative agent and collateral agent, (the “Credit Agreement”) in September 2018. The Credit Agreement provides for a $40.0 million secured asset-backed revolving credit facility with a $5 million letter of credit sub-facility. On December 20, 2019, we amended our revolving credit facility agreement with RBC (the “Amendment”) and increased the maximum borrowing amount to $75.0 million and extended the expiration to December 20, 2022.

The borrowing base under the Credit Agreement is comprised of an amount equal to (a) the lesser of (i) eighty percent (80%) of Eligible Commissions Receivables (as defined in the Credit Agreement) we actually collected during the immediately preceding period of three months or (ii) eighty percent (80%) of our Eligible Commission Receivables for the immediately

succeeding period of three months, plus (b) fifty percent (50%) of our Eligible Commission Receivables for the immediately succeeding period of six months (excluding the immediately succeeding period of three months), in each case subject to reserves established by RBC, or the Borrowing Base. The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes. We have the right to prepay the loans under the Credit Agreement in whole or in part at any time without penalty. Subject to availability under the Borrowing Base, amounts repaid may be reborrowed. Amounts not borrowed under the Credit Agreement are subject to a commitment fee of 0.5% per annum on the daily unused portion of the credit facility, to be paid in arrears on the first business day of each calendar quarter. At closing of the Credit Agreement, we paid a one-time facility fee of 1.75% of the total commitments of $40 million. We also paid a one-time closing fee of 0.5% of the new commitment of $75.0 million in connection with the Amendment. We are also obligated to pay other customary administration fees for a credit facility of this size and type.

As of December 31, 2018, we had $5.0 million outstanding principal amount under our revolving credit facility, which was repaid in full in January 2019. As of December 31, 2019, we had no outstanding principal amount under this revolving credit facility. See *Note 12 – Debt* of *Notes to Consolidated Financial Statements* included in this Annual Report on Form 10-K for additional information regarding this credit agreement and subsequent amendment.

Common Stock Issuance

In January 2019, we entered into an underwriting agreement relating to a public offering in which we issued 2,760,000 shares of common stock, including 360,000 shares of common stock issued pursuant to the exercise in full of the underwriters' option to purchase additional shares, at a price to the public of $48.50 per share. Net proceeds from the offering were approximately $126.2 million after deducting underwriting discounts and commissions and the expenses of the offering. We intend to use the net proceeds of the offering for general corporate purposes, including working capital.

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 comprehensive income 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;
- Business combinations;
- Realizability of long-lived assets; and
- Accounting for income taxes.

During the year ended December 31, 2019, there were no significant changes to our critical accounting policies and estimates.

Revenue Recognition

We are compensated by the receipt of commission payments from health insurance carriers whose health insurance policies are purchased through our ecommerce platforms or our customer care centers. We may also receive commission bonuses based on our attaining predetermined target sales levels for Medicare, individual and family, small business and ancillary health insurance products, or other objectives, as determined by the health insurance carrier, which we recognize as

commission revenue when we achieve the predetermined target sales levels or other objectives. In addition, we also generate revenue from non-commission revenue sources, which include sponsorship and advertising, technology licensing and lead referrals.

The core principle of ASC 606 is to recognize revenue upon the transfer of promised goods or services to customers in an amount that reflects the consideration the entity expects to be entitled to in exchange for those goods or services. Accordingly, we recognize revenue for our services in accordance with the following five steps outlined in ASC 606:

- *Identification of the contract, or contracts, with a customer.* A contract with a customer exists when (i) we enter into an enforceable contract with a customer that defines each party's rights regarding the goods or services to be transferred and identifies the payment terms related to these goods or services, (ii) the contract has commercial substance, and (iii) we determine that collection of substantially all consideration for goods or services that are transferred is probable based on the customer's intent and ability to pay the promised consideration.
- *Identification of the performance obligations in the contract.* Performance obligations promised in a contract are identified based on the goods or services that will be transferred to the customer that are both capable of being distinct, whereby the customer can benefit from the goods or service either on its own or together with other resources that are readily available from third parties or from us, and are distinct in the context of the contract, whereby the transfer of the goods or services is separately identifiable from other promises in the contract.
- *Determination of the transaction price.* The transaction price is determined based on the consideration to which we will be entitled in exchange for transferring goods or services to the customer.
- *Allocation of the transaction price to the performance obligations in the contract.* If the contract contains a single performance obligation, the entire transaction price is allocated to the single performance obligation. Contracts that contain multiple performance obligations require an allocation of the transaction price to each performance obligation based on a relative standalone selling price basis.
- *Recognition of revenue when, or as, we satisfy a performance obligation.* We satisfy performance obligations either over time or at a point in time, as discussed in further detail below. Revenue is recognized at the time the related performance obligation is satisfied by transferring the promised good or service to the customer.

***Commission Revenue* –** Our commission revenue results from approval of an application from health insurance carriers, which we define as our customers. Our commission revenue is primarily comprised of commissions from health insurance carriers which is computed using the estimated constrained lifetime values as the "constrained LTVs" of commission payments that we expect to receive.

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 the commission rates paid to us by the health insurance carriers. 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 purchased from the carrier by means of our health insurance exchange services.

For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission payment from insurance carriers once the plan is approved by the carrier and either a fixed, monthly, or annual commission payment beginning with and subsequent to the second plan year. 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. 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.

For individual and family, Medicare Supplement, small business and ancillary plans, our commissions generally represent a flat amount per member per month or a percentage of the premium amount collected by the carrier during the period that a member maintains coverage under a plan. Premium-based commissions are reported to us after the premiums are

collected by the carrier, generally on a monthly basis. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance plan is cancelled or we otherwise do not remain the agent on the policy.

We estimate commission revenue for each insurance product by using a portfolio approach to a group of approved members by plan type and the effective month of the relevant plan, which we refer to as "cohorts." We estimate the commissions we expect to collect for each approved member cohort by evaluating various factors, including but not limited to, commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship.

For Medicare-related, individual and family and ancillary health insurance plans, our services are complete once a submitted application is approved by the relevant health insurance carrier. Accordingly, we recognize commission revenue based upon the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application, net of an estimated constraint. We refer to these as estimated and constrained LTVs for the plan. We provide annual services in selling and renewing small business health insurance plans; therefore, we recognize small business health insurance plan commission revenue at the time the plan is approved by the carrier, and when it renews each year thereafter, equal to the estimated commissions we expect to collect from the plan over the following twelve months. Our estimate of commission revenue for each product line is based on a number of assumptions, which include, but are not limited to, estimating conversion of an approved member to a paying member, forecasting average plan duration and forecasting the commission amounts likely to be received per member. These assumptions are based on our analysis of historical trends for the different cohorts and incorporate management's judgment in interpreting those trends to apply the constraints discussed below. For our Medicare commission revenue, which represented 87%, 83% and 76% of our total commission revenue for the years ended December 31, 2019, 2018 and 2017, respectively, the estimated average plan duration used to calculate Medicare health insurance plan LTVs historically has been approximately 3 years for Medicare Advantage plans, approximately 5 years for Medicare Part D prescription drug plans, and approximately 5 years for Medicare Supplement plans. While the average plan duration has been approximately 3 years for Medicare Advantage plans, certain members may have a duration of up to 12 years. The estimated average plan duration used to calculate the LTV for major medical individual and family health insurance plans historically has been approximately 1.5 to 2 years. For short term health insurance plan LTVs, the estimated average plan duration historically has been less than six months. For all other ancillary health insurance plan LTVs, the estimated average plan duration has historically varied from 1 to 3 years. To the extent we make changes to the assumptions we use to calculate constrained LTVs, we recognize any material impact of the changes to commission revenue in the reporting period in which the change is made, including revisions of estimated lifetime commissions either below or in excess of previously estimated constrained LTV recognized as revenue.

We recognize revenue for members approved during the period by applying the latest estimated constrained LTV for that product. We recognize adjustment revenue for members approved in prior periods when our cash collections are different from the estimated constrained LTVs. Adjustment revenue is a result of a change in estimate of expected cash collections when actual cash collections have indicated a trend that is different from the estimated constrained LTV for the revenue recognized at the time of approval. We recognize adjustment revenue when we do not believe there is a probable reversal. We assess the risk of reversal based on statistical analysis given historical information and consideration of the constraints used at the time of approval.

Adjustment revenue can have a significant favorable or unfavorable impact on our revenue and we seek to enhance our LTV estimation models to improve the accuracy and to reduce the fluctuations of our LTV estimates. As we continue to evaluate our LTV estimation models, we may in the future make further changes based on a number of factors and such changes could result in significant increases or decreases in our revenue.

Other Revenue

Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee, which is recognized over the period that advertising is displayed, and often a performance fee based on metrics such as submitted health insurance applications, which is recognized when control has been transferred. We also offer Medicare advertising services, which include website development, hosting and maintenance. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue as control is transferred ratably over the service period.

Our commercial technology licensing business allows carriers the use of our ecommerce platform to offer their own health insurance policies on their websites and agents to utilize our technology to power their online quoting, content and application submission processes. Typically, we are paid a one-time implementation fee, which we recognize as control is transferred on a straight-line basis over the estimated term of the customer relationship (generally the initial term of the agreement), commencing once the technology is available for use by the third party, and a performance fee based on metrics such as submitted health insurance applications. The metrics used to calculate performance fees for both sponsorship and advertising and technology licensing are based on performance criteria that are either measured based on data tracked by us, or based on data tracked by the third party. In instances where the performance criteria data is tracked by us, we recognize revenue in the period of performance and when all other revenue recognition criteria has been met. In instances where the performance criteria data is tracked by the third party, we recognize revenue when reversal of such amount is not likely to occur. Typically, this occurs through our receipt of a cash payment from the third party along with a detailed statement containing the data that is tracked by the third party.

Deferred Revenue

Deferred revenue includes deferred technology licensing implementation fees and amounts billed for performance obligations, including professional services, undelivered performance obligations, as well as amounts billed or collected from sponsorship or technology licensing customers in advance of our performing our service for such customers. It also includes the amount by which both unbilled and billed services provided under our technology licensing arrangements exceed the revenue recognized to date.

Stock-Based Compensation

We recognize stock-based compensation expense in the accompanying Consolidated Statements of Comprehensive Income based on the fair value of our stock-based awards over their respective vesting periods, which is generally four years. The estimated grant date fair value of our stock options is determined using the Black-Scholes-Merton pricing model and a single option award approach. The weighted-average expected term for stock options granted is calculated using historical option exercise behavior. The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through December 31, 2019, we had not declared or paid any cash dividends, and we do not expect to pay any in the foreseeable future. We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options. Expected volatility is determined using a combination of the implied volatility of publicly traded options in our stock and historical volatility of our stock price. The estimated attainment of performance-based awards and related expense is based on the expectations of revenue and earnings target achievement. The estimated fair value of performance awards with market conditions is determined using the Monte-Carlo simulation model. The assumptions used in calculating the fair value of stock-based payment awards and expected attainment of performance-based awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected term and volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions could significantly impact the valuation of such instruments.

Business Combinations

We include the results of operations of acquired businesses prospectively from the acquisition date. We allocate the fair value of the purchase consideration of our acquired businesses to the tangible and intangible assets acquired and liabilities assumed based on their estimated fair values at the acquisition date. The excess of the fair value of purchase consideration over the fair values of these identifiable assets and liabilities is recorded as goodwill.

When determining the fair values of assets acquired and liabilities assumed, we make significant estimates and assumptions. When provisional amounts are recorded in the reporting period in which a business combination occurs, adjustments to the provisional amounts may be subsequently recognized to reflect new information obtained about facts and circumstances that existed as of the acquisition date that would have affected the measurement of the amounts recognized at the acquisition date. Adjustments to the provisional amounts identified during the measurement period, which is a period not to exceed one year from the acquisition date, are reported in the period the adjustment is identified by means of an adjustment to goodwill, with the effect on earnings measured as if the provisional amounts had been completed at the acquisition date. Adjustments to amounts recognized in a business combination that occur after the end of the measurement period are recognized in current period operations.

Realizability of Long-Lived Assets

We assess the realizability of our long-lived assets, including intangible assets and goodwill, whenever events or changes in circumstances indicate the carrying value of such assets may not be recoverable. Factors that we consider in deciding when to perform an impairment review include significant negative industry or economic trends or significant changes or planned changes in our use of the assets. Additionally, we test goodwill and our other indefinite-lived intangible assets for impairment on an annual basis on or about November 30 of each year. When performing the annual goodwill impairment test we first assess qualitative factors to determine whether it is “more likely than not” that the fair value of our reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test. When performing the annual impairment test for indefinite-lived intangible assets other than goodwill we first assess qualitative factors to determine whether it is “more likely than not” that the indefinite-lived intangible is impaired.

If events or changes in circumstances indicate the carrying value of such assets may not be recoverable, for long lived assets other than goodwill, including intangible assets with finite useful lives, which include purchased technology, pharmacy relationships, trade names, and trademarks, we measure the recoverability of assets that will continue to be used in our operations by comparing the carrying value of the asset grouping to our estimate of the related total future undiscounted net cash flows. If an asset grouping’s carrying value is not recoverable through the related undiscounted cash flows, the asset grouping is considered to be impaired. The impairment charge is calculated as the amount by which the asset grouping’s carrying value exceeds its fair value, which is defined as the price that would be received from selling an asset in an orderly transaction between market participants at the measurement date.

We must make subjective judgments in determining the independent cash flows that can be related to specific asset groupings. In addition, we must make subjective judgments regarding the remaining useful lives of assets with finite useful lives. When we determine that the useful life of an asset is shorter than we had originally estimated, we accelerate the rate of amortization over the new remaining useful life of the asset.

Accounting for Income Taxes

We account for income taxes using the liability method. Deferred income taxes are determined based on the differences between the financial reporting and tax bases of assets and liabilities, using enacted statutory tax rates in effect for the year in which the differences are expected to reverse.

Since tax laws and financial accounting standards differ in their recognition and measurement of assets, liabilities, equity, revenues, expenses, gains and losses, differences arise between the amount of taxable income and pretax financial income for a year and between the tax bases of assets or liabilities and their reported amounts in our financial statements. Because we assume that the reported amounts of assets and liabilities will be recovered and settled, respectively, a difference between the tax basis of an asset or a liability and its reported amount in the balance sheet will result in a taxable or a deductible amount in some future years when the related liabilities are settled or the reported amounts of the assets are recovered, which gives rise to a deferred tax asset or liability. We must then assess the likelihood that our deferred tax assets will be recovered from future taxable income and to the extent we believe that recovery does not meet the more likely than not criteria, we must establish a valuation allowance. Management judgment is required in determining any valuation allowance recorded against our net deferred tax assets.

As part of the process of preparing our consolidated financial statements, we are required to estimate our income taxes. This process involves estimating our actual current tax expense together with assessing temporary differences that may result in deferred tax assets.

Assessing the realizability of our deferred tax assets is dependent upon several factors, including the likelihood and amount, if any, of future taxable income in relevant jurisdictions during the periods in which those temporary differences become deductible. We forecast taxable income by considering all available positive and negative evidence, including our history of operating income and losses and our financial plans and estimates that we use to manage the business. These assumptions require significant judgment about future taxable income. As a result, the amount of deferred tax assets considered realizable is subject to adjustment in future periods if estimates of future taxable income change.

Future changes in various factors, such as the amount of stock-based compensation we record during the period and the related tax benefit we realize upon the exercise of employee stock options, potential limitations on the use of our federal and

state net operating loss credit carry forwards, pending or future tax law changes including rate changes and the tax benefit from or limitations on our ability to utilize research and development credits, the amount of non-deductible lobbying and acquisition-related costs, changes in our valuation allowance and state and foreign taxes, would impact our estimates, and as a result, could affect our effective tax rate and the amount of income tax expense we record, and pay, in future periods.

Contractual Obligations and Commitments

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and contractual service and licensing obligations as of December 31, 2019 (in thousands):

Years Ending December 31,	Operating Lease Obligations*	Service and Licensing Obligations	Total Obligations
2020	$ 7,040	$ 3,073	$ 10,113
2021	6,529	1,825	8,354
2022	5,266	692	5,958
2023	6,103	444	6,547
2024	5,909	229	6,138
Thereafter	21,983	—	21,983
Total	$ 52,830	$ 6,263	$ 59,093

* See *Note 11 – Leases* of our *Notes to Consolidated Financial Statements* for details of our operating lease obligations.

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.

Off-Balance Sheet Arrangements

We do not have any off-balance sheet arrangements, investments in special purpose entities or undisclosed borrowings or debt. We are also not engaged in any derivative contracts or synthetic leases.

