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

FORM 10-Q

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

For the quarterly period ended March 31, 2012

OR

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

For the transition period from to

001-33071
(Commission File Number)

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

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

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

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

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

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

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

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

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

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

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of April 30, 2012 was 19,588,351 shares.

EHEALTH, INC. FORM 10-Q

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PART I
FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

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

	December 31, 2011	March 31, 2012 (unaudited)
Assets		
Current assets:		
Cash and cash equivalents	$ 123,607	$ 116,241
Accounts receivable	8,055	6,240
Deferred income taxes	4,622	4,051
Prepaid expenses and other current assets	3,377	4,003
Total current assets	139,661	130,535
Property and equipment, net	4,631	4,261
Deferred income taxes	3,390	4,171
Other assets	5,641	9,122
Intangible assets, net	10,526	10,079
Goodwill	14,096	14,096
Total assets	$ 177,945	$ 172,264
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 2,391	$ 3,233
Accrued compensation and benefits	7,904	5,475
Accrued marketing expenses	6,195	3,665
Deferred revenue	314	1,589
Other current liabilities	1,547	2,808
Total current liabilities	18,351	16,770
Non-current liabilities	3,920	3,948
Stockholders' equity:		
Common stock	26	26
Additional paid-in capital	215,364	217,554
Treasury stock, at cost	(81,557)	(89,998)
Retained earnings	21,661	23,786
Accumulated other comprehensive income	180	178
Total stockholders' equity	155,674	151,546
Total liabilities and stockholders' equity	$ 177,945	$ 172,264

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

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

	Three Months Ended March 31,	
	2011	2012
Revenue		
Commission	$ 30,760	$ 31,464
Other	6,795	5,611
Total revenue	37,555	37,075
Operating costs and expenses:		
Cost of revenue	2,651	1,675
Marketing and advertising	12,909	12,987
Customer care and enrollment	5,410	5,971
Technology and content	5,470	5,482
General and administrative	6,721	6,604
Amortization of intangible assets	427	447
Total operating costs and expenses	33,588	33,166
Income from operations	3,967	3,909
Other income (expense), net	(19)	21
Income before provision for income taxes	3,948	3,930
Provision for income taxes	1,967	1,805
Net income	$ 1,981	$ 2,125
Net income per share:		
Basic	$ 0.09	$ 0.11
Diluted	$ 0.09	$ 0.10
Weighted-average number of shares used in per share amounts:		
Basic	21,351	19,536
Diluted	22,052	20,449
Comprehensive income:		
Net income	$ 1,981	$ 2,125
Foreign currency translation adjustment	(7)	(2)
Comprehensive income	$ 1,974	$ 2,123

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

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

	Three Months Ended March 31,	
	2011	2012
Operating activities		
Net income	$ 1,981	$ 2,125
Adjustments to reconcile net income to net cash provided by operating activities:		
Deferred income taxes	1,777	367
Depreciation and amortization	669	576
Amortization of intangible assets	427	447
Stock-based compensation expense	1,861	1,625
Excess tax benefits from stock-based compensation	(1,089)	(551)
Deferred rent	(9)	(10)
Loss on disposal of property and equipment	3	—
Changes in operating assets and liabilities:		
Accounts receivable	5,477	1,815
Prepaid expenses and other current assets	307	405
Other assets	(30)	(139)
Accounts payable	(1,380)	842
Accrued compensation and benefits	(2,183)	(2,432)
Accrued marketing expenses	105	(2,531)
Deferred revenue	(884)	1,275
Other current liabilities	(257)	1,279
Net cash provided by operating activities	6,775	5,093
Investing activities		
Purchases of property and equipment	(505)	(203)
Books of business transfers	(765)	(4,373)
Net cash used in investing activities	(1,270)	(4,576)
Financing activities		
Proceeds from exercise of common stock options	26	994
Cash used to net-share settle equity awards	(542)	(980)
Excess tax benefits from stock-based compensation	1,089	551
Repurchase of common stock	(3,796)	(8,441)
Principal payments in connection with capital leases	(14)	(6)
Net cash used in financing activities	(3,237)	(7,882)
Effect of exchange rate changes on cash and cash equivalents	(8)	(1)
Net increase in cash and cash equivalents	2,260	(7,366)
Cash and cash equivalents at beginning of period	128,074	123,607
Cash and cash equivalents at end of period	$ 130,334	$ 116,241

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

Note 1—Summary of Business and Significant Accounting Policies

Description of Business—eHealth, Inc. (the "Company," "eHealth," "we" or "us") offers Internet-based health insurance agency services for individuals, families and small businesses in the United States, as well as technology licensing and Internet advertising services. Our services and technology enable individuals, families and small businesses to compare and purchase health insurance plans from health insurance carriers across the nation. We also 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. We are licensed to market and sell health insurance in all 50 states and the District of Columbia.