Recent Accounting Pronouncements

See *Note 1 – Summary of Business and Significant Accounting Policies* in the *Notes to Consolidated Financial Statements* for the recently issued accounting standards that could have an effect on us.

ITEM 7A. 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. Our cash and cash equivalents are summarized as follows (in thousands):

	December 31, 2019	December 31, 2018
Cash [1]	$ 16,205	$ 12,766
Money market funds [2]	7,261	323
Total cash and cash equivalents	$ 23,466	$ 13,089

[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] As of December 31, 2019 and 2018, money market funds consisted of investments 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.

We do not require collateral or other security for our total accounts receivable. As of December 31, 2019, three customers represented 22%, 20%, and 20%, respectively, for a combined total of 62% of our $591.6 million total outstanding accounts receivable balance. As of December 31, 2018, three customers represented 19%, 19%, and 19%, respectively, or a combined total of 57%, of our $349.5 million total outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable as of December 31, 2019 and December 31, 2018. We believe the potential for collection issues with any of our customers was minimal as of December 31, 2019. Accordingly, our estimate for uncollectible amounts as of December 31, 2019 was immaterial.

Significant Customers

Substantially all revenue for the years ended December 31, 2019, 2018, and 2017 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue are presented in the table below:

	Year Ended December 31,		
	2019	2018	2017
Humana	26%	22%	20%
UnitedHealthcare [1]	19%	19%	23%
Aetna [2]	17%	14%	10%

[1] UnitedHealthcare also includes other carriers owned by UnitedHealthcare.
[2] Aetna also includes other carriers owned by Aetna.

Foreign Currency Exchange Risk

To date, substantially all of our revenue has been derived from transactions denominated in United States Dollars. We have exposure to adverse changes in exchange rates associated with operating expenses of our foreign operations, which are denominated in Chinese Yuan Renminbi. Foreign currency fluctuations have not had a material impact historically on our results of operations; however, there can be no assurance that future fluctuations will not have material adverse effects on our results of operations. We have not engaged in any foreign currency hedging or other derivative transactions to date.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

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Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of eHealth, Inc.

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of eHealth, Inc. (the Company) as of December 31, 2019 and 2018, the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2019, and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2019 and 2018, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2019, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated March 2, 2020 expressed an unqualified opinion thereon.

Basis for Opinion

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

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

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of the critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Revenue recognition: Estimated constrained lifetime value of commission revenue

Description of the Matter	The Company recognized commission revenue of approximately $466.7 million in 2019 and the related commissions receivable were approximately $589.2 million at December 31, 2019. As described in Notes 1 and 2 to its consolidated financial statements, the Company's commission revenue is recognized in the amount of the total estimated lifetime value of the commissions expected to be received when a member obtains a plan through the Company and is approved by the carrier ("LTV"). Auditing management's determination of the LTV of commission revenue was especially complex and highly judgmental due to the complexity of the models used and the subjectivity required by the Company to estimate the amount and timing of future cash flows (which can extend up to 12 years), calculate the amount of commission revenue that is probable of not being reversed (the constraint), and determine the timing and amount of any adjustment revenue that results from changes in the estimates of previously recorded LTV. For the Medicare Advantage LTV, which comprises the substantial majority of commission revenue, the Company utilized statistical tools and methodologies to estimate member attrition, which is a key driver when estimating the amount and timing of future cash flows and can be particularly volatile during the first several years. To determine the constraint to be applied to LTV, the Company evaluates the difference between prior estimates of LTV and actual cash received and applies judgment to determine the constraint to apply. For the ongoing evaluation of the constraint, the Company also analyzes whether circumstances have changed and considers any known or potential modifications to the inputs into LTV and the factors that can impact the amount of cash expected to be collected in future periods such as commission rates, carrier mix, estimated average plan duration, changes in laws and regulations, and cancellations of insurance plans offered by health insurance carriers with which the Company has a relationship. The Company also compares actual versus expected cash collections of previously recorded LTV and assesses qualitative and quantitative factors to determine whether adjustment revenue should be recognized and, if so, the amount and timing of such.
How We Addressed the Matter in Our Audit	We obtained an understanding, evaluated the design, and tested the operating effectiveness of controls over the Company's process to estimate the amount and timing of future cash flows and LTV. These processes and controls include those covering the models and methods used to calculate LTV, the use of management judgment to determine the constraint applied to LTV, management's evaluation of any required adjustments to previously recorded LTV estimates, and the completeness and accuracy of the data used in such estimates and calculations. Our audit procedures also included, among others, evaluating the methodology used and significant assumptions discussed above, and testing the completeness and accuracy of the underlying data used by the Company. We involved our valuation specialists to assist in our testing of the estimated average plan duration, which includes member attrition assumptions, used to develop the Medicare Advantage LTV, including performing certain corroborative calculations. We inspected and compared the results of the Company's retrospective review analysis of historical estimates for certain plan effective years to historical cash collection experience, including reperforming the calculations and validating the completeness and accuracy of the underlying data used. In addition, we performed inquiries of key personnel regarding their evaluation of changes to LTV, the adjustments made to the constraint for current and expected future economic conditions, and any decisions on the timing and amount of adjustment revenue recognized. We also reviewed analyst reports, press releases, and other relevant third-party and/or industry trends data for contrary evidence.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2000.
Redwood City, California
March 2, 2020

EHEALTH, INC.

CONSOLIDATED BALANCE SHEETS
(In thousands, except per share amounts)

	December 31, 2019*	December 31, 2018
Assets		
Current assets:		
Cash and cash equivalents	$ 23,466	$ 13,089
Accounts receivable	2,332	3,601
Commissions receivable — current	174,526	134,190
Prepaid expenses and other current assets	7,822	5,288
Total current assets	208,146	156,168
Commissions receivable — non-current	414,696	211,668
Property and equipment, net	10,518	7,684
Operating lease right-of-use assets	36,621	—
Restricted cash	3,354	—
Other assets	18,004	11,276
Intangible assets, net	10,062	12,249
Goodwill	40,233	40,233
Total assets	$ 741,634	$ 439,278
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 24,554	$ 5,688
Accrued compensation and benefits	29,578	20,763
Accrued marketing expenses	12,041	11,013
Earnout liability — current	37,273	20,730
Lease liabilities — current	4,759	—
Deferred revenue	2,570	876
Other current liabilities	2,210	1,549
Total current liabilities	112,985	60,619
Debt	—	5,000
Earnout liability — non-current	—	19,270
Deferred income taxes — non-current	64,130	47,901
Lease liabilities — non-current	34,305	—
Other non-current liabilities	3,050	3,339
Stockholders' equity:		
Preferred stock, par value $0.001 per share; 10,000 authorized; none issued and outstanding	—	—
Common stock, par value $0.001 per share; 100,000 authorized; 34,752 and 30,863 issued as of December 31, 2019 and 2018, respectively; 23,136 and 19,437 outstanding as of December 31, 2019 and 2018, respectively	35	31
Additional paid-in capital	455,159	298,024
Treasury stock, at cost: 11,616 and 11,426 shares as of December 31, 2019 and 2018, respectively	(199,998)	(199,998)
Retained earnings	271,852	204,965
Accumulated other comprehensive income	116	127
Total stockholders' equity	527,164	303,149
Total liabilities and stockholders' equity	$ 741,634	$ 439,278

* Reflects the impact from the adoption of ASC 842 on January 1, 2019. See Note 11 – Leases for details.

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

EHEALTH, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(In thousands, except per share amounts)

	Year Ended December 31,		
	2019	2018	2017
Revenue			
Commission	$ 466,676	$ 227,211	$ 176,883
Other	39,525	24,184	13,823
Total revenue	506,201	251,395	190,706
Operating costs and expenses			
Cost of revenue	2,738	1,228	582
Marketing and advertising	150,249	82,939	65,874
Customer care and enrollment	134,304	70,547	59,183
Technology and content	47,085	31,970	32,889
General and administrative	64,150	45,828	39,969
Change in fair value of earnout liability	24,079	12,300	—
Amortization of intangible assets	2,187	2,091	1,040
Restructuring charges	—	1,865	—
Acquisition costs	—	76	621
Total operating costs and expenses	424,792	248,844	200,158
Income (loss) from operations	81,409	2,551	(9,452)
Other income, net	2,090	755	1,182
Income (loss) before provision (benefit) for income taxes	83,499	3,306	(8,270)
Provision (benefit) for income taxes	16,612	3,065	(33,696)
Net income	$ 66,887	$ 241	$ 25,426
Net income per share:			
Basic	$ 2.90	$ 0.01	$ 1.37
Diluted	$ 2.73	$ 0.01	$ 1.33
Weighted-average number of shares used in per share amounts:			
Basic	23,075	19,294	18,512
Diluted	24,539	20,409	19,047
Comprehensive income:			
Net income	$ 66,887	$ 241	$ 25,426
Foreign currency translation adjustment, net of taxes	(11)	(75)	29
Comprehensive income	$ 66,876	$ 166	$ 25,455

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

EHEALTH, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands)

	Common Stock		Additional Paid-in Capital	Treasury Stock		Retained Earnings	Accumulated Other Comprehensive Income	Total Stockholders' Equity
	Shares	Amount		Shares	Amount			
Balance at December 31, 2016	**29,492**	**$ 29**	**$ 272,778**	**(11,136)**	**$(199,998)**	**$ 179,298**	**$ 173**	**$ 252,280**
Issuance of common stock in connection with exercise of common stock options	388	1	1,036	—	—	—	—	1,037
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(1,802)	(102)	—	—	—	(1,802)
Stock-based compensation expense	—	—	9,694	—	—	—	—	9,694
Foreign currency translation adjustment, net of taxes	—	—	—	—	—	—	29	29
Net income	—	—	—	—	—	25,426	—	25,426
Balance at December 31, 2017	**29,880**	**30**	**281,706**	**(11,238)**	**(199,998)**	**204,724**	**202**	**286,664**
Issuance of common stock in connection with exercise of common stock options	688	1	2,687	—	—	—	—	2,688
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(4,504)	(188)	—	—	—	(4,504)
Shares issued for GMG acquisition	295	—	5,595	—	—	—	—	5,595
Stock-based compensation expense	—	—	12,540	—	—	—	—	12,540
Foreign currency translation adjustment, net of taxes	—	—	—	—	—	—	(75)	(75)
Net income	—	—	—	—	—	241	—	241
Balance at December 31, 2018	**30,863**	**31**	**298,024**	**(11,426)**	**(199,998)**	**204,965**	**127**	**303,149**
Issuance of common stock in connection with exercise of common stock options	834	1	5,534	—	—	—	—	5,535
Repurchase of shares to satisfy employee tax withholding obligations	—	—	(14,281)	(190)	—	—	—	(14,281)
Shares issued in equity offering	2,760	3	126,048	—	—	—	—	126,051
Settlement of earnout liability	295	—	17,264	—	—	—	—	17,264
Stock-based compensation expense	—	—	22,570	—	—	—	—	22,570
Foreign currency translation adjustment, net of taxes	—	—	—	—	—	—	(11)	(11)
Net income	—	—	—	—	—	66,887	—	66,887
Balance at December 31, 2019	**34,752**	**$ 35**	**$ 455,159**	**(11,616)**	**$(199,998)**	**$ 271,852**	**$ 116**	**$ 527,164**

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

EHEALTH, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended December 31,		
	2019	2018	2017
Operating activities			
Net Income	$ 66,887	$ 241	$ 25,426
Adjustments to reconcile net income to net cash used in operating activities:			
Depreciation and amortization	2,983	2,479	2,837
Amortization of internally developed software	3,821	2,201	1,464
Amortization of intangible assets	2,187	2,091	1,040
Stock-based compensation expense	22,570	12,540	9,694
Deferred income taxes	16,197	2,812	(30,341)
Change in fair value of earnout liability	24,079	12,300	—
Other non-cash items	(755)	675	(101)
Changes in operating assets and liabilities:			
Accounts receivable	1,270	(2,127)	473
Commissions receivable	(243,364)	(50,967)	(21,640)
Prepaid expenses and other assets	(466)	232	(1,933)
Accounts payable	19,694	1,414	(1,866)
Accrued compensation and benefits	8,814	5,133	4,578
Accrued marketing expenses	1,028	6,320	(3,365)
Deferred revenue	1,694	491	(466)
Accrued restructuring charges	—	—	—
Accrued expenses and other liabilities	1,869	935	(1,341)
Net cash used in operating activities	(71,492)	(3,230)	(15,541)
Investing activities			
Capitalized internal-use software and website development costs	(10,231)	(6,294)	(3,210)
Purchases of property and equipment and other assets	(6,641)	(4,534)	(1,868)
Payments for security deposits	(72)	—	—
Acquisition of business, net of cash acquired	—	(14,929)	—
Cash used in investing activities	(16,944)	(25,757)	(5,078)
Financing activities			
Proceeds from issuance of common stock, net of issuance costs	126,051	—	—
Net proceeds from exercise of common stock options	5,535	2,688	1,037
Repurchase of shares to satisfy employee tax withholding obligations	(14,281)	(4,504)	(1,802)
Proceeds from line of credit	—	5,000	—
Debt issuance costs	(517)	(1,221)	—
Repayment of debt	(5,000)	—	—
Acquisition-related contingent payments	(9,542)	—	—
Principal payments in connection with leases	(105)	(103)	(105)
Net cash provided by (used in) financing activities	102,141	1,860	(870)
Effect of exchange rate changes on cash, cash equivalents and restricted cash	26	(77)	1
Net increase (decrease) in cash, cash equivalents and restricted cash	13,731	(27,204)	(21,488)
Cash, cash equivalents and restricted cash at beginning of period	13,089	40,293	61,781
Cash, cash equivalents and restricted cash at end of period	$ 26,820	$ 13,089	$ 40,293
Supplemental disclosure of non-cash investing and financing activities			
Supplemental disclosure of cash flows			
Cash paid for interest	$ 42	$ 44	$ 20
Cash refunds from (paid for) income taxes, net	$ 741	$ (139)	$ (219)

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

Note 1 – Summary of Business and Significant Accounting Policies

Description of Business – eHealth, Inc. (the "Company," "eHealth," "we" or "us") is a leading private health insurance exchange 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*, *www.PlanPrescriber.com and www.GoMedigap.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 – Our consolidated financial statements include the accounts of eHealth, Inc. and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation. The consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP.") Certain prior period amounts have been reclassified to conform with our current period presentation. Our Consolidated Balance Sheet as of December 31, 2019 reflects the impact from the adoption of ASC 842 on January 1, 2019. See Note 11 – Leases for details.

Operating Segments – We report segment information based on how our chief executive officer, who is our chief operating decision maker ("CODM"), regularly reviews our operating results, allocates resources and makes decisions regarding our business operations. The performance measures of our segments include total revenue and profit (loss). Our business structure is comprised of two operating segments:

- Medicare; and
- Individual, Family and Small Business

The Medicare segment consists primarily of commissions earned from our sale of Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans, and to a lesser extent, ancillary products sold to our Medicare-eligible customers, including but not limited to, dental and vision insurance, as well as our advertising program that allows Medicare-related carriers to purchase advertising on a separate website developed, hosted and maintained by us and our delivery and sale to third parties of Medicare-related health insurance leads generated by our ecommerce platforms and our marketing activities.

The Individual, Family and Small Business segment consists primarily of commissions earned from our sale of individual and family and small business health insurance plans and ancillary products sold to our non-Medicare-eligible customers, including but not limited to, dental, vision, life, short term disability and long term disability insurance. To a lesser extent, the Individual, Family and Small Business segment consists of amounts earned from our online sponsorship program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website, our licensing to third parties the use of our health insurance ecommerce technology and our delivery and sale to third parties of individual and family health insurance leads generated by our ecommerce platforms and our marketing activities.

Marketing and advertising, customer care and enrollment, technology and content and general and administrative operating expenses that are directly attributable to a segment are reported within the applicable segment. Indirect marketing and advertising, customer care and enrollment and technology and content operating expenses are allocated to each segment based on usage. Other indirect general and administrative operating expenses are managed in a corporate shared services environment and, since they are not the responsibility of segment operating management, are not allocated to the two operating segments and are presented as a reconciling item to our consolidated financial results.

Segment profit is calculated as total revenue for the applicable segment less direct and allocated marketing and advertising, customer care and enrollment, technology and content and general and administrative operating expenses, excluding stock-based compensation, depreciation and amortization expense and amortization of intangible assets.