Basis of Presentation—The accompanying condensed consolidated balance sheet as of March 31, 2012, the condensed consolidated statements of comprehensive income for the three months ended March 31, 2011 and 2012 and the condensed consolidated statements of cash flows for the three months ended March 31, 2011 and 2012, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2011 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2011, which was filed with the Securities and Exchange Commission on March 15, 2012. The accompanying statements should be read in conjunction with the audited consolidated financial statements and related notes contained in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles, or U.S. GAAP, for interim financial information. Accordingly, they do not include all of the financial information and footnotes required by U.S. GAAP for complete financial statements. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2011, and include all adjustments necessary for the fair presentation of eHealth's statement of financial position as of March 31, 2012, its results of operations for the three months ended March 31, 2011 and 2012 and its cash flows for the three months ended March 31, 2011 and 2012. All adjustments are of a normal recurring nature. The results for the three months ended March 31, 2012 are not necessarily indicative of the results to be expected for any subsequent quarter or for the fiscal year ending December 31, 2012.

Seasonality—The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by these patterns. The reasons for these seasonal patterns are not entirely clear.

The vast majority of Medicare plans are sold in the fourth quarter of each year during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, we have generated the majority of our Medicare plan-related revenue in the fourth quarter of the year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

In 2011, we significantly increased our temporary customer care center staff during the third quarter in preparation for the Medicare annual enrollment period. We employed our temporary customer care center staff until the end of the Medicare annual enrollment period in December 2011. As a result, our customer care center staffing costs were significantly higher in the third and fourth quarters of 2011 compared to the first and second quarters of 2011. We expect this seasonal trend to occur again in 2012. We also incurred significantly greater Medicare plan-related online advertising expenses during the third and fourth quarters of 2011 compared to the first and second quarters of 2011. We expect this seasonal trend to occur again in 2012. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our temporary customer care center staffing costs and Medicare-related online advertising expenses incurred in the third quarter have had a significant negative impact on our profitability during the third quarter.

Based on these seasonal trends, we expect our revenue to be highest in the fourth quarter of the year and we expect our profitability to be relatively higher in the second and fourth quarters and relatively lower in the third quarter of the year.

Book-of-Business Transfers—In November 2010, May 2011, October 2011 and March 2012, we entered into 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 in exchange for total consideration of $3.3 million, $3.1 million, $1.2 million and $4.4 million, respectively, which is included in "Prepaid expenses and other current assets" and also in "Other assets" in the accompanying condensed consolidated balance sheets. The consideration, which was based on the discounted commissions expected to be received over the remaining life of each transferred Medicare plan member, is being amortized to "Cost of revenue" in the condensed consolidated statements of comprehensive income as we recognize commission revenue related to the transferred Medicare plan members, over a period of up to five years. Amortization expense recorded to cost of revenue for these books-of-business for the three months ended March 31, 2011 and 2012 totaled $0.1 million and $1.1 million, respectively. Cash consideration paid in connection with the book-of-business transfers are presented under investing activities in the condensed consolidated statements of cash flows.

Recent Contractual Obligations—In March 2012, we entered into an agreement to lease a building to be constructed in Mountain View, California, adjacent to our headquarters office. The term of the operating lease is ten years and the monthly base rent is approximately $0.6 million for the first year of the lease. The base rent increases annually by 3%. Future minimum payments related to this operating lease are estimated to total $6.8 million over the ten-year term of the lease, but may differ depending on actual rentable square footage. Lease payments are expected to begin in the second or third quarter of 2013, although the actual commencement of lease payments will depend upon the date of completion and delivery of the newly constructed building.

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

In March 2012, we entered into a service agreement with a vendor to support our customer care center telephonic system and equipment. Service obligations related to this agreement total $0.7 million over the three-year term of the agreement.

Note 2 – Cash, Cash Equivalents and Accounts Receivable

Cash and Cash Equivalents—As of December 31, 2011 and March 31, 2012, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. At December 31, 2011 and March 31, 2012, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three months ended March 31, 2011 and 2012.

Accounts Receivable—We do not require collateral or other security for our accounts receivable. As of December 31, 2011, one customer represented 73%, or $5.9 million, of our $8.1 million accounts receivable. As of March 31, 2012, one customer represented 61%, or $3.8 million, of our $6.2 million outstanding accounts receivable. No other customers represented 10% or more of our total accounts receivable at December 31, 2011 and March 31, 2012. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2012. Accordingly, our estimate for uncollectible amounts at March 31, 2012 was not material.

As of December 31, 2011 and March 31, 2012, our accounts receivable consisted of the following (in thousands):

	December 31, 2011	March 31, 2012
Accounts receivable – from other revenues	$ 7,702	$ 4,677
Commissions receivable	353	1,563
Total accounts receivable	$ 8,055	$ 6,240

As of December 31, 2011 and March 31, 2012, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2011	March 31, 2012
Cash	$ 17,256	$ 14,887
Money market funds	106,351	101,354
Total cash and cash equivalents	$ 123,607	$ 116,241

We used observable prices in active markets in determining the classification of our money market funds as Level 1.