Use of Estimates – The preparation of consolidated financial statements and related disclosures in conformity with U.S. GAAP requires management to make estimates, judgments and assumptions that affect the amounts reported and disclosed in the consolidated financial statements and accompanying notes. On an ongoing basis, we evaluate our estimates, including those related to, but not limited to, the useful lives of intangible assets, fair value of investments, recoverability of intangible assets, the commissions we expect to collect for each approved member cohort, valuation allowance for deferred income taxes, provision for income taxes and the assumptions used in determining stock-based compensation. We base our estimates of the carrying value of certain assets and liabilities on historical experience and on various other assumptions that we believe to be reasonable. Actual results may differ from these estimates.

Cash Equivalents – We consider all investments with an original maturity of 90 days or less from the date of purchase to be cash equivalents. Cash and cash equivalents are stated at fair value.

Property and Equipment – Property and equipment are stated at cost, less accumulated depreciation and amortization. Finance lease amortization expenses are included in depreciation expense in our Consolidated Statements of Comprehensive Income. Maintenance and minor replacements are expensed as incurred. Depreciation and amortization is computed using the straight-line method based on estimated useful lives as follows:

Computer equipment and software	3	to	5 years
Office equipment and furniture	5 years		
Leasehold improvements*	5	to	10 years

____
* Lesser of useful life or related lease term

See *Note 4 – Supplemental Financial Statement Information* of the *Notes to Consolidated Financial Statements* for additional information regarding our property and equipment.

Business Combinations – We allocate the fair value of the acquisition consideration transferred in exchange for our acquired businesses to the tangible assets, liabilities and intangible assets acquired based on their estimated fair values at the acquisition date. The excess of the fair value of acquisition consideration over the fair values of these identifiable assets and liabilities is recorded as goodwill. Acquisition-related costs are recognized separately from the business combination and are expensed as incurred.

Goodwill and Intangible Assets – Goodwill represents the excess of the consideration paid over the estimated fair value of assets acquired and liabilities assumed in a business combination. In the event that we realign our reporting units, we allocate our goodwill to the new reporting units using the relative fair value approach. We test our goodwill for impairment on an annual basis in the fourth quarter of each year or whenever events or changes in circumstances indicate that the asset may be impaired. Factors that we consider in deciding when to perform an impairment test include significant negative industry or economic trends or significant changes or planned changes in our use of the intangible assets.

Our goodwill is allocated among our two segments, (1) Medicare and (2) Individual, Family and Small Business. No goodwill impairment has been identified in any of the years presented in the accompanying Consolidated Statements of Comprehensive Income.

Intangible assets are reviewed for impairment whenever events or changes in circumstances indicate a potential reduction in their fair values below their respective carrying amounts. Intangible assets with finite useful lives, which include purchased technology, pharmacy and customer relationships, trade names, and certain trademarks, are amortized over their estimated useful lives.

Goodwill and intangible assets are considered non-financial assets and therefore, subsequent to their initial recognition are not revalued at fair value each reporting period unless an impairment charge is recognized.

We must make subjective judgments in determining the independent cash flows that can be related to specific asset groupings. In addition, we must make subjective judgments regarding the remaining useful lives of assets with finite useful lives. When we determine that the useful life of an asset is shorter than we had originally estimated, we accelerate the rate of amortization over the assets' new, remaining useful life. We evaluated the remaining useful lives of our intangible assets with finite lives and determined no material adjustments to the remaining lives were required. See *Note 4 – Supplemental Financial*

Statement Information of the *Notes to Consolidated Financial Statements* for additional information regarding our intangible assets.

Other Long-Lived Assets – We evaluate other long-lived assets for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. If such assets are considered to be impaired, the impairment to be recognized is measured by the amount by which the carrying amount of the asset exceeds its fair value.

Revenue Recognition – In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU 2014-09, *Revenue from Contracts with Customers (ASC 606)*, requiring 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 in exchange for those goods or services. Effective January 1, 2018, we adopted the requirements of Accounting Standards *ASC 606* using the full retrospective method, which permits adjusting prior periods as if ASC 606 had been in effect as of the beginning of the earliest period presented.

We are compensated by the receipt of commission payments from health insurance carriers whose health insurance policies are purchased through our ecommerce platforms or our customer care centers. We may also receive commission bonuses based on our attaining predetermined target sales levels for Medicare, individual and family, small business and ancillary health insurance products, or other objectives, as determined by the health insurance carrier, which we recognize as commission revenue when we achieve the predetermined target sales levels or other objectives. In addition, we also generate revenue from non-commission revenue sources, which include online sponsorship and advertising, technology licensing and lead referrals. Payment of commissions typically commences within 60 days from the effective date. Payment terms for non-commission revenue are typically 30 days from the invoice date.

We account for revenue under ASC 606 – Revenue from Contracts with Customers. The core principle of ASC 606 is to recognize revenue upon the transfer of promised goods or services to customers in an amount that reflects the consideration the entity expects to be entitled in exchange for those goods or services. Accordingly, we recognize revenue for our services in accordance with the following five steps outlined in ASC 606:

- *Identification of the contract, or contracts, with a customer.* A contract with a customer exists when (i) we enter into an enforceable contract with a customer that defines each party’s rights regarding the goods or services to be transferred and identifies the payment terms related to these goods or services, (ii) the contract has commercial substance, and (iii) we determine that collection of substantially all consideration for goods or services that are transferred is probable based on the customer’s intent and ability to pay the promised consideration.
- *Identification of the performance obligations in the contract.* Performance obligations promised in a contract are identified based on the goods or services that will be transferred to the customer that are both capable of being distinct, whereby the customer can benefit from the goods or service either on its own or together with other resources that are readily available from third parties or from us, and are distinct in the context of the contract, whereby the transfer of the goods or services is separately identifiable from other promises in the contract.
- *Determination of the transaction price.* The transaction price is determined based on the consideration to which we will be entitled in exchange for transferring goods or services to the customer.
- *Allocation of the transaction price to the performance obligations in the contract.* If the contract contains a single performance obligation, the entire transaction price is allocated to the single performance obligation. Contracts that contain multiple performance obligations require an allocation of the transaction price to each performance obligation based on a relative standalone selling price basis.
- *Recognition of revenue when, or as, we satisfy a performance obligation.* We satisfy performance obligations either over time or at a point in time, as discussed in further detail below. Revenue is recognized at the time the related performance obligation is satisfied by transferring the promised good or service to the customer.

Commission Revenue — Our commission revenue results from approval of an application from health insurance carriers, which we define as our customers. Our commission revenue is primarily comprised of commissions from health insurance carriers which is computed using the estimated constrained lifetime value of commission payments that we expect to receive.

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 the commission rates paid to us by the health insurance carriers. 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 purchased from the carrier by means of our health insurance exchange services.

For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission payment from insurance carriers once the plan is approved by the carrier and either a fixed, monthly, or annual commission payment beginning with and subsequent to the second plan year. 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. 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.

For individual and family, Medicare Supplement, small business and ancillary plans, our commissions generally represent a flat amount per member per month or a percentage of the premium amount collected by the carrier during the period that a member maintains coverage under a plan. Premium-based commissions are reported to us after the premiums are collected by the carrier, generally on a monthly basis. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance plan is cancelled or we otherwise do not remain the agent on the policy.

Since the adoption of ASC 606, we recognize revenue at the time of plan approval by applying the latest estimated constrained LTV for that product. We estimate commission revenue for each product by using a portfolio approach to a group of approved members by plan type and the effective month of the relevant plan, which we refer to as “cohorts”. We estimate the cash commissions we expect to collect for each approved member cohort by evaluating various factors, including but not limited to, commission rates, carrier mix, estimated average plan duration, the regulatory environment, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship. On a quarterly basis, we recompute LTV at a cohort level for all outstanding cohorts, review and monitor changes in the data used to estimate LTV as well as the cash received for each cohort as compared to our original estimates. The fluctuations of cash received for each cohort and LTV can be significant and may or may not be indicative of the need to adjust LTVs for prior period cohorts. Management analyzes these fluctuations and, to the extent we see changes in our estimates of the cash commission collections that we believe are indicative of an increase or decrease to prior period LTVs, we will adjust LTV for the affected cohorts at the time such determination is made. Changes in LTV may result in an increase or a decrease to revenue and a corresponding increase or decrease to commissions receivable, accordingly. We refer the net commission revenue from members approved in prior periods as “adjustment revenue” and our revenue can fluctuate significantly from period to period as a result of adjustment revenue.

For Medicare-related, individual and family and ancillary health insurance plans, our services are complete once a submitted application is approved by the relevant health insurance carrier. Accordingly, we recognize commission revenue based upon the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application, net of an estimated constraint. We refer to these as estimated and constrained LTVs for the plan. We provide annual services in selling and renewing small business health insurance plans; therefore, we recognize small business health insurance plan commission revenue at the time the plan is approved by the carrier, and when it renews each year thereafter, equal to the estimated commissions we expect to collect from the plan over the following twelve months. Our estimate of commission revenue for each product line is based on a number of assumptions, which include, but are not limited to, estimating conversion of an approved member to a paying member, forecasting average plan duration and forecasting the commission amounts likely to be received per member. These assumptions are based on our analysis of historical trends for the different cohorts and incorporate management’s judgment in interpreting those trends to apply the constraints discussed below. For our Medicare commission revenue, which represented 87%, 83% and 76% of our total commission revenue for the years ended December 31, 2019, 2018 and 2017, respectively, the estimated average plan duration used to calculate Medicare health insurance plan LTVs historically has been approximately 3 years for Medicare Advantage plans, approximately 5 years for Medicare Part D prescription drug plans, and approximately 5 years for Medicare Supplement plans. While the average plan duration has been approximately 3 years for Medicare Advantage plans, certain members may have a duration of up to 12 years. The estimated average plan duration used to calculate the LTV for major medical individual and family health insurance plans historically has been approximately 1.5 to 2 years. For short term health insurance plan LTVs, the estimated average plan duration historically

has been less than six months. For all other ancillary health insurance plan LTVs, the estimated average plan duration has historically varied from 1 to 3 years. To the extent we make changes to the assumptions we use to calculate constrained LTVs, we recognize any material impact of the changes to commission revenue in the reporting period in which the change is made, including revisions of estimated lifetime commissions either below or in excess of previously estimated constrained LTV recognized as revenue.

Other Revenue **–** Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee, which is recognized over the period that advertising is displayed, and often a performance fee based on metrics such as submitted health insurance applications, which is recognized when control has been transferred. We also offer Medicare advertising services, which include website development, hosting and maintenance. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue as control is transferred ratably over the service period.

Our commercial technology licensing business allows carriers the use of our ecommerce platform to offer their own health insurance policies on their websites and agents to utilize our technology to power their online quoting, content and application submission processes. Typically, we are paid a one-time implementation fee, which we recognize as control is transferred on a straight-line basis over the estimated term of the customer relationship (generally the initial term of the agreement), commencing once the technology is available for use by the third party, and a performance fee based on metrics such as submitted health insurance applications. The metrics used to calculate performance fees for both sponsorship and advertising and technology licensing are based on performance criteria that are either measured based on data tracked by us, or based on data tracked by the third party. In instances where the performance criteria data is tracked by us, we recognize revenue in the period of performance and when all other revenue recognition criteria has been met. In instances where the performance criteria data is tracked by the third party, we recognize revenue as control is transferred at amounts where reversal of such amounts is not likely to occur. Typically, this occurs through our receipt of a cash payment from the third party along with a detailed statement containing the data that is tracked by the third party.

Deferred Revenue **–** Deferred revenue includes deferred technology licensing implementation fees and amounts billed to or collected from sponsorship or technology licensing customers in advance of our performing our service for such customers. It also includes the amount by which both unbilled and billed services provided under our technology licensing arrangements exceed the straight-line revenue recognized to date.

Incremental Costs to Obtain a Contract — Our sales compensation plans, which are directed at converting leads into approved members, represent fulfillment costs and not costs to obtain a contract with a customer. Additionally, we reviewed compensation plans related to personnel responsible for identifying new health insurance carriers and entering into contracts with new health insurance carriers and concluded that no incremental costs are incurred to obtain such contracts.

Book-of-Business Transfers **–** We entered into several agreements with a broker partner, whereby the partner transferred certain of its existing Medicare plan members to us as the broker of record on the underlying policies. The first of these book-of-business transfers occurred in November 2010 and the most recent in June 2012. Total consideration paid by us for these books-of-business was $13.9 million. The consideration we paid to the broker partner was based on the discounted commissions expected to be received over the remaining life of each transferred Medicare plan member. As we receive commission payments from health insurance carriers for these plan members, we record the margin earned to other income , net in the Consolidated Statements of Comprehensive Income. The margin earned and recorded to other income, net for these books-of-business for the years ended December 31, 2019, 2018 and 2017 totaled $0.6 million, $0.8 million, and $0.9 million, respectively.

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.

Marketing and Advertising Expenses **–** 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. We recognize direct marketing expenses in our direct member acquisition channel in the period in which they are incurred. We recognize online marketing expenses associated with search advertising in

the period in which the consumer clicks on the advertisement. Advertising costs incurred in the years ended December 31, 2019, 2018 and 2017 totaled $122.6 million, $64.4 million, and $56.0 million, respectively.

Our direct channel expenses primarily consist of costs for direct mail, email marketing and television and radio advertising. Advertising costs for our direct channel are expensed the first time the related advertising takes place. Our marketing partner channel expenses primarily consist of fees paid to marketing partners with which we have a relationship. Our online advertising channel expenses primarily consist of paid keyword search advertising on search engines and retargeting campaigns. Advertising costs for our marketing partner channel and our online advertising channel are expensed as incurred.

Research and Development Expenses – Research and development expenses consist primarily of compensation and related expenses incurred for employees on our engineering and technical teams. Research and development costs, which totaled $8.1 million, $6.9 million and $7.6 million for the years ended December 31, 2019, 2018 and 2017, respectively, are included in technology and content expense in the accompanying Consolidated Statements of Comprehensive Income.

Deferred Contract Costs – Deferred contract costs primarily represent direct costs related to professional services provided in connection with technology licensing arrangements that are accounted for as a single unit of accounting. The direct professional services costs are deferred up until the commencement of revenue recognition of the single unit and then recognized as cost of revenue ratably over the same period as the related revenue.

Internal-Use Software and Website Development Costs – We capitalize costs of materials, consultants and compensation and benefits costs of employees who devote time to the development of internal-use software during the application development stage. Our judgment is required in determining the point at which various projects enter the phases at which costs may be capitalized, in assessing the ongoing value of the capitalized costs and in determining the estimated useful lives over which the costs are amortized, which is generally 3 years. For the years ended December 31, 2019, 2018 and 2017, we capitalized internal-use software and website development costs of $10.2 million, $6.3 million and $3.2 million respectively, and recorded amortization expense of $3.8 million, $2.2 million, and $1.5 million respectively.

Stock-Based Compensation – We recognize stock-based compensation expense in the accompanying Consolidated Statements of Comprehensive Income based on the fair value of our stock-based awards over their respective vesting periods, which is generally 4 years. The estimated grant date fair value of our stock options is determined using the Black-Scholes-Merton pricing model and a single option award approach. The weighted-average expected term for stock options granted is calculated using historical option exercise behavior. The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through December 31, 2019, we had not declared or paid any cash dividends, and we do not expect to pay any in the foreseeable future. We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options. Expected volatility is determined using a combination of the implied volatility of publicly traded options in our stock and historical volatility of our stock price. The estimated attainment of performance-based awards and related expense is based on the expectations of revenue and earnings target achievement. The estimated fair value of performance awards with market conditions is determined using the Monte-Carlo simulation model. The assumptions used in calculating the fair value of stock-based payment awards and expected attainment of performance-based awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected term and volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions could significantly impact the valuation of such instruments.

401(k) Plan – In September 1998, our board of directors adopted a defined contribution retirement plan ("401(k) Plan"), which qualifies under Section 401(k) of the Internal Revenue Code of 1986. Participation in the 401(k) Plan is available to substantially all employees in the United States. Employees can contribute up to 25% of their salary, up to the federal maximum allowable limit, on a before-tax basis to the 401(k) Plan. Employee contributions are fully vested when contributed. Our contributions to the 401(k) Plan are discretionary and are expensed when incurred. We also match employee contributions to our 401(k) Plan at 25% of an employee’s contribution each pay period, up to a maximum of 3% of the employee’s salary during such pay period for the year ended December 31, 2019, compared to a maximum of 2% and 1% for the years ended December 31, 2018 and 2017, respectively. Our matching contributions are expensed as incurred and vest one-third for each of the first three years of the recipient’s service. The recipient is fully vested in all 401(k) Plan matching contributions after three years of service. We recognized expense of $2.3 million, $1.0 million and $0.4 million for the years ended December 31, 2019, 2018 and 2017, respectively, related to 401(k) matching contributions.