Note 3 – Stockholders' Equity

Stock Plans—The following table summarizes option activity under our 2006 Equity Incentive Plan, 1998 Stock Plan and 2005 Stock Plan (collectively, the "Stock Plans") (in thousands, except per share amounts and weighted average remaining contractual life data):

	Shares Available for Grant (1)
Shares available for grant December 31, 2011	3,870
Additional shares authorized (2)	795
Options granted	—
Restricted stock units granted	—
Options cancelled	21
Restricted stock units cancelled	20
Shares available for grant March 31, 2012	4,706

(1) Shares available for grant exclude treasury stock of 5.9 million shares and 6.5 million shares at December 31, 2011 and March 31, 2012, respectively, that could be granted if we determined to do so.

(2) On January 1, 2012, the number of shares authorized for issuance under the 2006 Equity Incentive Plan was automatically increased pursuant to the terms of the 2006 Equity Incentive Plan by 0.8 million shares. The following table summarizes stock option activity under the Stock Plans (in thousands, except per share amounts and weighted average remaining contractual life data):

	Number of Stock Options	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding at December 31, 2011	3,412	$ 11.36	3.80	$ 17,078
Granted	—	$ —		
Exercised	(100)	$ 9.99		
Cancelled	(21)	$ 16.35		
Balance outstanding at March 31, 2012	3,291	$ 11.37	3.54	$ 20,017
Vested and expected to vest at March 31, 2012	3,251	$ 11.33	3.52	$ 19,923
Exercisable at March 31, 2012	2,663	$ 10.54	3.12	$ 18,727

(1) The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2011 and March 31, 2012 and the exercise price of in-the-money options as of those dates.

The total grant date fair value of stock options vested during the three months ended March 31, 2011 and 2012 was $1.5 million and $0.9 million, respectively.

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

	Number Outstanding	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding as of December 31, 2011	474	1.92	$ 6,958
Granted	—		
Vested	(164)		
Cancelled	(20)		
Balance outstanding as of March 31, 2012	290	1.90	$ 4,736

(1) The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31, 2011 and March 31, 2012 multiplied by the number of restricted stock units outstanding as of December 31, 2011 and March 31, 2012, respectively.

The fair value of the restricted stock units is based on eHealth's stock price on the date of grant, and compensation expense is recognized on a straight-line basis over the vesting period. The total grant date fair value of restricted stock units vested during the three months ended March 31, 2011 and 2012 was $1.5 million and $2.6 million, respectively.

Stock Repurchase Programs—On July 27, 2010, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock. In January 2011, we completed this stock repurchase program, having repurchased in the aggregate 2.3 million shares for approximately $30.0 million at an average price of $13.06 per share including commissions. Purchases under this repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

On June 14, 2011, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to an additional $30 million of our common stock. In February 2012, we completed this stock repurchase program, having repurchased in the aggregate 2.2 million shares for approximately $30.0 million at an average price of $13.78 per share including commissions. Purchases under this repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

For accounting purposes, common stock repurchased under our stock repurchase programs was recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method. All shares repurchased under these programs are returned to the status of authorized but unissued shares of common stock.

Stock repurchase activity under our stock repurchase programs during the three months ended March 31, 2012 is summarized as follows (dollars in thousands, except share and per share amounts):

	Total Number of Shares Purchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2011 (1)	5,797,806	$ 14.07	$ 81,557
Repurchases of common stock	554,284	$ 15.23	8,441
Cumulative balance at March 31, 2012 (1)	6,352,090	$ 14.17	$ 89,998

(1) Cumulative balances at December 31, 2011 and March 31, 2012 include shares repurchased in connection with our stock repurchase programs announced on July 27, 2010 and June 14, 2011, as well as a previous stock repurchase plan announced in 2008.
(2) Average price paid per share includes commissions.

In addition to the 6.4 million shares repurchased under our repurchase programs as of March 31, 2012, we have in treasury 0.2 million shares that were surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2011 and March 31, 2012, we had a total of 5.9 million shares and 6.5 million shares, respectively, held in treasury.

Stock-Based Compensation—No stock options were granted to employees during the three months ended March 31, 2012. The fair value of stock options granted to employees for the three months ended March 31, 2011 was estimated using the following weighted average assumptions:

	Three Months Ended March 31, 2011
Expected term	4.6 years
Expected volatility	49.6%
Expected dividend yield	0%
Risk-free interest rate	1.79%
Weighted-average fair value (1)	$ 5.30

The following table summarizes stock-based compensation expense recorded during the three months ended March 31, 2011 and 2012 (in thousands):

	Three Months Ended March 31,	
	2011	2012
Common stock options	$ 1,047	$ 691
Restricted stock units	814	934
Total stock-based compensation expense	$ 1,861	$ 1,625

The following table summarizes stock-based compensation expense by operating function for the three months ended March 31, 2011 and 2012 (in thousands):

	Three Months Ended March 31,	
	2011	2012
Marketing and advertising	$ 246	$ 240
Customer care and enrollment	107	79
Technology and content	455	333
General and administrative	1,053	973
Total stock-based compensation expense	$ 1,861	$ 1,625

Note 4 – Income Taxes

During the three months ended March 31, 2012, we recorded a provision for income taxes of $1.8 million representing an effective tax rate of approximately 45.9%. During the three months ended March 31, 2011, we recorded a provision for income taxes of $2.0 million representing effective tax rates of approximately 49.8%. Our effective tax rates in the three months ended March 31, 2012 and 2011 were higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments.

During the three months ended March 31, 2012, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $0.6 million in “Additional paid-in capital” in the condensed consolidated balance sheet. During the three months ended March 31, 2011, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $1.1 million in “Additional paid-in capital” in the condensed consolidated balance sheet. These amounts are classified in the condensed consolidated statements of cash flows as both financing cash inflows and operating cash outflows.

Note 5 – 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 (excluding shares subject to repurchase). 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, including options, restricted stock and restricted stock units. The dilutive effect of outstanding awards is reflected in diluted earnings 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):

	Three Months Ended March 31,	
	2011	2012
Basic:		
Numerator:		
Net income allocated to common stock	$ 1,981	$ 2,125
Denominator:		
Weighted average number of common stock shares	21,623	19,996
Weighted average number of common stock shares held in treasury	(272)	(460)
Net weighted average number of common stock shares outstanding	21,351	19,536
Net income per share—basic:	$ 0.09	$ 0.11
Diluted:		
Numerator:		
Net income allocated to common stock	$ 1,981	$ 2,125
Denominator:		
Net weighted average number of common stock shares outstanding	21,351	19,536
Weighted average number of options	665	759
Weighted average number of restricted stock units	36	154
Total common stock shares used in per share calculation	22,052	20,449
Net income per share—diluted:	$ 0.09	$ 0.10

For each of the three months ended March 31, 2011 and 2012, we had securities outstanding that could potentially dilute earnings 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 weighted average anti-dilutive shares that were excluded from the computation of diluted net income per share consisted of the following (in thousands):

	Three Months Ended March 31,	
	2011	2012
Common stock options	1,881	1,323
Restricted stock units	100	—
Total	1,981	1,323

Note 6 – Geographic Information and Significant Customers

Geographic Information—As of December 31, 2011 and March 31, 2012, our long-lived assets consisted primarily of property and equipment, goodwill and other indefinite-lived intangible assets and finite-lived intangible assets. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area were as follows (in thousands):

	As of December 31, 2011	As of March 31, 2012
United States	$ 34,469	$ 37,192
China	425	366
Total	$ 34,894	$ 37,558

Significant Customers—Substantially all revenue for the three months ended March 31, 2011 and 2012 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three months ended March 31, 2011 and 2012 are presented in the table below:

	Three Months Ended March 31,	
	2011	2012
Humana	4%	16%
UnitedHealthcare (1)	13%	13%
WellPoint (2)	12%	12%
Aetna	11%	8%

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

Commission revenue attributable to major medical individual and family health insurance plans was approximately 90% and 77% of our commission revenue in the three months ended March 31, 2011 and 2012, respectively. We define our individual and family plan offerings as major medical individual and family health insurance plans, which do not include Medicare-related health insurance plan offerings or other ancillary products such as small business, short-term, stand-alone dental, life and student insurance plan offerings.

As of December 31, 2011, one customer represented 73%, or $5.9 million, of our $8.1 million accounts receivable. As of March 31, 2012, one customer represented 61%, or $3.8 million, of our $6.2 million outstanding accounts receivable. No other customers represented 10% or more of our total accounts receivable at December 31, 2011 and March 31, 2012. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2012.

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

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to revenue, sources of revenue, profitability, cost of revenue, seasonality, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses, general and administrative expenses, tax rates and cash outlay for taxes; our potential for collection issues; the timing and amount of our future lease obligations; the impact of health care reform laws on the health insurance industry and on our business; our plans and expectations relating to our Medicare business and factors impacting its success; impact of medical loss ratio regulations and commission rate changes; our expectations and projections relating to membership and commission rates; the timing and source of our Medicare-related revenue; estimates relating to critical accounting policies and related impact on our financial statements; the sufficiency of our cash and cash equivalents; future capital requirements; impact of the Supreme Court decision regarding the constitutionality of healthcare reform; expenditures related to the development of our business; our projections relating to future revenue growth and earnings per share; our future competitors; expansion into new business areas and additional geographic regions; our need for additional regulatory licenses and approvals; our strategy to market our ecommerce technology to government entities; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those discussed in this report, and in particular, the risks discussed under the heading "Risk Factors" in Part II, Item 1A of this report and those discussed in our other Securities and Exchange Commission filings. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2012, and the audited consolidated financial statements and related notes contained therein. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements.