Income Taxes **–** We account for income taxes using the liability method. Deferred income taxes are determined based on the differences between the financial reporting and tax bases of assets and liabilities, using enacted statutory tax rates in effect for the year in which the differences are expected to reverse.

We utilize a two-step approach for evaluating uncertain tax positions. Step one, *Recognition*, requires a company to determine if the weight of available evidence indicates that a tax position is more likely than not to be sustained upon audit, including resolution of related appeals or litigation processes, if any. Step two, *Measurement*, is based on the largest amount of benefit, which is more likely than not to be realized on ultimate settlement. We record interest and penalties related to uncertain tax positions as income tax expense in the consolidated financial statements.

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. As a result, our Medicare plan-related commission revenue is highest in our fourth quarter.

The majority of our individual and family health insurance plans are sold in the fourth quarter during 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.

Recently Adopted Accounting Pronouncements

Leases (Topic 842) **–** In February 2016, the FASB issued ASU No. 2016-02, *Leases*. ASU 2016-02 requires lessees to recognize a right-of-use asset and lease liability for all leases with terms of more than 12 months. Recognition, measurement, and presentation of expenses will depend on classification as a finance or operating lease. 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 was effective for annual reporting periods beginning after December 15, 2018, including interim periods within that reporting period. We adopted the standard using the optional modified retrospective transition method on January 1, 2019. As a result of adopting the ASU, on January 1, 2019, we recorded a right-of-use asset and lease liability of $23.3 million and $24.6 million, respectively. See *Note 11– Leases* for further discussion on our leases.

Recent Accounting Pronouncement Not Yet Adopted

Financial Instruments – Credit Losses (Topic 326) **–** In June 2016, the FASB issued ASU No. 2016-13, *Financial Instruments — Credit Losses*, which amends the guidance for accounting for assets that are potentially subject to credit risk. The amendments affect contract assets, loans, debt securities, trade receivables, net investments in leases, off-balance-sheet credit exposures, reinsurance receivables, and any other financial assets not excluded from the scope that have the contractual right to receive cash. ASU 2016-13 is effective for us beginning January 1, 2020 using a modified retrospective transition method. We are still in the process of assessing the impact on our consolidated financial statements and disclosure from the adoption of this standard update.

Income Taxes (Topic 740) **–** In December 2019, the FASB issued ASU No. 2019-12, Income Tax, *Simplifying the Accounting for Income Taxes*, which aims to simplify the accounting by removing certain exceptions to the general principles in Topic 740 and improve consistent application of and simplify GAAP for other areas under this Topic by clarifying existing guidance. ASU 2019-12 is effective for us beginning January 1, 2021. The amendments in this standard update have individually different adoption approaches. We are still in the process of assessing the impact on our consolidated financial statements and disclosure from the adoption of this standard update.

Note 2 – Revenue

Adoption of ASC 606

As discussed in *Note 1 - Summary of Business and Significant Accounting Policies*, the FASB issued ASU 2014-09 in

2014, which, as amended, created ASC 606. The core principle of ASC 606 is that an entity shall recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services. The standard also contains significant new disclosure requirements regarding the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers. We adopted ASC 606 effective January 1, 2018, on a full retrospective basis. We have applied the standard to all contracts. Upon adoption, our retained earnings balance increased by $174.7 million as of December 31, 2016.

Revenue Recognition Based on Estimated Constrained LTV

We recognize revenue for plans approved during the period by applying the latest estimated constrained LTV for that product. We recognize adjustment revenue for plans approved in prior periods when there is a change in estimate to expected cash collections as a result of sufficient evidence that demonstrates a trend that is different from the estimated constrained LTV at the time of approval. We recognize adjustment revenue when we do not believe there is a probable significant reversal. We assess the risk of significant revenue reversal based on statistical and qualitative analysis given historical information and current market conditions.

For Medicare-related, individual and family and ancillary health insurance plans, we apply constraints to determine the amount of commission revenue to recognize per approved plan. The constraints are applied to help ensure that the total estimated lifetime commissions expected to be collected for an approved member’s plan are recognized as revenue only to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with future commissions receivable from the plan is subsequently resolved. The judgments that can be significant in estimating LTVs are related to the constraint. To determine the constraints to be applied to LTV, we compare prior calculations of LTV to actual cash received and review the reasons for any differences. We then apply judgment in assessing whether the difference between historical cash collections and LTV is representative of differences that can be expected in future periods. We also analyze whether circumstances have changed and consider any known or potential modifications to the inputs into LTV in light of the factors that can impact the amount of cash expected to be collected in future periods including but not limited to commission rates, carrier mix, plan duration, changes in laws and regulations, and cancellations of insurance plans offered by health insurance carriers with which we have a relationship. We evaluate the appropriateness of our constraints on a quarterly basis, and we update the assumptions when we observe a sufficient level of evidence that would suggest that the long-term expectation underlying the assumptions has changed.

We recorded adjustment revenue for plans approved in prior periods of $88.1 million, $10.8 million and $13.0 million, respectively, or $3.82, $0.56, $0.70 per basic share, or $3.59, $0.53, $0.68 per diluted shares, respectively, for the years ended December 31, 2019, 2018 and 2017.

Commission revenue by segment is presented in the table below (in thousands):

	Years Ended December 31,		
	2019	2018	2017
Medicare			
Commission Revenue from Members Approved During the Period [1]	$ 355,916	$ 192,382	$ 134,093
Net Commission Revenue from Members Approved in Prior Periods [2]	55,292	(124)	917
Total Medicare Segment Commission Revenue	$ 411,208	$ 192,258	$ 135,010
Individual, Family and Small Business			
Commission Revenue from Members Approved During the Period [1]	$ 22,614	$ 24,079	$ 29,767
Net Commission Revenue from Members Approved in Prior Periods [2]	32,854	10,874	12,106
Total Individual, Family and Small Business Segment Commission Revenue	$ 55,468	$ 34,953	$ 41,873

(1) These amounts include commission bonus revenue.
(2) These amounts reflect our revised estimates of cash collections for certain members approved prior to the relevant reporting period that are recognized as adjustments to revenue within the relevant reporting period. These amounts include revenue associated with renewing small business health insurance members. Adjustment revenue includes reductions to revenue for certain prior periods cohorts of $3.1 million, $3.2 million and $0.0 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Since the adoption of ASC 606, we have evaluated changes in estimated cash collections and compare these to the initial estimates of LTV at the time of approval. We have historically recorded adjustment revenue in the period when the risk of significant reversal in not probable. We continue to enhance our LTV estimation models to improve the accuracy and to reduce the fluctuations of our LTV estimates. For Medicare Advantage, our principal product, the quarterly revisions to expected cash collections have generally exceeded the estimated constrained LTVs and revenue recognized at the time of approval. At the time of ASC 606 adoption, we had been selling Medicare Advantage plans for approximately 7 years with limited volumes until the enrollment season in the fourth quarter of 2015 and volumes have continued to increase. During the fourth quarter of 2019, with additional data on Medicare Advantage plans and the application of statistical tools we were able to enhance our Medicare Advantage LTV estimation model to increase the accuracy of LTV estimates with an emphasis on improving member attrition forecasting. The enhancements to the Medicare Advantage LTV estimation model provide greater statistical certainty on expected cash collections, particularly for earlier period cohorts. As we had sufficient additional information with respect to increases in LTVs and estimates of future cash collections related to earlier period cohorts, we concluded that it was probable that a significant reversal of cumulative revenue would not occur for certain prior period cohorts and, accordingly, recognized adjustment revenue related to these prior period cohorts in 2019. For the Medicare segment, we recognized adjustment revenue of $55.3 million for the year ended December 31, 2019, of which $50.8 million was recognized for Medicare Advantage plans during the fourth quarter of 2019. For the Individual, Family and Small Business segment, we recognized adjustment revenue of $32.9 million for the year ended December 31, 2019, in response to observing longer plan duration than initially anticipated at the time of enrollment for these plans.

Disaggregation of Revenue – The table below depicts the disaggregation of revenue by product and is consistent with how we evaluate our financial performance (in thousands):

	Year Ended December 31,		
	2019	2018	2017
Medicare			
Medicare Advantage	$ 339,810	$ 143,445	$ 107,567
Medicare Supplement	40,345	31,166	15,436
Medicare Part D	26,824	14,609	11,085
Total Medicare	406,979	189,220	134,088
Individual and Family [(1)]			
Non-Qualified Health Plans	17,559	6,470	10,024
Qualified Health Plans	6,866	5,789	7,055
Total Individual and Family	24,425	12,259	17,079
Ancillary			
Short-term	10,524	5,583	5,503
Dental	5,238	2,717	5,062
Vision	2,002	1,467	1,607
Other	3,985	4,941	3,877
Total Ancillary	21,749	14,708	16,049
Small Business	9,922	8,595	7,501
Commission Bonus	3,601	2,429	2,166
Total Commission Revenue	466,676	227,211	176,883
Other Revenue	39,525	24,184	13,823
Total Revenue	$ 506,201	$ 251,395	$ 190,706

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(1) We define our individual and family plan offerings as major medical individual and family health insurance plans, which does not include Medicare-related, small business or ancillary plans. Individual and family health insurance plans include both qualified and non-qualified plans. Qualified health plans are individual and family health insurance plans that meet the requirements of the Affordable Care Act and are offered through the government-run health insurance exchange in the relevant jurisdiction. Non-qualified health plans are individual and family health insurance plans that meet the requirements of the Affordable Care Act and are not offered through the exchange in the relevant jurisdiction. Individuals that purchase non-qualified health plans cannot receive a subsidy in connection with the purchase of those plans.

Note 3 – Acquisition

On January 22, 2018, we completed our acquisition of all outstanding membership interests of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. The acquisition consideration consisted of cash of $15.0 million, less $0.1 million of cash acquired, and 294,637 shares of our common stock. In addition, the members of GoMedigap are entitled to receive earnout payments ("Earnout Consideration") consisting of up to $20.0 million in cash and 589,275 shares of our common stock. The Earnout Consideration became payable, subject to the terms and conditions of the purchase agreement relating to the acquisition, upon the final determination of the achievement of certain milestones in 2018 and 2019.

The GoMedigap acquisition was accounted for using the acquisition method of accounting under ASC 805, *Business Combinations.* The acquisition method of accounting requires, among other things, that assets acquired and liabilities assumed be recognized at their fair values as of the acquisition date. The major classes of assets and liabilities to which we have allocated the acquisition consideration were as follows (in thousands):

Acquisition Consideration		
Cash paid	$	15,000
Fair value of equity awards issued to GoMedigap members [1]		5,595
Estimated fair value of earnout liability		27,700
	$	48,295
Allocation		
Cash and cash equivalents	$	71
Commission receivable - current		4,371
Prepaid expenses and other current assets		11
Commission receivable - non-current		11,103
Property and equipment, net		174
Accounts payable		(110)
Accrued compensation and benefits		(132)
Other current liabilities		(130)
Net tangible assets acquired		15,358
Intangible assets		6,800
Goodwill		26,137
Total intangible assets acquired		32,937
Total net assets acquired	$	48,295

[1] The fair value of equity awards issued was determined based on the January 22, 2018 closing price of our common stock of $18.99 per share.

Goodwill and Intangible Assets – Goodwill represents the excess of the purchase price of the acquired business over the acquisition date fair value of the net assets acquired. Goodwill is primarily attributable to the assembled workforce, new product development capabilities and anticipated synergies and economies of scale expected from the operations of the combined company. The goodwill was assigned to our Medicare segment. Goodwill is tested for impairment on an annual basis in the fourth quarter of each year or whenever events or changes in circumstances indicate that the asset may be impaired. Factors that we consider in deciding when to perform an impairment test include significant negative industry or economic trends or significant changes or planned changes in our use of the intangible assets. Goodwill will be deductible for tax purposes over 15 years.

Earnout liability – The earnout liability represents the fair value of the Earnout Consideration payable and is adjusted to fair value at each reporting date until settled. Changes in fair value were recognized in income (loss) from operations. The first and second earnout liability payments were made in February 2019 and January 2020, respectively. See *Note 5 – Fair Value Measurements* for further discussion regarding the earnout liability.

Fair Value Measurements – The assets acquired and liabilities assumed of GoMedigap have been recognized at fair value in accordance with ASC 820, *Fair Value Measurement.* ASC 820 defines fair value as the price that would be received to sell an asset or would be paid to transfer a liability in an orderly transaction between market participants at the measurement date. ASC 820 requires three levels of hierarchy, which prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy level assigned to each asset and liability is based on the assessment of the transparency and reliability of inputs used in the valuation of such items based on the lowest level of input that is significant to fair value measurement. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and lowest priority to unobservable inputs (Level 3 measurements).

Assets acquired and liabilities assumed measured and reported at fair value are classified in one of the following categories based on inputs:

Level 1	Unadjusted quoted prices in active markets for identical assets or liabilities.
Level 2	Unadjusted quoted prices in active markets for similar assets or liabilities; or unadjusted quoted prices for identical or similar assets or liabilities in markets that are not active; or inputs other than quoted prices that are observable for the asset or liability.
Level 3	Unobservable inputs for the asset or liability.

The fair value of prepaid expenses and other current assets, property and equipment, net, accounts payable, accrued compensation and benefits and other current liabilities approximated their carrying value at the date of acquisition. The fair value of commissions receivable was determined using a discounted rate of interest, which is a Level 2 input. Intangible assets and the earnout liability were valued using Level 3 inputs.

The fair values of the acquired technology were determined by using income and cost methods. Fair value of trade names were determined using the profit allocation method, which is based on the estimated royalties we are relieved from paying because we own the assets.

The fair value of the Earnout Consideration payable was measured using probability-weighted analysis and is discounted using a rate that appropriately captures the risk associated with the obligation. Key assumptions included new enrollments and volatility for the years ended December 31, 2019 and 2018, as well as eHealth's simulated stock price at the time of payment. The Earnout Consideration payable was part of the acquisition consideration and was adjusted to fair value at each reporting date until settled. The fair value adjustments to the earnout liability during the year ended December 31, 2019 and 2018 were $24.1 and $12.3 million, respectively.

Following are the details of the acquisition consideration allocated to the intangible assets acquired (in thousands):

Technology	$	2,000
Trade names, trademarks and website addresses		4,800
Total intangible assets	$	6,800

We are amortizing the existing technology, trade names, trademarks, and website addresses using the straight-line method over an estimated life of 3 and 10 years, respectively. The estimated useful lives are based on the time periods during which the intangibles are expected to result in incremental cash flows.

We incurred $0.1 million of acquisition-related costs during the year ended December 31, 2018, which were expensed as incurred.

Prior to the acquisition date, GoMedigap recognized revenue and expenses on the cash basis of accounting. GoMedigap's historical books and records did not contain the information required to recognize revenue or prepare financial statements on a basis that would be comparable to us. Thus, the required pro-forma financial disclosures are not presented herein.

GoMedigap generated revenue of $15.2 million for the period from the acquisition date of January 22, 2018 through December 31, 2018.

Note 4 – Supplemental Financial Statement Information

Cash, Cash Equivalents and Restricted Cash – As of December 31, 2019 and 2018, 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. As of December 31, 2019 and 2018, 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 years ended December 31, 2019 and 2018. As of December 31, 2019, we had $3.4 million restricted cash to collateralize letters of credit related to certain lease commitments.

Our cash, cash equivalent and restricted cash balances are summarized as follows (in thousands):

	December 31, 2019	December 31, 2018
Cash	$ 16,205	$ 12,766
Money market funds	7,261	323
Cash and cash equivalents	$ 23,466	$ 13,089
Restricted cash	3,354	—
Total cash, cash equivalents and restricted cash	$ 26,820	$ 13,089

Concentration of Credit Risk – Our financial instruments that are exposed to concentrations of credit risk principally consist of cash, cash equivalents and total accounts receivable (which includes commissions receivable). We invest our cash and cash equivalents with major banks and financial institutions and, at times, such investments 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.

We do not require collateral or other security for our total accounts receivable. As of December 31, 2019, three customers represented 22%, 20%, and 20%, respectively, for a combined total of 62% of our $591.6 million total outstanding accounts receivable balance. As of December 31, 2018, three customers represented 19%, 19%, and 19%, respectively, or a combined total of 57%, of our $349.5 million total outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at either December 31, 2019 or 2018. We believe the potential for collection issues with any of our customers was minimal as of December 31, 2019. Accordingly, our estimate for uncollectible amounts as of December 31, 2019 was immaterial.

Accounts Receivable – Our total accounts receivable are summarized as of the periods presented below (in thousands):

	December 31, 2019	December 31, 2018
Commissions receivable - current	$ 174,526	$ 134,190
Commissions receivable - non-current	414,696	211,668
Accounts receivable	2,332	3,601
Total accounts receivable	$ 591,554	$ 349,459

Commission Receivable – Our commission receivable activities are summarized as follows (in thousands):

	For the year ended December 31,		
	2019	2018	2017
Beginning balance	$ 345,858	$ 279,417	$ 257,777
Commission revenue from members approved during the period [(1)]	378,530	216,461	163,860
Net commission revenue adjustments from members approved in prior period [(2)]	88,146	10,750	13,023
Cash receipts	(223,312)	(160,770)	(155,243)
Ending balance	$ 589,222	$ 345,858	$ 279,417

(1) These amounts include commission bonus revenue.
(2) These amounts reflect our revised estimates of cash collections for certain members approved prior to the relevant reporting period that are recognized as adjustments to revenue within the relevant reporting period. These amounts include revenue associated with renewing small business health insurance members.

The commissions receivable balance at the end of each year primarily relates to Medicare Advantage and Medicare Part D plans sold during the fourth quarter with effective dates in the following year.

Prepaid Expenses and Other Current Assets **–** Our prepaid expenses and other current assets are summarized as of the periods presented below (in thousands):

	December 31, 2019	December 31, 2018
Prepaid maintenance contracts	$ 3,853	$ 1,937
Equity issuance costs	—	294
Prepaid insurance	918	161
Prepaid rent	96	324
Income tax receivable	584	1,108
Other current assets	2,371	1,464
Prepaid expenses and other current assets	$ 7,822	$ 5,288

Property and Equipment **–** Our property and equipment are summarized as of the periods presented below (in thousands):

	December 31, 2019	December 31, 2018
Computer equipment and software	$ 17,893	$ 17,246
Office equipment and furniture	4,995	3,319
Leasehold improvements	6,051	6,345
Property and equipment, gross	28,939	26,910
Less accumulated depreciation and amortization	(18,421)	(19,226)
Property and equipment, net	$ 10,518	$ 7,684

Depreciation and amortization expense related to property and equipment totaled $3.0 million, $2.5 million, and $2.8 million in the years ended December 31, 2019, 2018 and 2017, respectively.

Other Assets **–** Other assets are summarized as of the periods presented below (in thousands):

	December 31, 2019	December 31, 2018
Capitalized software project costs	$ 14,718	$ 8,308
Debt issuance costs - non-current	1,149	1,099
Security deposits	555	483
Deferred tax assets	264	232
Income tax receivable	456	913
Other	862	241
Other assets	$ 18,004	$ 11,276

Intangible Assets – The carrying amounts, accumulated amortization, net carrying value and weighted average remaining life of our definite-lived amortizable intangible assets, as well as our indefinite-lived intangible trademarks, are presented in the tables below (dollars in thousands, useful life in years):

	December 31, 2019				December 31, 2018			
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted-average remaining useful life	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted-average remaining useful life
Technology	$ 2,000	$ (1,278)	$ 722	1.1	$ 2,000	$ (611)	$ 1,389	2.1
Pharmacy and customer relationships	9,500	(9,183)	317	0.3	9,500	(8,234)	1,266	1.3
Trade names, trademarks and website addresses	5,700	(1,791)	3,909	8.0	5,700	(1,220)	4,480	8.9
Total intangible assets subject to amortization	$ 17,200	$ (12,252)	4,948		$ 17,200	$ (10,065)	$ 7,135	
Indefinite-lived trademarks and domain names			5,114	Indefinite			5,114	Indefinite
Intangible assets			$ 10,062				$ 12,249	

During the years ended December 31, 2019, 2018, and 2017, amortization expense related to intangible assets totaled $2.2 million, $2.1 million, and $1.0 million, respectively.

As of December 31, 2019, our expected amortization expense in future periods were as follows (in thousands):

Years Ending December 31,	Technology	Pharmacy and Customer Relationships	Trade Names, Trademarks and Website Addresses	Total
2020	$ 667	$ 317	$ 509	$ 1,493
2021	55	—	480	535
2022	—	—	480	480
2023	—	—	480	480
2024	—	—	480	480
Thereafter	—	—	1,480	1,480
Total	$ 722	$ 317	$ 3,909	$ 4,948

Note 5 – Fair Value Measurements

We define fair value as the price that would be received for an asset or paid to transfer a liability (an exit price) in the principal or most advantageous market for the asset or liability in an orderly transaction between market participants on the measurement date. Valuation techniques we use to measure fair value maximize the use of observable inputs and minimize the use of unobservable inputs. We classify the inputs used to measure fair value into the following hierarchy:

Level 1	Unadjusted quoted prices in active markets for identical assets or liabilities.
Level 2	Unadjusted quoted prices in active markets for similar assets or liabilities; unadjusted quoted prices for identical or similar assets or liabilities in markets that are not active; inputs other than quoted prices that are observable for the asset or liability.
Level 3	Unobservable inputs for the asset or liability.

The following table is a summary of financial assets measured at fair value on a recurring basis and their classification within the fair value hierarchy (in thousands):

	December 31, 2019				December 31, 2018			
	Carrying Value	Level 1	Level 3	Total	Carrying Value	Level 1	Level 3	Total
Assets								
Money market funds	$ 7,261	$ 7,261	$ —	$ 7,261	$ 323	$ 323	$ —	$ 323
Liability								
Earnout liability - current	$ 37,273	$ —	$ 37,273	$ 37,273	$ 20,730	$ —	$ 20,730	$ 20,730
Earnout liability - non-current	—			$ —	19,270	—	$ 19,270	$ 19,270
Total liabilities measured and recorded at fair value	$ 37,273	$ —	$ 37,273	$ 37,273	$ 40,000	$ —	$ 40,000	$ 40,000

Our cash equivalents were invested in money market funds and were classified as Level 1. We endeavor to utilize the best available information in measuring fair value. We used observable prices in active markets in determining the classification of our money market funds as Level 1. There were no transfers between the hierarchy levels during the years ended December 31, 2019 and 2018.

We measure the earnout liability using internally developed assumptions; therefore, it is classified as Level 3. The fair value of the earnout liability was measured using probability-weighted analysis and is discounted using a rate that appropriately captures the risk associated with the obligation. The fair value of the earnout liability as of December 31, 2019 was adjusted to the amount that we settled in January 2020. Key assumptions included new enrollments and volatility for the years ended December 31, 2019 and 2018 and our stock price at the time of payment.

Our earnout liability activities are summarized as follows (in thousands):

Balance as of December 31, 2017	$ —
Recognition of earnout liability upon acquisition of GoMedigap on January 22, 2018	27,700
Change in fair value	12,300
Balance as of December 31, 2018	$ 40,000
Change in fair value	24,079
Settlements	(26,806)
Balance as of December 31, 2019	$ 37,273

In February 2019, we made the first earnout payment to GoMedigap consisting of $9.5 million in cash and 294,608 shares of our common stock with a value of $17.3 million. In January 2020, we made the second payment, which consisted of $8.8 million in cash and 294,608 shares of our common stock with a value of $28.5 million.

Note 6 – Equity

Our board of directors has the authority, without any further action by our stockholders, to issue up to 110.0 million shares, par value $0.001 per share, of which 10.0 million shares are designated as preferred stock. As of December 31, 2019 and 2018, there were no shares of preferred stock outstanding.

Common Stock – On all matters submitted to our stockholders for vote, our common stockholders are entitled to one vote per share, voting together as a single class, and do not have cumulative voting rights. Accordingly, the holders of a majority of the shares of common stock entitled to vote in any election of directors can elect all of the directors standing for election, if they so choose. Subject to preferences that may apply to any shares of preferred stock outstanding, the holders of common stock are entitled to share equally in any dividends, when and if declared by our board of directors. Upon the occurrence of a liquidation, dissolution or winding-up, the holders of common stock are entitled to share equally in all assets remaining after the payment of any liabilities and the liquidation preferences on any outstanding preferred stock. Holders of common stock have no preemptive or conversion rights or other subscription rights and there are no redemption or sinking funds provisions applicable to the common stock.

Pursuant to the effective registration statement which was filed on December 17, 2018, and amended on January 22, 2019, we entered into an underwriting agreement to issue 2.4 million shares of common stock, which included the exercise in full of the underwriters' option to purchase 0.4 million additional shares of common stock, at a price to the public of $48.50 per share in January 2019, for a total of 2.8 million shares issued in connection with the offering. Net proceeds from the offering were approximately $126.1 million after deducting underwriting discounts, commissions and estimated expenses of the offering. We intend to use the net proceeds of the offering for general corporate purposes, including working capital.

Shares Reserved **–** We generally issue previously unissued common stock upon the exercise of stock options, the vesting of restricted stock units and upon granting of restricted common stock awards; however we may reissue previously acquired treasury shares to satisfy these future issuances. Shares of authorized but unissued common stock reserved for future issuance were as follows (in thousands):

	December 31, 2019	December 31, 2018
Stock options issued and outstanding	649	1,005
Restricted stock units issued and outstanding	2,201	1,869
Shares available for grant	2,197	512
Total shares reserved	5,047	3,386

Stock Plans **–** On June 12, 2014, upon approval at the Annual Meeting of Stockholders, we adopted the 2014 Equity Incentive Plan (the "2014 Plan"). The 2014 Plan replaced the 2006 Equity Incentive Plan and 4.5 million shares were authorized for issuance under the 2014 Plan. The 2014 Plan does not include an evergreen provision to automatically increase the number of shares available under it and increases in the number of shares authorized for issuance under the 2014 Plan require stockholder approval. Also, under the 2014 Plan the following shares are not recycled for future grant under the 2014 Plan: (i) shares used in connection with the exercise of an option and/or stock appreciation right to pay the exercise price or purchase price of such award or satisfy applicable tax withholding obligations; and (ii) the gross number of shares subject to stock appreciation rights that are exercised. Furthermore, the 2014 Plan included a provision that prohibits repricing of outstanding stock options or stock appreciation rights and formalized and updated procedures to qualify awards as "performance-based" compensation under Section 162(m) of the Internal Revenue Code in order to preserve full tax deductibility of such awards.

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

Our stock options granted under the 2014 Plan generally vest over four years at a rate of 25% after one year and 1/48th per month thereafter. Stock options granted under the 2014 Plan generally expire after seven years from the date of grant. On December 31, 2018, no shares were subject to repurchase.

Our restricted stock unit awards granted under the 2014 Plan, 2006 Plan and 2005 Stock Plan generally vest over four years at a rate of 25% after one year and 25% annually thereafter.

We have granted market-based restricted stock units to our executive officers and certain members of our senior management team. Each market-based stock unit represents a contingent right to receive certain shares of our common stock upon the attainment of certain stock prices over a four-year performance period. Once a stock price threshold is achieved, the portion of the award related to that threshold will vest on the one-year anniversary of the date of achievement, subject to the employee's continued service through each vesting date. Compensation expense related to these awards is recognized on an accelerated basis over the requisite service period.

The following table summarizes activity under our 2014 Equity Incentive Plan (the "2014 Plan") for the year ended December 31, 2019 (in thousands):

Beginning balance [1]	512
Additional shares authorized	2,500
Restricted stock units granted [2]	(970)
Options granted [3]	(19)
Restricted stock units cancelled [4]	124
Options cancelled	50
Ending balance	2,197

(1) Shares available for grant do not include treasury stock shares that could be granted if we determined to do so.
(2) Includes grants of restricted stock units with service, performance-based or market-based vesting criteria.
(3) Includes grants of stock options with service, performance-based or market-based vesting criteria.
(4) Includes cancelled restricted stock units with service, performance-based or market-based vesting criteria.

The following table summarizes stock option activity under the Stock Plans (in thousands, except weighted-average exercise price 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]
Outstanding as of December 31, 2018	1,005	$ 18.34	5.0	$ 20,226
Granted	19	$ 63.54		
Exercised	(319)	$ 17.45		
Cancelled	(56)	$ 24.71		
Outstanding balance as of December 31, 2019	649	$ 19.57	4.4	$ 49,661
Vested and expected to vest at December 31, 2019	631	$ 19.32	4.3	$ 48,404
Exercisable at December 31, 2019	428	$ 16.67	3.9	$ 33,995

(1) Includes certain stock options with service, performance-based or market-based vesting criteria.
(2) The aggregate intrinsic value is calculated as the product between eHealth's closing stock price as of December 31, 2019 and 2018 at the exercise price of in-the-money options as of those dates.

The following table provides information pertaining to our stock options for the years presented below (in thousands, except weighted-average fair values):

	Year Ended December 31,		
	2019	2018	2017
Weighted average fair value of options granted	$ 33.19	$ 12.78	$ 9.03
Total fair value of options vested	$ 2,924	$ 2,263	$ 799
Intrinsic value of options exercised	$ 19,890	$ 1,461	$ 430

The following table summarizes restricted stock unit activity under the Stock Plans (in thousands, except weighted-average grant date fair value and weighted-average remaining contractual life data):

	Number of Restricted Stock Units [1]	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Service Period	Aggregate Intrinsic Value [2]
Unvested as of December 31, 2018	1,869	$ 16.95	4.8	$ 71,816
Granted	970	$ 17.96		
Vested	(514)	$ 17.01		
Cancelled	(124)	$ 31.50		
Unvested as of December 31, 2019	2,201	$ 39.08	7.2	$ 211,443

(1) Includes certain restricted stock units with service, performance-based or market-based vesting criteria.
(2) The aggregate intrinsic value is calculated as the difference of our closing stock price as of December 31, 2019 and 2018 multiplied by the number of restricted stock units outstanding as of December 31, 2019 and 2018, respectively.

Stock Repurchase Programs – We had no stock repurchase activity during the years ended December 31, 2019, 2018 or 2017. In addition to 10.7 million shares repurchased under our past repurchase programs as of December 31, 2019, we had in treasury 1.0 million 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, 2019 and 2018, we had a total of 11.6 million shares and 11.4 million, respectively, held in treasury.

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

Stock-Based Compensation Expense – The fair value of stock options granted to employees was estimated using the following weighted average assumptions for the years presented below:

	Year Ended December 31,		
	2019	2018	2017
Expected term	4.3	4.3	4.3
Expected volatility	65.3%	68.3%	69.8%
Expected dividend yield	—%	—%	—%
Risk-free interest rate	2.1%	2.7%	1.8%

The weighted-average fair value of the market-based options and restricted stock units was determined using the Monte Carlo simulation model using the following weighted average assumptions:

	Year Ended December 31,		
	2019	2018	2017
Expected term	1.4	1.6	1.6
Expected volatility	57.8%	69.8%	70.9%
Expected dividend yield	—%	—%	—%
Risk-free interest rate	2.4%	2.5%	1.7%
Weighted-average grant date fair value	$58.16	$13.48	$9.42

The following table summarizes stock-based compensation expense recorded for the years presented below (in thousands):

	Year Ended December 31,		
	2019	2018	2017
Common stock options	$ 2,215	$ 1,991	$ 1,863
Restricted stock units	20,355	10,549	7,831
Total stock-based compensation expense	**$ 22,570**	**$ 12,540**	**$ 9,694**

The following table summarizes stock-based compensation expense by operating function for the years presented below (in thousands):

	Year Ended December 31,		
	2019	2018	2017
Marketing and advertising	$ 4,230	$ 1,974	$ 1,033
Customer care and enrollment	1,451	816	418
Technology and content	3,611	1,675	1,410
General and administrative	13,278	7,824	6,833
Restructuring charges	—	251	—
Total stock-based compensation expense	**$ 22,570**	**$ 12,540**	**$ 9,694**

As of December 31, 2019, there was $2.7 million of total unamortized compensation cost, net of estimated forfeitures, related to stock options, expected to be recognized over a weighted average period of 2.2 years. As of December 31, 2019, there was $65.5 million of total unamortized compensation cost, net of estimated forfeitures, related to restricted stock units, expected to be recognized over a weighted average period of 2.8 years.

Accelerated Vesting

During the year ended December 31, 2018, due to changes in our senior management, we accelerated the vesting dates of certain stock options and restricted stock units granted to two former employees. We recorded a $0.5 million incremental stock-based compensation expense in connection with this modification.