Overview

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

We have invested heavily in technology and content related to our ecommerce platform. We have also invested significant time and resources in obtaining licenses to sell health insurance in all 50 states and the District of Columbia, developing diverse member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with over 180 leading insurance carriers, enabling us to offer thousands of health insurance plans online. Our ecommerce platforms can be accessed directly through our website as well as through our network of marketing partners.

We generate revenue primarily from commissions we receive from health insurance carriers whose individual, family, Medicare and small business health insurance policies are purchased through our ecommerce platform. Commission revenue represented 82% and 85% of total revenue for the three months ended March 31, 2011 and 2012, respectively. The commission payments we receive for individual, family and small business health insurance policies are typically a percentage of the premium on an individual, family or small business health insurance policy that we sold and are typically made to us on a monthly basis for as long as a policy remains active with us.

We actively market the availability of Medicare-related health insurance plans through our online Medicare plan platforms (*www.eHealthMedicare.com* and *www.PlanPrescriber.com)*. Our Medicare plan platforms enable consumers to

research and compare Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Commission payments we receive for Medicare Advantage and Medicare Part D prescription drug plans sold by us are typically fixed and are earned over a period of up to six years, or longer depending on the carrier arrangement, and are paid to us either monthly or annually. Medicare commissions we receive are included in commission revenue.

As a result of our commission structure, much of our revenue for a given financial reporting period relates to health insurance plans that we sold prior to the beginning of the period and is recurring in nature. Additionally, health insurance pricing, which is set by the health insurance carrier and approved by regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the health insurance industry in substantial ways. Among several other provisions, they include a mandate requiring individuals to be insured or face tax penalties; a mandate that certain employers offer their employees group health insurance coverage or face tax penalties; a requirement that persons 26 years of age and younger be able to stay on a parent's health insurance plan; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels; and medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality and, if they do not, to provide rebates to policyholders. While many aspects of health care reform do not become effective until 2014, health insurance carriers have been required to maintain medical loss ratios of eighty percent in their individual and family health insurance business since the beginning of 2011. The implementation of the medical loss ratio requirements by insurance carriers has resulted in a reduction in the commission rates that we are paid as a result of our selling individual and family health insurance plans. These commission rate changes began to impact our individual and family health insurance plan commission-based revenue in 2011.

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

We derive revenue from licensing the use of our health insurance ecommerce technology. Our technology platform enables health insurance carriers and agents to market and distribute health insurance plans online. We license our ecommerce technology for use by government agencies and are currently marketing this technology to states implementing health insurance exchanges as a result of health care reform legislation.

The Medicare revenue we have generated also includes referral fees paid to us based on Medicare leads generated by our online platforms that are delivered and sold to third parties. Beginning in June 2012 and thereafter, we intend to directly service most of the Medicare leads we generate as a health insurance agent while significantly reducing the number of Medicare leads we sell to third parties. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, we generate revenue from commissions we receive from health insurance carriers, rather than one-time referral fees we receive for the sale of Medicare leads.

Sources of Revenue

Commission Revenue

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

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

Our individual and family health insurance plan commission revenue was adversely impacted in 2011 due to the reduction in the commission rates that we are paid on new policies as a result of our selling individual and family health insurance plans subsequent to the implementation of the medical loss ratio requirements beginning in 2011 as a result of health care reform legislation. Commission rate changes due to the implementation of the medical loss ratio requirements applied prospectively to applicable commissions earned on or after January 1, 2011 and the majority of the changes applied only to commissions earned on new individual and family plan members approved in 2011 and thereafter. We define a member as an individual covered by an insurance plan, including individual, family, Medicare-related, small business, short-term and ancillary plans, for which we are entitled to receive compensation. For the majority of individual and family plan members that were approved prior to the effective date of the commission rate changes, we are being paid commissions at the rates in effect prior to the changes. As a result, the adverse impact to our overall individual and family health insurance commission rate structure is phasing in as the number of members approved after the commission rate changes becomes a greater proportion of our individual and family plan membership. Although we expect our overall individual and family health insurance commission rate structure to stabilize by early 2013, our actual future individual and family commission rate structure will depend on the mix between individual and family plan members approved prior to the commission rate changes and those approved after the changes, any future changes to commission rates and the mix of new approved members by state, health insurance carrier and type of health plan, among other factors. Additionally, other programs that health insurance carriers have supported, such as commission overrides and our sponsorship and advertising programs, have also been reduced as carriers look to reduce costs to comply with the new medical loss ratio requirements.

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

Commission revenue attributable to major medical individual and family health insurance plans was 77% of commission revenue in the three months ended March 31, 2012 compared to 90% in the three months ended March 31, 2011. The decline was due primarily to an increase in commission revenue attributable to Medicare insurance plans and to a decrease in individual and family health insurance plans commission revenue as a result of a decrease in commission rates we are paid on those plans. Major medical individual and family health insurance plans do not include Medicare-related health insurance plan offerings and do not include other ancillary products such as small business, stand-alone dental, life and student insurance plan offerings.