Note 7 – Net Income Per Share

Basic net income per share is computed by dividing net income by the weighted-average number of common shares outstanding for the period. Diluted net income per share is computed by dividing the net income for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net income 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 per share by application of the treasury stock method.

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

	Year Ended December 31,		
	2019	2018	2017
Basic			
Net income	$ 66,887	$ 241	$ 25,426
Shares used in per share calculation - basic	23,075	19,294	18,512
Net income per share – basic	**$ 2.90**	**$ 0.01**	**$ 1.37**
Diluted			
Net income	$ 66,887	$ 241	$ 25,426
Shares used in per share calculation - basic	23,075	19,294	18,512
Dilutive effect of common stock	1,464	1,115	535
Total common stock shares used in diluted share calculation	24,539	20,409	19,047
Net income per share – diluted	**$ 2.73**	**$ 0.01**	**$ 1.33**

For each of the years ended December 31, 2019, 2018 and 2017, we had securities outstanding that could potentially dilute net income per share, but the shares from the assumed conversion or exercise of these securities were excluded in the computation of diluted net income per share as their effect would have been anti-dilutive. The number of outstanding anti-dilutive shares that were excluded from the computation of diluted net income per share consisted of the following (in thousands):

	Year Ended December 31,		
	2019	2018	2017
Common stock options	11	291	908
Restricted stock units	41	13	1,296
Total	52	304	2,204

Note 8 – Commitments and Contingencies

Contingencies

From time to time, we receive inquiries from governmental bodies and also may be subject to various legal proceedings and claims arising in the ordinary course of business. We assess contingencies to determine the degree of probability and range of possible loss for potential accrual in our consolidated financial statements. An estimated loss contingency is accrued in the consolidated financial statements if it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. We accrued approximately $1.2 million as of December 31, 2019 for amounts we believe will be payable for certain current legal proceedings, including the matters discussed below. Legal proceedings or other contingencies could result in material costs, even if we ultimately prevail.

Legal Proceedings

The Gonzalez and Le'Vita Complaints – On April 6, 2018, a former employee, Lupita Gonzalez, filed a complaint against us in the Superior Court of the State of California for the County of Sacramento (the “Gonzalez Complaint”). The Gonzalez Complaint is brought under the California Private Attorney General Act (“PAGA”) on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The claim alleges that we violated wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing compliant meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The Gonzalez Complaint seeks penalties and costs, expenses and attorneys’ fees.

On July 1, 2019, two other current or former employees, Michael Le'Vias and Ramona Meadows, filed a related complaint against us and eHealth Ins. Serv. Co., in the Superior Court of the State of California for the County of Santa Clara (the "Le'Vias Complaint"). A substantial overlap exists between the facts and circumstances alleged in the Gonzalez Complaint and the Le'Vias Complaint. Specifically, the Le'Vias Complaint is also brought under PAGA on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The claim alleges that we violated wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing compliant meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The Le'Vias Complaint seeks unpaid wages, penalties and costs, expenses and attorneys' fees.

The parties have agreed to resolve both the Le'Vias and Gonzalez Complaints, which settlement will require court approval. In the interim, the parties have stipulated to vacate or, in the alternative, stay proceedings, including all discovery, with the exception of any deadlines or proceedings necessary to effectuate the settlement. The parties are seeking a court order vacating or, in the alternative, continuing the April 13, 2020 trial date for the Gonzalez matter.

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. As the benefits of these agreements are experienced uniformly over the applicable contractual periods, 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 contractual service and licensing obligations as of December 31, 2019 (in thousands):

For the Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2020	$ 7,040	$ 3,073	$ 10,113
2021	6,529	1,825	8,354
2022	5,266	692	5,958
2023	6,103	444	6,547
2024	5,909	229	6,138
Thereafter	21,983	—	21,983
Total	$ 52,830	$ 6,263	$ 59,093

Note 9 – Segment and Geographic Information

Operating Segments

The results of our operating segments are summarized for the periods presented below (in thousands):

	Year Ended December 31,		
	2019	**2018**	**2017**
Revenue			
Medicare	$ 446,961	$ 210,570	$ 142,448
Individual, Family and Small Business	59,240	40,825	48,258
Total revenue	$ 506,201	$ 251,395	$ 190,706
Segment profit			
Medicare segment profit	$ 155,234	$ 60,844	$ 22,137
Individual, Family and Small Business segment profit	23,368	5,803	9,573
Total segment profit	178,602	66,647	31,710
Corporate	(45,374)	(32,996)	(26,970)
Stock-based compensation expense	(22,570)	(12,289)	(9,694)
Depreciation and amortization	(2,983)	(2,479)	(2,837)
Change in fair value of earnout liability	(24,079)	(12,300)	—
Restructuring charge	—	(1,865)	—
Acquisition costs	—	(76)	(621)
Amortization of intangible assets	(2,187)	(2,091)	(1,040)
Other income (expense), net	2,090	755	$ 1,182
Income (loss) before provision (benefit) for income taxes	$ 83,499	$ 3,306	$ (8,270)

There are no internal revenue transactions between our operating segments. Our CODM does not separately evaluate assets by segment, and therefore assets by segment are not presented.

Geographic Information

Our long-lived assets consist primarily of property and equipment and internally-developed software. All of our intangible assets are located in the United States. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets (excluding intangible assets and goodwill) by geographical area are summarized as follows (in thousands):

	December 31, 2019	**December 31, 2018**
United States	$ 64,408	$ 18,228
China	471	499
Total	$ 64,879	$ 18,727

Significant Customers

Substantially all revenue for the years ended December 31, 2019, 2018 and 2017 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue are summarized as follows:

	Year Ended December 31,		
	2019	2018	2017
Humana	26%	22%	20%
UnitedHealthcare [1]	19%	19%	23%
Aetna [2]	17%	14%	10%

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

Note 10 – Restructuring

In February 2018, our Board of Directors approved a plan to close our sales call center in Massachusetts and to terminate the employment of other employees in certain other locations. As part of this plan, we eliminated approximately 110 full-time positions, representing approximately 10% of our workforce, primarily within customer care and enrollment, and to a lesser extent, in our marketing and advertising and general and administrative groups.

We recognized $1.9 million in pre-tax restructuring charges, which included approximately $1.6 million for employee termination benefits and $0.3 million in non-cash accelerated stock-based compensation in the year ended December 31, 2018. The restructuring activities comprising the plan were completed in June 2018.

The following table summarizes the total cash and non-cash restructuring charges recognized during the periods presented below (in thousands):

	December 31, 2018
Employee termination costs	$ 1,605
Non-cash employee termination costs - stock-based compensation	251
Other restructuring related costs	9
Total restructuring charges	$ 1,865

The following table summarizes the accrued restructuring charges activity during the periods presented below (in thousands):

	Year Ended December 31, 2018			
	Beginning balance	Charges	Payments	Ending balance
Employee termination costs	$ —	$ 1,605	$ (1,605)	$ —
Accrued restructuring charges - current	$ —	$ 1,605	$ (1,605)	$ —

There were no restructuring charges and payments during the year ended December 31, 2019. Accrued restructuring charges balance remained zero as of December 31, 2019.

Note 11 – Leases

Adoption of ASC 842

On January 1, 2019, we adopted *ASC 842 – Leases*, using the optional modified retrospective transition method. We have operating and finance leases for our corporate offices and certain equipment. Our leases have remaining lease terms of 1 to 10 years. Our operating lease expense recognized under ASC 842 was $6.4 million for the year ended December 31, 2019, and our cash outflows related to operating leases were $5.4 million for the year ended December 31, 2019. As a result of adopting the ASC, on January 1, 2019, we recorded a right-of-use asset and lease liability of $23.3 million and $24.6 million, respectively. During 2019, we recorded an additional lease liability of $10.8 million related to newly leased office space in Indianapolis, Indiana, which is described further below, and $1.1 million and $0.8 million related to an expansion and lease extension, respectively, of our office space in Gold River, California. We recorded additional lease liabilities totaling $4.9 million related to amendments made to our Salt Lake City office lease agreement during 2019. During the year ended December 31, 2019, we had non-cash investing activities of $40.6 million relating to right-of-use assets in the Consolidated Statements of Cash Flows.

Supplemental information as of December 31, 2019 related to leases is as follows (in thousands):

Operating lease right-of-use assets	$	36,621
Operating lease liabilities	$	39,064
Weighted-average remaining lease term of operating leases		7.6 years
Weighted-average discount rate used to recognize operating lease right-of-use-assets*		5.9%

* As our leases do not provide an implicit rate of interest, we use our incremental borrowing rate based on the information available at commencement date or remeasurement date in determining the present value of lease payments.

As of December 31, 2019, maturities of operating lease liabilities are as follows (in thousands):

Year ending December 31,		
2020	$	7,040
2021		6,529
2022		5,266
2023		6,103
2024		5,909
Thereafter		21,983
Total lease payments		**52,830**
Less imputed interest		(13,766)
Total	**$**	**39,064**

Operating Lease Obligations

We lease our operating facilities and certain of our equipment, furniture and fixtures under various operating leases, the latest of which expires in January 2030. 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 June 2019, we entered into a sublease agreement for 56,276 square feet and a lease agreement for 81,515 square feet as a sublessee and lessee, respectively, of office space in Indianapolis, Indiana. The sublease consists of two suites (Suite 200 and Suite 300). The lease term of Suite 300 commenced on June 3, 2019, and the lease term of Suite 200 commenced on July 1, 2019. The term of the sublease will terminate on October 31, 2022. The term of the lease, which will commence after the sublease, extends from November 1, 2022 to January 31, 2030, which, in addition to Suite 200 and Suite 300, includes an additional 25,239 square feet of office space in Suite 100. As of December 31, 2019, future minimum payments related to the Indiana office space are expected to be $17.6 million over the remaining term of the lease, plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease. The landlord also agreed to

contribute up to $1.9 million toward the cost of leasehold improvements. In connection with the Indianapolis, Indiana lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.8 million.

In April 2019, we entered into an amendment to the lease agreement for our Gold River, California, office to expand our office space to a total of 63,206 square feet from 44,738 square feet. The lease term for the expanded office space commenced on May 1, 2019. The term of the expanded office space will terminate on September 30, 2021. As of December 31, 2019, future minimum payments are expected to be $2.9 million over the remaining term of the lease plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease. In addition, we have an option to extend the lease for one additional period of five years at the end of the term of the lease and will receive a one-time refurbishment allowance from the landlord if the option to renew is exercised.

In March 2019, we entered into an amendment to the lease agreement for our Salt Lake City, Utah, office to expand our office space to a total of 41,813 square feet from 28,915 square feet. The lease term for the expanded office space commenced on May 1, 2019. The term of the lease for the original and expanded office space was also extended to terminate on the last day of the month that is 84 months after the commencement date of the expanded space. As of December 31, 2019, future minimum payments are expected to be $8.7 million over the remaining term of the lease plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease.

In April 2018, we entered into a lease agreement to lease approximately 32,492 square feet of office space located in Santa Clara, California. We entered into this lease agreement as a result of the expiration of one of our leases in Mountain View, California on December 31, 2018. The term of the lease is approximately 10.3 years, commencing on October 1, 2018 and ending on an estimated date of February 28, 2029. In August 2019, we entered into an amendment to the lease agreement for our Santa Clara, California, office to expand our office space to a total of 45,657 square feet from 32,492 square feet. In connection with this lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.3 million. As of December 31, 2019, future minimum payments are expected to be $16.1 million over the remaining term of 9 years plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease.

In connection with the Santa Clara, California lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $1.5 million, which may be reduced in increments of 20% of the original amount thereof on the second, third, fourth and fifth anniversaries of the commencement date, and may be reduced by an additional 8% of the original amount on the sixth anniversary of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease.

In March 2018, we entered into an agreement to lease 26,878 square feet of office space in Austin, Texas. The term of this lease agreement is 90 months, commencing in September 2018 and ending in May 2026. As of December 31, 2019, future minimum payments are expected to be $4.1 million over the remaining term of the lease plus our proportionate share of certain operating expenses, insurance costs and taxes for each calendar year during the lease.

In connection with the Austin, Texas office lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced on the third and subsequent anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease.

In March 2012, we entered into an agreement to lease 18,272 square feet of office space in Mountain View, California. In connection with this lease agreement, we entered into a financial guarantee consisting of a standby letter of credit for $0.1 million. As of December 31, 2019, our future minimum payments are expected to be $2.8 million over the remaining term of 3.6 years. We entered into an agreement to sublease this office space to a third party, which commenced in late December 2018. We recorded $1.1 million sublease income during the year ended December 31, 2019.

In March 2018, we renewed our agreement to lease approximately 1,413 square feet of office space in Washington, DC. The lease commenced in November 2018 and is for a term of 5.4 years. As of December 31, 2019, future minimum payments are $0.3 million.

Total rent expense under all operating leases was approximately $7.3 million, $5.3 million, and $4.6 million for the years ended December 31, 2019, 2018 and 2017, respectively.

Note 12 – Debt

On September 17, 2018, we entered into a Credit Agreement with Royal Bank of Canada (“RBC”), as administrative agent and collateral agent (the “Credit Agreement”). The Credit Agreement provides for a $40.0 million secured asset-backed revolving credit facility with a $5.0 million letter of credit sub-facility.

On December 20, 2019, we amended our revolving credit facility agreement with RBC (the “Amendment”) and increased the borrowing amount from $40.0 to $75.0 million. The maturity date has been extended to December 20, 2022.

The borrowing base under the Credit Agreement is comprised of an amount equal to (a) the lesser of (i) eighty percent (80%) of Eligible Commissions Receivables (as defined in the Credit Agreement) we actually collected by during the immediately preceding period of three months or (ii) eighty percent 80%) of our Eligible Commission Receivables for the immediately succeeding period of three months, plus (b) fifty percent (50%) of our Eligible Commission Receivables for the immediately succeeding period of six months (excluding the immediately succeeding period of three months), in each case subject to reserves established by RBC (the “Borrowing Base”). The proceeds of the loans under the Credit Agreement may be used for working capital and general corporate purposes. The Borrowers have the right to prepay the loans under the Credit Agreement in whole or in part at any time without penalty. Subject to availability under the Borrowing Base, amounts repaid may be reborrowed.

Amounts not borrowed under the Credit Agreement will be subject to a commitment fee of 0.5% per annum on the daily unused portion of the credit facility, to be paid in arrears on the first business day of each calendar quarter. At the closing of the Credit Agreement, we paid a one-time facility fee of 1.75% of the total commitments of $40.0 million. We also paid a one-time closing fee of 0.5% of the new commitment of $75.0 million in connection with the Amendment. The Company is also obligated to pay other customary administration fees for a credit facility of this size and type.

The availability under the credit facility was up to the lesser of $40.0 million or the Borrowing Base in the original credit agreement. The Amendment increased the availability up to the lesser of $75.0 million or the Borrowing Base, which may be reduced from time to time pursuant to the Credit Agreement.

Financial covenants in the original Credit Agreement required that we maintain Excess Availability (as defined in the Credit Agreement) at or above $6.0 million at any time. The Amendment also changed the financial covenants to require us to maintain at least $6.0 million of Excess Availability at all times or, if greater, up to $11.3 million depending on our borrowing base as determined by eligible past and future commission receivables. In addition, the Amendment also included changes in the payment conditions to, among other things, require us to have at least $10.0 million of liquidity or, if greater, up to $18.8 million depending on our borrowing base as determined by eligible past and future commission receivables, in order for us to make certain permitted acquisitions, investments, distributions and payments of indebtedness. The Amendment also stated the seasonal amount thresholds used in connection with the cash dominion and field examination covenants in the Credit Agreement.

We incurred $1.2 million of issuance costs in connection with the Credit Agreement, which were capitalized as part of Other assets on our Consolidated Balance Sheet as of December 31, 2018 and 2019. The Amendment did not change the interest rate. In connection with this Amendment, we incurred closing costs totaling $0.5 million, which was capitalized and recorded as Other assets on our Consolidated Balance Sheet as of December 31, 2019. The remaining balance of unamortized issuance costs was $1.1 million as of December 31, 2019.

As of December 31, 2018, we had $5.0 million outstanding principal amount under our revolving credit facility, which was repaid in full in January 2019. As of December 31, 2019, there were no outstanding amounts under this revolving credit facility and we were in compliance with all covenant requirements.