During the three months ended March 31, 2012, the number of individuals approved for Medicare insurance and other ancillary products increased 50% compared to the three months ended March 31, 2011. Partially offsetting this increase was a 1% decrease in the number of individuals approved for individual and family health insurance during the three months ended March 31, 2012. This decrease was related to a 3% decrease in the number of applications submitted through us for individual and family health insurance during the three months ended March 31, 2012 compared to the three months ended March 31, 2011. The decrease in the number of applications submitted through us for individual and family health insurance was impacted by our decision in the second half of 2011 to reduce our marketing and advertising spending in our online advertising channel relating to those plans given the reduction in the commission rates that we are paid on new individual and family plans as a result of the implementation of health care reform medical loss ratio requirements.

We actively market the availability of Medicare-related insurance plans through our online Medicare plan platforms (*www.eHealthMedicare.com* and *www.PlanPrescriber.com).* These platforms enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We offer online application and telephonic enrollment capabilities for certain Medicare plans. To the extent that

we assist in the sale of Medicare-related insurance plans as a health insurance agent, through either online applications or telephonically, we generate revenue from commissions we receive from health insurance carriers. The commission payments we receive for Medicare Supplement plans are typically a percentage of the premium on the policy that we sold and are paid to us on a monthly basis for as long as a policy remains active with us. For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission from insurance carriers after the policy is approved by the carrier and either a fixed, monthly commission beginning with and subsequent to the second policy year for a Medicare Advantage policy or a fixed, annual commission beginning with and subsequent to the second policy year for a Medicare Part D prescription drug policy. We may earn commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans typically for a period of up to six years, or longer depending on the carrier arrangement, provided that the policy remains active with us.

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

We expect to recognize a majority of our first year Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the fourth quarter of each year as a result of the Medicare annual enrollment period, which occurs in the fourth quarter of each year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

We expect commission revenue to increase in absolute dollars in 2012 compared to 2011, primarily as a result of an increase in Medicare-related commission revenue.

Other Revenue

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

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

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

We license our technology for use by government agencies and we are currently marketing our ecommerce technology to states implementing health insurance exchanges as a result of health care reform legislation. In our government systems business, which may also include information services, we may earn a combination of fixed license fees and time- and materials-based fees or we may be paid performance-based fees.

Medicare Lead Referral. Our online Medicare plan platforms (*www.eHealthMedicare.com* and *www.PlanPrescriber.com)* enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. The Medicare-related revenue we have generated includes referral fees paid to us based on Medicare leads generated by our online platforms that are delivered and sold to third parties. We currently sell these leads to a single lead purchaser. The majority of our lead referral revenue is generated during the Medicare annual enrollment period, which occurs during the fourth quarter of the calendar year, when we generate and sell the majority of our Medicare leads. We intend to perform services for a greater number of our Medicare leads ourselves as a health insurance agent. To the extent that we do so, we will be entitled to receive commissions rather than a one-time referral fee, and we expect our Medicare lead referral revenue to decline.

We expect other revenue to decline in absolute dollars in 2012 compared to 2011 due primarily to a decrease in Medicare lead referral revenue as a result of our strategic decision to directly service most of the Medicare leads we generate as a health insurance agent, while significantly reducing the number of Medicare leads we sell to third parties. As a result of this decision, we expect Medicare-related commission revenue to increase in 2012. We expect the decline in Medicare lead referral revenue to be partially offset by an increase in online sponsorship and advertising revenue.

Member Acquisition

An important factor in our revenue growth is the growth of our member base. We have acquired individual and family as well as Medicare members through transactions with broker partners, whereby these brokers have transferred certain of their existing individual and family plan and Medicare plan members to us as the broker of record on the underlying policies. In addition, our marketing initiatives are an important component of our strategy to grow our member base and are focused on three primary member acquisition channels: direct, marketing partners and online advertising. Our marketing initiatives are primarily designed to encourage consumers to complete an application for health insurance. In addition, we may refer Medicare-eligible individuals to third parties who may assist them in enrolling in a Medicare plan. Our marketing channels are as follows:

Direct. Our direct member acquisition channel consists of consumers who access our website addresses (*www.eHealth.com*, *www.eHealthInsurance.com*, *www.eHealthMedicare.com* and *www.PlanPrescriber.com*) either directly or through algorithmic natural search listings on Internet search engines and directories. For the three months ended March 31, 2011 and 2012, applications submitted through us for individual and family health insurance from our direct channel constituted 43% and 44%, respectively, of all individual and family health insurance applications submitted on our website.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our websites through a network of affiliate partners and financial services and other companies. Growth in our marketing partner channel depends upon our expanding marketing programs with existing partners and adding new partners to our network. For the three months ended March 31, 2011 and 2012, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 32% and 33%, respectively, of all individual and family health insurance applications submitted on our website.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our websites through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, as well as various Internet marketing programs such as banner advertising and email marketing. For the three months ended March 31, 2011 and 2012, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 25% and 23%, respectively, of all individual and family health insurance applications submitted on our website.

Operating Costs and Expenses

Cost of Revenue

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

Cost of revenue also includes direct labor and other direct costs incurred in connection with our contract with the federal government. The term of this contract expired in January 2012.

Additionally, cost of revenue includes the amortization of consideration we paid to certain brokers in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies. These transfers have included both individual and family plan members as well as Medicare plan members. In November 2010, May 2011, October 2011 and March 2012, we entered into separate agreements with a partner, whereby the partner transferred certain of its existing Medicare plan members to us as the broker of record on the underlying policies for arrangement consideration totaling $3.3 million, $3.1 million, $1.2 million and $4.4 million, respectively. All book-of-business transfers are being amortized to cost of revenue as we recognize commission revenue related to the transferred members over a period of up to five years for each arrangement.

We expect cost of revenue to decrease in absolute dollars in 2012 compared to 2011 due to a decrease in direct labor and other direct costs incurred in connection with the expiration of the contract with the federal government in January 2012, partially offset by an increase in amortization of the consideration we paid in connection with the transfer of certain Medicare members to us from a partner.

Marketing and Advertising

Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct, marketing partner and online advertising member acquisition channels, in addition to compensation and other expenses related to marketing, business development, partner management, public relations and carrier relations personnel who support our offerings. Our direct channel expenses primarily consist of costs for e-mail marketing and may also include costs for television advertising, radio advertising, print advertising, direct mail and email marketing.

Our marketing partner channel expenses consist primarily of fees paid to marketing partners with which we have a relationship. We compensate a significant number of our marketing partners by paying a fee each time a consumer referral from a partner results in a submitted health insurance application, regardless of whether the consumer’s application is approved by the health insurance carrier. Many of our marketing partners have tiered arrangements in which the amount of the fee increases as the volume of submitted applications we receive from the marketing partner increases over a particular period. We recognize these expenditures in the period when a marketing partner’s referral results in the submission of a health insurance application. The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening in individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our website, those expenses are influenced by these patterns. In addition, because the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. An unanticipated increase in submitted applications resulting from marketing partner referrals could cause our net income to be lower than our expectation, since the revenue to be derived from submitted applications that are approved by health insurance carriers will not be recognized until future periods.

Paid keyword search advertising on search engines represents the majority of expenses in our online advertising channel. We incur expenses associated with search engine advertising in the period in which the consumer clicks on the advertisement. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of search engine advertising. For example, due to the substantial increase in the number of consumers referred to our website from paid keyword search advertising during the Medicare annual enrollment period in the fourth quarter of 2011, we experienced a significant increase in online advertising expenses during the fourth quarter of 2011 compared to other quarters in 2011. We also increased our spending for Medicare plan-related online advertising in the third and fourth quarters of 2011, compared to first and second quarters, in conjunction with the Medicare annual enrollment period in the fourth quarter of 2011. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our discretionary online advertising expenses had a negative impact on our profitability during the third quarter of 2011. We expect these seasonal patterns to occur again in 2012.

We expect our marketing and advertising expenses to increase in absolute dollars in 2012 compared to 2011 due to an increase in our Medicare-related online marketing and advertising expenditures during 2012, including paid keyword search advertising.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits costs for personnel engaged in pre-sales assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the underwriting process. In 2011, we began hiring, training and obtaining health insurance licenses and health insurance carrier appointments for additional employees in our customer care centers to service the increase in the volume of Medicare leads we received in the fourth quarter of 2011 as a result of the Medicare annual enrollment period. Most of these additional customer care center employees were temporary and their employment ended after the conclusion of the Medicare annual enrollment period in December 2011. As a result of our temporary customer care center staffing requirements, we expect our customer care and enrollment costs to be higher in the third and fourth quarters of each year compared to the first and second quarters. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our temporary customer care center staffing costs incurred in the second and third quarters have had a significant negative impact on our profitability during the respective quarters. We expect this seasonal pattern to occur again in 2012.

We expect customer care and enrollment expenses to increase in absolute dollars and as a percentage of total revenue in 2012 compared to 2011 as a result of additional personnel we expect to hire to service the expected increase in the volume of Medicare demand in 2012 and due to an increase in expenditures to develop and expand our Medicare plan sales capabilities.

Technology and Content

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

We expect technology and content expenses to remain relatively flat in absolute dollars in 2012 compared to 2011.