Note 13 – Income Taxes

The components of our income (loss) before provision (benefit) for income taxes were as follows (in thousands):

	Year Ended December 31,		
	2019	2018	2017
United States	$ 82,391	$ 2,458	$ (9,242)
Foreign	1,108	848	972
Income (loss) before provision (benefit) for income taxes	$ 83,499	$ 3,306	$ (8,270)

The federal and state income tax provision (benefit) is summarized as follows (in thousands):

	Year Ended December 31,		
	2019	2018	2017
Current:			
Federal	$ —	$ 5	$ (275)
State	75	48	(1,433)
Foreign	326	213	179
Total current	401	266	(1,529)
Deferred:			
Federal	13,594	165	(28,161)
State	2,635	2,648	(3,992)
Foreign	(18)	(14)	(14)
Total deferred	16,211	2,799	(32,167)
Provision (benefit) for income taxes	$ 16,612	$ 3,065	$ (33,696)

In 2019, we had worldwide consolidated income before tax of $83.5 million, and tax expense of $16.6 million, with an annual effective tax rate of 19.9%.

The effective tax rate of our provision (benefit) for income taxes differs from the federal statutory rate as follows:

	Year Ended December 31,		
	2019	2018	2017
Statutory rate	21.0 %	21.0 %	35.0 %
State income taxes, net of federal benefit	2.6	(7.2)	31.7
Stock-based compensation shortfalls (windfalls), net	(7.0)	(29.4)	1.9
Non-deductible stock-based compensation	2.5	21.6	(9.7)
Non-deductible lobbying expenses	1.0	15.2	(9.1)
Research and development credits	(0.9)	(17.1)	(1.5)
Changes in valuation allowance	—	72.8	—
Tax reform - tax rate change	—	—	355.9
Foreign income tax and income inclusion	0.1	6.8	2.7
Non-deductible parking expense	0.2	3.1	—
Other permanent differences	0.4	5.9	0.7
Effective tax rate	19.9 %	92.7 %	407.6 %

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes, together with operating losses and tax credit carryforwards.

The tax effects of significant items comprising our deferred taxes as of December 31, 2019 and 2018 were as follows (in thousands):

	December 31, 2019	December 31, 2018
Deferred tax assets:		
Net operating losses	$ 60,023	$ 22,181
Accruals and reserves	4,143	3,370
Operating lease liabilities	9,471	—
Intangible assets	6,306	2,269
Tax credits	5,818	4,508
Stock-based compensation	2,835	2,388
Fixed assets	203	61
Other	187	250
Total deferred tax assets	88,986	35,027
Valuation allowance	(2,407)	(2,407)
Total deferred tax assets net of valuation allowance	86,579	32,620
Deferred tax liabilities:		
Commissions receivable	(141,566)	(80,289)
Right-of-use assets	(8,879)	—
Total deferred tax liabilities	$ (150,445)	$ (80,289)
Net deferred tax liabilities	$ (63,866)	$ (47,669)

Assessing the realizability of our deferred tax assets is dependent upon several factors, including the likelihood and amount, if any, of future taxable income in relevant jurisdictions during the periods in which those temporary differences become deductible. We forecast taxable income by considering all available positive and negative evidence, including our history of operating income and losses and our financial plans and estimates that we use to manage the business. These assumptions require significant judgment about future taxable income. As a result, the amount of deferred tax assets considered realizable is subject to adjustment in future periods if estimates of future taxable income change. During the year ended December 31, 2018, a partial valuation allowance of $2.4 million was recorded against certain state net operating losses expected to expire unutilized. The valuation allowance was recorded as a result of increased uncertainty regarding our future taxable income and a lack of sources of other taxable income to realize those net operating losses. The changes of our valuation allowance is summarized as follows (in thousands):

Deferred Tax Assets - Valuation Allowance	Balance at beginning of year	Provision for income taxes	Balance at end of year
Year Ended December 31, 2019	$ 2,407	$ —	$ 2,407
Year Ended December 31, 2018	$ —	$ 2,407	$ 2,407
Year Ended December 31, 2017	$ —	$ —	$ —

We had net operating loss carryforwards as of December 31, 2019 of approximately $238.3 million and $168.1 million for federal income tax and state income tax purposes, respectively. Federal and state net operating loss carry forwards begin expiring in 2034 and 2021, respectively. As of December 31, 2019, we had tax credit carry forwards of approximately $5.2 million and $6.1 million for federal income tax and state income tax purposes, respectively. The federal tax credit carryforwards begin expiring in 2021. The state tax credits carry forward indefinitely.

Utilization of the net operating loss carryforwards and credits may be subject to a substantial annual limitation due to ownership changes that may have occurred or that could occur in the future, as required by Section 382 of the Internal Revenue Code and similar state provisions. These ownership change limitations may limit the amount of net operating loss carryforwards and other tax attributes that can be utilized annually to offset future taxable income and tax, respectively.

A reconciliation of the beginning and ending amount of our unrecognized tax benefits is as follows (in thousands):

	Unrecognized Tax Benefits
Balance as of December 31, 2016	$ 5,253
Decrease based on tax positions related to the prior year	(862)
Lapse of statute of limitations	(1,637)
Additions based on tax positions related to the current year	342
Balance as of December 31, 2017	3,096
Increase based on tax positions related to the prior year	579
Lapse of statute of limitations	(5)
Additions based on tax positions related to the current year	70
Balance as of December 31, 2018	3,740
Additions based on tax positions related to the current year	969
Balance as of December 31, 2019	$ 4,709

As of December 31, 2019, the total amount of gross unrecognized tax benefits was $4.7 million, of which $4.2 million, if recognized, would affect our effective tax rate. As of December 31, 2018, the total amount of gross unrecognized tax benefits was $3.7 million, of which $3.3 million, if recognized, would affect our effective tax rate.

We record interest and penalties related to unrecognized tax benefits in income tax expense. As of December 31, 2019, the amount accrued for estimated interest related to uncertain tax positions was immaterial. We did not record an accrual for penalties.

Included in the balance of income tax liabilities and accrued interest as of December 31, 2019 is an immaterial amount related to tax positions for which it is reasonably possible that the statute of limitations will expire in various jurisdictions and income tax exams will close within the next twelve months.

We are subject to taxation in various jurisdictions, including federal, state and foreign. Our federal and state income tax returns are generally not subject to examination by taxing authorities for fiscal years before 2007 due to our net operating losses.

Note 14 – Selected Quarterly Financial Data (Unaudited)

Selected summarized quarterly financial information for 2019 and 2018 is as follows (in thousands, except per share amounts):

For the Year Ended December 31, 2019	First Quarter	Second Quarter	Third Quarter	Fourth Quarter*	Year
Revenue	$ 68,773	$ 65,767	$ 69,913	$ 301,748	$ 506,201
Income (loss) from operations	(9,183)	(12,311)	(20,241)	123,144	81,409
Net income (loss)	(5,159)	(5,754)	(11,024)	88,824	66,887
Net income (loss) per share:					
Basic	$ (0.24)	$ (0.25)	$ (0.47)	$ 3.74	$ 2.90
Diluted	$ (0.24)	$ (0.25)	$ (0.47)	$ 3.58	$ 2.73

For the Year Ended December 31, 2018	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Year
Revenue	$ 43,070	$ 32,657	$ 40,751	$ 134,917	$ 251,395
Income (loss) from operations	(6,720)	(16,920)	(15,454)	41,645	2,551
Net income (loss)	(4,845)	(12,014)	(8,972)	26,072	241
Net income (loss) per share:					
Basic	$ (0.26)	$ (0.63)	$ (0.47)	$ 1.32	$ 0.01
Diluted	$ (0.26)	$ (0.63)	$ (0.47)	$ 1.25	$ 0.01

* See Note 2 – Revenue for details regarding the change in estimate in the fourth quarter of 2019.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. 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 as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended, as of the end of the period covered by this Annual Report on Form 10-K.

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.

Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934, as amended. Under the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2019 based on the guidelines established in *Internal Control—Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework). Our internal control over financial reporting includes policies and procedures that provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles.

Based on the results of our evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2019. We reviewed the results of management's assessment with our Audit Committee.

Ernst & Young LLP, our independent registered public accounting firm, has issued a report on the Company's internal control over financial reporting as of December 31, 2019, which is presented below.

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 December 31, 2019 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.

Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of eHealth, Inc.

Opinion on Internal Control over Financial Reporting

We have audited eHealth, Inc.'s internal control over financial reporting as of December 31, 2019, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, eHealth, Inc. (the Company) maintained, in all material respects, effective internal control over financial reporting as of December 31, 2019, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the 2019 consolidated financial statements of the Company and our report dated March 2, 2020 expressed an unqualified opinion thereon.

Basis for Opinion

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

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

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

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

/s/ Ernst & Young LLP

Redwood City, California
March 2, 2020

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information concerning our directors, executive officers, compliance with Section 16(a) of the Securities Exchange Act of 1934, as amended, and corporate governance required by this Item 10 of Form 10-K is incorporated by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2019.

We have adopted a code of ethics that applies to all employees, including our principal executive officer, Scott Flanders, principal financial officer, Derek Yung, and all other executive officers. The code of ethics is available on the about us/investor relations/corporate governance page of our website at *www.eHealth.com*. A copy may also be obtained without charge by contacting investor relations, attention Vice President of Investor Relations, 2625 Augustine Drive, Second Floor, Santa Clara, CA, 95054 or by calling (650) 584-2700.

We plan to post on our website at the address described above any future amendments or waivers of our Code of Conduct.

ITEM 11. EXECUTIVE COMPENSATION

The information required by Item 11 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2019.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by Item 12 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2019.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by Item 13 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2019.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 14 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after our fiscal year ended December 31, 2019.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) We have filed the following documents as part of this Annual Report on Form 10-K:

1. Consolidated Financial Statements

Information in response to this Item is included in Item 8 of Part II of this Annual Report on Form 10-K.

2. Financial Statement Schedules

All schedules are omitted because they are not applicable, not required or because the required information is included in the consolidated financial statements or notes thereto.

3. Exhibits

See Item 15(b) below.

(b) ***Exhibits***—We have filed, or incorporated into this Annual Report on Form 10-K by reference, the exhibits listed on the accompanying Index to Exhibits of this Annual Report on Form 10-K.

(c) ***Financial Statement Schedule***—See Item 15(a) above.

ITEM 16. FORM 10-K SUMMARY

None.

SIGNATURES

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

March 2, 2020
eHealth, Inc.

/s/ SCOTT N. FLANDERS	/s/ DEREK N. YUNG
Scott N. Flanders	Derek N. Yung
Chief Executive Officer	*Chief Financial Officer*

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated on March 2, 2020.

Signature	Title
/s/ SCOTT N. FLANDERS Scott N. Flanders	Chief Executive Officer (Principal Executive Officer) and Director
/s/ DEREK N. YUNG Derek N. Yung	Chief Financial Officer (Principal Financial and Accounting Officer)
/s/ ANDREA BRIMMER Andrea Brimmer	Director
/s/ BETH A. BROOKE Beth A. Brooke	Director
/s/ MICHAEL D. GOLDBERG Michael D. Goldberg	Director
/s/ RANDALL S. LIVINGSTON Randall S. Livingston	Director
/s/ JACK L. OLIVER III Jack L. Oliver III	Director
/s/ DALE B. WOLF Dale B. Wolf	Director

EXHIBIT INDEX

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein	
			Form	Date
2.1		Purchase Agreement dated January 16, 2018 by and among eHealth, Inc., Wealth, Health and Life Advisors, LLC (d/b/a GoMedigap), WHL Advisors, Inc., Qavah Ventures, LLC, Richard Cantu, Kevin Walbrick, and Kevin Walbrick as the exclusive member representative thereunder	Current Report on Form 8-K (File No. 001-33071)	January 16, 2018
3.1		Amended and Restated Certificate of Incorporation of the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
3.2		Amended and Restated Bylaws of the Registrant	Current Report on Form 8-K (File No. 001-33071)	November 17, 2008
4.1		Form of the Registrant’s Common Stock Certificate	Registration Statement on Form S-l, as amended (File No. 333-133526)	June 28, 2006
4.2	†	Description of Capital Stock		
10.1*		Form of Indemnification Agreement entered into between the Registrant and its directors and officers	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.2*		Employment Agreement, dated May 31, 2016, between Scott N. Flanders and eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.3*		Employment Agreement, dated July 11, 2016, between David Francis and eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.4*		Form of Severance Letter with Robert Hurley	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.5*		Letter Agreement, dated November 17, 2005, between Jack L. Oliver III and the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.6*		Employment Agreement, dated June 4, 2018, between Derek Yung and eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 7, 2018
10.7		Credit Agreement, dated September 17, 2018, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Current Report on Form 8-K (File No. 001-33071)	September 19, 2018
10.7.1		Amendment No. 1 to Credit Agreement, dated October 16, 2018, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2019
10.7.2		Amendment No. 2 to Credit Agreement, dated July 2, 2019, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2019
10.7.3		Amendment No. 3 to Credit Agreement, dated December 20, 2019, by and among eHealth, Inc., eHealthInsurance Services, Inc., Wealth, Health and Life Advisors, LLC, PlanPrescriber, Inc., Royal Bank of Canada and other lenders identified therein	Current Report on Form 8-K (File No. 001-33071)	December 26, 2019
10.8		Security Agreement, dated September 17, 2018, by and among eHealth, Inc., eHealthInsurance Services, Inc., PlanPrescriber, Inc., Wealth, Health and Life Advisors, LLC, and Royal Bank of Canada	Current Report on Form 8-K (File No. 001-33071)	September 19, 2018
10.9		Guaranty, dated September 17, 2018, by and between PlanPrescriber, Inc. and Royal Bank of Canada	Current Report on Form 8-K (File No. 001-33071)	September 19, 2018
10.10		Lease Agreement, dated March 29, 2018, between Ascentris-116b, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 2, 2018
10.11		Lease Agreement, dated April 25, 2018, between Augustine Bowers LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 30, 2018
10.11.1		First Amendment to Lease, dated August 19, 2019, between Augustine Bowers LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 21, 2019
10.12		Lease Agreement, dated May 2004, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust, as amended	Registration Statement on Form S-l, as amended(File No. 333-133526)	April 25, 2006
10.12.1		First Amendment to Lease Agreement, effective as of May 15, 2009, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Current Report on Form 8-K (File No. 001-33071)	May 21, 2009
10.12.2		Second Amendment to Lease Agreement, effective as of August 5, 2010 between eHealth Insurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Current Report on Form 8-K (File No. 001-33071)	August 18, 2010

10.12.3	Third Amendment to Lease Agreement, effective as of July 8, 2011, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Generations Trust	Current Report on Form 8-K (File No. 001-33071)	July 12, 2011
10.12.4	Fourth Amendment to Lease Agreement, effective as of July 13, 2018, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Quarterly Report on Form 10-Q (File No. 001-33071)	November 6, 2018
10.13	Standard Lease Agreement, dated June 10, 2004, between eHealthInsurance Services, Inc. and Gold Pointe E LLC, as amended	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.13.1	Fourth Amendment to Standard Lease Agreement (Office), effective as of November 6, 2007, between eHealthInsurance Services, Inc. and Carlsen Investments, LLC	Current Report on Form 8-K (File No. 001-33071)	November 7, 2007
10.13.2	Sixth Amendment to Lease and Acknowledgment to Standard Lease Agreement, dated August 29, 2012, between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 31, 2012
10.13.3	Seventh Amendment to Lease and Acknowledgment to Standard Lease Agreement, dated August 6, 2014, between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2014
10.13.4	Eighth Amendment to Standard Lease Agreement (Officer) and Partial Termination of Lease dated June 23, 2016 between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	June 28, 2016
10.13.5	Ninth Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) dated August 17, 2016 between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 22, 2016
10.13.6	Tenth Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 12, 2019
10.13.7	Eleventh Amendment to Lease and Acknowledgment to Standard Lease Agreement (Office) between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	February 4, 2020
10.14.1	Office Lease Contract, effective as of September 1, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.14.2	Property Management Service Contract, effective as of September 1, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.14.3	Office Lease Contract, effective as of September 15, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.14.4	Property Management Service Contract, effective as of September 15, 2019, between eHealth China (Xiamen) Technology Co., Ltd and Xiamen Software Industry Investment & Development Co. Ltd.	Current Report on Form 8-K (File No. 001-33071)	September 6, 2019
10.15	Lease Agreement, dated March 23, 2012, between 340 Middlefield, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	March 27, 2012
10.15.1	First Amendment to Lease Agreement, effective as of May 28, 2013, between 340 Middlefield, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	May 29, 2013
10.15.2	Sublease, dated November 2, 2018, between JJ Lake Corporation and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	November 30, 2018
10.15.3	Consent to Sublease, dated November 27, 2018, by and among 340 Middlefield, LLC, JJ Lake Corporation and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	November 30, 2018
10.16	Office Lease, dated May 7, 2012, between Lake Pointe Three, LC, and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 9, 2012
10.16.1	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.	Quarterly Report on Form 10-Q (File No. 001-33071)	November 8, 2016
10.16.2	Amendment No. 1 to Lease, dated August 17, 2017, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 22, 2017
10.16.3	Amendment No. 2 to Lease, dated December 12, 2017, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Annual Report on Form 10-K (File No. 001-33071)	March 19, 2018
10.16.4	Amendment No. 3 to Lease, dated March 20, 2019, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	March 26, 2019
10.16.5	Amendment No. 4 to Lease, dated November 19, 2019, between SLC Lake Pointe SPE LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	November 19, 2019
10.17	Sublease Agreement, dated June 3, 2019, between Home Point Financial Corporation and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	June 7, 2019

10.17.1	Office Lease, dated June 3, 2019, between Precedent Lakeside Acquisitions, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	June 7, 2019
10.17.2	Consent to Sublease, dated June 3, 2019, between Home Point Financial Corporation, eHealthInsurance Services, Inc. and Precedent Lakeside Acquisitions, LLC.	Current Report on Form 8-K (File No. 001-33071)	June 7, 2019
10.18*	Executive Bonus Plan	Quarterly Report on Form 10-Q (File No. 001-33071)	November 7, 2017
10.19*	eHealth, Inc. Performance Bonus Plan	Definitive Proxy Statement on Schedule 14A (File No. 001-33071)	April 28, 2014
10.20*	2006 Equity Incentive Plan of the Registrant, as amended and restated June 15, 2010	Current Report on Form 8-K (File No. 001-33071)	June 21, 2010
10.20.1*	Form of Notice of Stock Option Grant and Stock Option Agreement under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.20.2*	Form of Notice of Stock Option Grant and Stock Option Agreement (Initial Director Grant) under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.20.3*	Form of Notice of Stock Option Grant and Stock Option Agreement (Annual Director Grant) under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.20.4*	Form of Notice of Stock Unit Grant and Stock Unit Agreement under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.20.5*	Form of Notice of Initial Outside Director Stock Unit Grant Under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009
10.20.6*	Form of Notice of Annual Outside Director Stock Unit Grant Under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009
10.20.7*	Form of Outside Director Stock Unit Agreement	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009
10.20.8*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2006 Equity Incentive Plan of the Registrant	Quarterly Report on Form 10-Q (File No. 001-33071)	May 6, 2011
10.20.9*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2006 Equity Incentive Plan of the Registrant	Quarterly Report on Form 10-Q (File No. 001-33071)	May 7, 2013
10.21.0*	Amended and Restated 2014 Equity Incentive Plan	Current Report on Form 8-K (File No. 001-33071)	June 14, 2019
10.21.1*	Form of Notice of Stock Option Grant and Stock Option Agreement under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.21.2*	Form of Notice of Stock Unit Grant and Stock Unit Agreement under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.21.3*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Initial Director Grant) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.21.4*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Annual Director Grant) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.21.5	Form of Notice of Stock Option Grant and Stock Option Agreement (People's Republic of China) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.21.6	Form of Notice of Stock Unit Grant and Stock Unit Agreement (People's Republic of China) under the 2014 Equity Incentive Plan of the Registrant	Registration Statement on Form S-8 (File No. 333-196675)	June 11, 2014
10.21.7*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of the Registration	Current Report on Form 8-K (File No. 001-33071)	March 23, 2015
10.21.8*	Form of Notice of Stock Option Grant and Stock Option Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.21.9*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2014 Equity Incentive Plan of eHealth, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 8, 2016
10.22*	Form of Deferral Election Form for Newly Eligible Individual with Existing Awards	Quarterly Report on Form 10-Q (File No. 001-33071)	November 6, 2015
10.22.1*	Form of Deferral Election Form for Eligible Individual for Award to be Granted in the Next Calendar Year	Quarterly Report on Form 10-Q (File No. 001-33071)	November 6, 2015
10.23	Employment Agreement, dated as of February 20, 2020, between eHealthInsurance Services, Inc. and Robert Hurley.	Current Report on Form 8-K (File No. 001-33071)	February 21, 2020
21.1	List of Subsidiaries	Annual Report on Form 10-K (File No. 001-33071)	March 19, 2018
23.1 †	Consent of Independent Registered Public Accounting Firm		

31.1	†	Certification of Scott N. Flanders, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a) and 15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	†	Certification of Derek N. Yung, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a) and 15d-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 Derek N. Yung, 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 - The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document
101.SCH	†	Inline XBRL Taxonomy Extension Schema Document
101.CAL	†	Inline XBRL Taxonomy Extension Calculation Linkbase Document
101.DEF	†	Inline XBRL Taxonomy Extension Definition Linkbase Document
101.LAB	†	Inline XBRL Taxonomy Extension Label Linkbase Document
101.PRE	†	Inline XBRL Taxonomy Extension Presentation Linkbase Document
104		The cover page from the Company’s Annual Report on Form 10-K for the fiscal year ended December 31, 2019, formatted in Inline XBRL

† Filed herewith.
‡ Furnished herewith.
* Indicates a management contract or compensatory plan or arrangement.

DESCRIPTION OF THE REGISTRANT'S SECURITIES
REGISTERED PURSUANT TO SECTION 12 OF THE
SECURITIES EXCHANGE ACT OF 1934

eHealth, Inc. has one class of securities registered under Section 12 of the Securities Exchange Act of 1934, as amended: our common stock, $0.001 par value per share.

The following description summarizes the general terms and provisions of our common stock as set forth in our certificate of incorporation and amended and restated bylaws ("bylaws"). This summary does not purport to be complete and is subject to, and qualified in its entirety by the provisions of our certificate of incorporation and bylaws, each of which is included as an exhibit to the Annual Report on Form 10-K to which this description is an Exhibit, and each of which may be amended from time to time. We encourage you to read our certificate of incorporation and bylaws and the applicable provisions of the General Corporation Law of the State of Delaware for additional information.

Our authorized capital stock consists of 100 million shares of common stock, $0.001 par value per share, and 10 million shares of undesignated preferred stock, $0.001 par value per share.

Common Stock

On all matters submitted to our stockholders for vote, our common stockholders are entitled to one vote per share, voting together as a single class, and do not have cumulative voting rights. Accordingly, the holders of a majority of the shares of common stock entitled to vote in any election of directors can elect all of the directors standing for election, if they so choose. Subject to preferences that may apply to any shares of preferred stock outstanding, the holders of common stock are entitled to share equally in any dividends that our board of directors may determine to issue from time to time. Upon our liquidation, dissolution or winding-up, the holders of common stock shall be entitled to share equally all assets remaining after the payment of any liabilities and the liquidation preferences on any outstanding preferred stock. Holders of common stock have no preemptive or conversion rights or other subscription rights and there are no redemption or sinking funds provisions applicable to the common stock.

Preferred Stock

Our board of directors has the authority, without further action by our stockholders, to issue up to 10 million shares of preferred stock in one or more series. Our board of directors is able to determine, with respect to any series of preferred stock, the powers, preferences and relative, participating, optional or other special rights, and the qualifications, limitations or restrictions thereof, including, without limitation:

- the designation of the series;
- the number of shares of the series, which our board of directors may, except where otherwise provided in the preferred stock designation, increase (but not above the total number of authorized shares of the class) or decrease (but not below the number of shares then outstanding);
- whether dividends, if any, will be cumulative or non-cumulative and the dividend rate of the series;
- the dates at which dividends, if any, will be payable;
- the redemption rights and price or prices, if any, for shares of the series;
- the terms and amounts of any sinking fund provided for the purchase or redemption of shares of the series;
- the amounts payable on shares of the series in the event of any voluntary or involuntary liquidation, dissolution or winding-up of the affairs of our company;
- whether the shares of the series will be convertible into shares of any other class or series, or any other security, of our company or any other entity, and, if so, the specification of the other class or series or other security, the conversion price or prices or rate or rates, any rate adjustments, the date or dates as of which the shares will be convertible and all other terms and conditions upon which the conversion may be made;
- restrictions on the issuance of shares of the same series or of any other class or series; and
- the voting rights, if any, of the holders of the series.

We could issue a series of preferred stock that could, depending on the terms of the series, impede or discourage an acquisition attempt or other transaction that some, or a majority, of the holders of our common stock might believe to be in their best interests or in which the holders of our common stock might receive a premium for their common stock over the market price of the common stock. Additionally, the issuance of preferred stock may adversely affect the holders of our common stock by restricting dividends on the common stock, diluting the voting power of the common stock or subordinating the liquidation rights of the common stock. As a result of these or other factors, the issuance of preferred stock could have an adverse impact on the market price of our common stock.

Anti-Takeover Effects of Delaware Law and Our Certificate of Incorporation and Bylaws

The provisions of Delaware law, our certificate of incorporation and our bylaws may have the effect of delaying, deferring or discouraging another person from acquiring control of our company. These provisions, which are summarized below, may have the effect of discouraging takeover bids. They are also designed, in part, to encourage persons seeking to acquire control of us to negotiate first with our board of directors. We believe that the benefits of increased protection of our potential ability to negotiate with an unfriendly or unsolicited acquirer outweigh the disadvantages of discouraging a proposal to acquire us because negotiation of these proposals could result in an improvement of their terms.

Delaware Law

We are subject to the provisions of Section 203 of the Delaware General Corporation Law regulating corporate takeovers. In general, Section 203 prohibits a publicly-held Delaware corporation from engaging, under certain circumstances, in a business combination with an interested stockholder for a period of three years following the date the person became an interested stockholder unless:

- prior to the date of the transaction, the board of directors approved either the business combination or the transaction which resulted in the stockholder becoming an interested stockholder;
- upon completion of the transaction that resulted in the stockholder becoming an interested stockholder, the interested stockholder owned at least 85% of the voting stock of the corporation outstanding at the time the transaction commenced, excluding for purposes of determining the voting stock outstanding, but not for determining the outstanding voting stock owned by the interested stockholder, (1) voting stock owned by persons who are directors and also officers, and (2) voting stock owned by employee stock plans in which employee participants do not have the right to determine confidentially whether shares held subject to the plan will be tendered in a tender or exchange offer; or
- at or subsequent to the date of the transaction, the business combination is approved by the board of directors and authorized at an annual or special meeting of stockholders, and not by written consent, by the affirmative vote of at least 66 2/3% of the outstanding voting stock which is not owned by the interested stockholder.

Generally, a business combination includes a merger, asset or stock sale, or other transaction resulting in a financial benefit to the interested stockholder. An interested stockholder is a person who, together with affiliates and associates, owns or, within three years prior to the determination of interested stockholder status, did own 15% or more of a corporation’s outstanding voting stock. These provisions may have the effect of delaying, deferring or preventing a change in our control.

Certificate of Incorporation and Bylaw Provisions

Our certificate of incorporation and our bylaws include a number of provisions that could deter hostile takeovers or delay or prevent changes in control of our management team, including the following:

- *Board of directors vacancies*. Our certificate of incorporation and our bylaws authorize only our board of directors to fill vacant directorships, including newly created seats. In addition, the number of directors constituting our board of directors is permitted to be set only by a resolution adopted by our board of directors. These provisions prevent a stockholder from increasing the size of our board of directors and then gaining control of our board of directors by filling the resulting vacancies with its own nominees. This makes it more difficult to change the composition of our board of directors but promotes continuity of management.

- *Election and Removal of Directors*. Our certificate of incorporation and our bylaws provide that our board is classified into three classes of directors. Our certificate of incorporation does not provide for cumulative voting. In addition, directors may be removed from office by our stockholders only for cause. This system of electing and removing directors may tend to discourage a third party from making a tender offer or otherwise attempting to obtain control of us, because it generally makes it more difficult for stockholders to replace a majority of directors.

- *Stockholder action; special meeting of stockholders*. Our certificate of incorporation provides that our stockholders may not take action by written consent, but may only take action at annual or special meetings of our stockholders. As a result, a holder controlling a majority of our capital stock is not be able to amend our bylaws or remove directors without holding a meeting of our stockholders called in accordance with our bylaws. Our certificate of incorporation and our bylaws further provide that special meetings of our stockholders may be called only by a majority of our board of directors, the Chairperson of the Board of Directors, our Chief Executive Officer or our President (in the absence of a Chief Executive Officer), thus prohibiting a stockholder from calling a special meeting. These provisions might delay the ability of our stockholders to force consideration of a proposal or for stockholders controlling a majority of our capital stock to take any action, including the removal of directors.

- *Advance notice requirements for stockholder proposals and director nominations*. Our bylaws provide advance notice procedures for stockholders seeking to bring business before our annual meeting of stockholders or to nominate candidates for election as directors at our annual meeting of stockholders. Our bylaws also specify certain requirements regarding the form and content of a stockholder's notice. These provisions might preclude our stockholders from bringing matters before our annual meeting of stockholders or from making nominations for directors at our annual meeting of stockholders if the proper procedures are not followed. We expect that these provisions may also discourage or deter a potential acquirer from conducting a solicitation of proxies to elect the acquirer's own slate of directors or otherwise attempting to obtain control of our company.

- *Amendment of charter provisions*. Any amendment of the above provisions in our certificate of incorporation would require approval by a majority of our board of directors and the holders of at least 66 2/3% of our then outstanding voting securities.

- *Issuance of undesignated preferred stock*. Our board of directors has the authority, without further action by the stockholders, to issue up to 10 million shares of undesignated preferred stock with rights and preferences, including voting rights, designated from time to time by our board of directors. The existence of authorized but unissued shares of preferred stock would enable our board of directors to render more difficult or to discourage an attempt to obtain control of us by means of a merger, tender offer, proxy contest or other means.

The provisions of Delaware law and our certificate of incorporation and our bylaws could have the effect of discouraging others from attempting hostile takeovers and, as a consequence, they may also inhibit temporary fluctuations in the market price of our common stock that often result from actual or rumored takeover attempts. These provisions may also have the effect of preventing changes in our management. It is possible that these provisions could make it more difficult to accomplish transactions that stockholders may otherwise deem to be in their best interests.

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements:

(1) Registration Statement (Form S-3 No. 333-228862) of eHealth, Inc.,
(2) Registration Statements (Forms S-8 No. 333-232252 and No. 333-196675) pertaining to the 2014 Equity Incentive Plan,
(3) Registration Statements (Forms S-8 No. 333-181252 and No. 333-163269) pertaining to the 2006 Equity Incentive Plan, and
(4) Registration Statement (Form S-8 No. 333-137999) pertaining to the 2006 Equity Incentive Plan, 2005 Stock Plan and 1998 Stock Plan of eHealth, Inc., and 2004 Stock Plan of eHealth China;

of our reports dated March 2, 2020, with respect to the consolidated financial statements of eHealth, Inc. and the effectiveness of internal control over financial reporting of eHealth, Inc. included in this Annual Report (Form 10-K) of eHealth, Inc. for the year ended December 31, 2019.

/s/ Ernst & Young LLP

Redwood City, California
March 2, 2020

Exhibit 31.1

CERTIFICATION

I, Scott N. Flanders, certify that:

1. I have reviewed this Annual Report on Form 10-K 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 the registrant's most recent fiscal quarter (the registrant's fourth fiscal 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 the 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:	March 2, 2020	/s/ SCOTT N. FLANDERS
		Scott N. Flanders
		Chief Executive Officer

CERTIFICATION

I, Derek N. Yung, certify that:

1. I have reviewed this Annual Report on Form 10-K 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 the registrant’s most recent fiscal quarter (the registrant’s fourth fiscal 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 the 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:	March 2, 2020	/s/ DEREK N. YUNG
		Derek N. Yung
		Chief Financial Officer

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 Annual Report of eHealth, Inc. on Form 10-K (the “Form 10-K”) for the annual period ended December 31, 2019, 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-K, 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-K 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
March 2, 2020

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.

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 Annual Report of eHealth, Inc. on Form 10-K (the “Form 10-K”) for the annual period ended December 31, 2019, as filed with the Securities and Exchange Commission on the date hereof (the “Report”), I, Derek N. Yung, 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-K, 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-K fairly presents, in all material respects, the financial condition and results of operations of eHealth, Inc.

/s/ DEREK N. YUNG

Derek N. Yung
Chief Financial Officer
March 2, 2020

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.