General and Administrative

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

We expect our general and administrative expenses to decline in absolute dollars and as a percentage of total revenue in 2012 compared to 2011 due primarily to a decrease in government affairs expenses.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics as of March 31, 2011 and 2012 and for the three months ended March 31, 2011 and 2012:

	Three Months Ended March 31, 2011	Three Months Ended March 31, 2012
Key Metrics:		
Operating cash flows (1)	$ 6,775,000	$ 5,093,000
IFP submitted applications (2)	119,000	115,400
IFP approved members (3)	101,800	100,500
Total approved members (4)	141,000	151,800
Commission revenue (5)	$ 30,760,000	$ 31,464,000
Commission revenue per estimated member for the period (6)	$ 38.95	$ 37.82
Total revenue (7)	$ 37,555,000	$ 37,075,000
Total revenue per estimated member for the period (8)	$ 47.55	$ 44.56

	As of March 31, 2011	As of March 31, 2012
IFP estimated membership (9)	693,400	686,800
Total estimated membership (10)	801,200	848,600

	Three Months Ended March 31, 2011	Three Months Ended March 31, 2012
Marketing and advertising expenses (11)	$ 12,909,000	$ 12,987,000
Marketing and advertising expenses as a percentage of total revenue (12)	34%	35%
Other Metrics:		
Source of IFP submitted applications (as a percentage of total IFP applications for the period):		
Direct (13)	43%	44%
Marketing partners (14)	32%	33%
Online advertising (15)	25%	23%
Total	100%	100%

Notes:

(1) Net cash provided by operating activities for the period from the condensed consolidated statements of cash flows.

(2) IFP applications submitted on eHealth's website during the period. Applications are counted as submitted when the applicant completes the application, provides a method for payment and clicks the submit button on our website and submits the application to us. The applicant generally has additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information and providing an electronic signature. In addition, an applicant may submit more than one application. We include applications for IFP plans for which we receive commissions as well as other forms of payment. We define our "IFP" offerings as major medical individual and family health insurance plans, which does not include small business, short-term, stand-alone dental, life, student or Medicare-related health insurance plans.

(3) New IFP members reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.

(4) New members for all plans, including Medicare plans, reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.

(5) Commission revenue (from all sources) recognized during the period from the condensed consolidated statements of comprehensive income.

(6) Calculated as commission revenue recognized during the period (see note (5) above) divided by average estimated membership for the period (calculated as beginning and ending estimated membership for all plans for the period, divided by two).

(7) Total revenue (from all sources) recognized during the period from the condensed consolidated statements of comprehensive income.

(8) Calculated as total revenue recognized during the period (see note (7) above) divided by average estimated membership for the period (calculated as beginning and ending estimated membership for all plans for the period, divided by two).

(9) Estimated number of members active on IFP insurance policies as of the date indicated.

(10) Estimated number of members active on all insurance policies, including Medicare policies, as of the date indicated.
(11) Marketing and advertising expenses for the period from the condensed consolidated statements of comprehensive income.
(12) Calculated as marketing and advertising expenses for the period (see note (11) above) divided by total revenue for the period (see note (7) above).
(13) Percentage of IFP submitted applications from applicants who came directly to the eHealth website through algorithmic search engine results or otherwise. See note (2) above for further information as to what constitutes a submitted application.
(14) Percentage of IFP submitted applications from applicants sourced through eHealth's network of marketing partners. See note (2) above for further information as to what constitutes a submitted application.
(15) Percentage of IFP submitted applications from applicants sourced through paid search and other online advertising activities. See note (2) above for further information as to what constitutes a submitted application.

Our insurance carrier partners bill and collect insurance premiums paid by our members. Carrier partners do not report to us the number of members that we have as of a given date. The majority of our members who terminate their policies do so by discontinuing their premium payments to the carrier and do not inform us of the cancellation. Also, some of our members pay their premiums less frequently than monthly. Given the number of months required to observe non-payment of commissions in order to confirm cancellations, we estimate the number of members who are active on insurance policies as of a specified date. We estimate the number of continuing members on all policies other than small business insurance policies as of a specific date by taking the sum of (i) the number of members for whom we have received or applied a commission payment for the month that is six months (or three months in the case of Medicare, short-term, student and dental insurance) prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over, as applicable, the three-month or six-month period); and (ii) the number of approved members over the six-month period (or three months in the case of Medicare, short-term, student and dental insurance) prior to the date of estimation (after reducing that number using historical experience for an assumed number of members who do not accept their approved policy and for estimated member cancellations through the date of the estimate). We estimate the number of small business group members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier in the period it is reported. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us. Additionally, our carrier partners often do not communicate this information to us. We often are made aware of policy cancellations at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

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

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 condensed consolidated financial statements and the accompanying notes. These estimates and assumptions are based on current facts, historical experience, and various other factors that we believe are reasonable under the circumstances to determine reported amounts of assets, liabilities, revenue and expenses that are not readily apparent from other sources. To the extent there are material differences between our estimates and the actual results, our future consolidated results of operations may be affected.

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

- Revenue recognition;
- Stock-Based Compensation;
- Goodwill and Intangible Assets; and
- Accounting for Income Taxes.

During the three months ended March 31, 2012, there were no significant changes to our critical accounting policies and estimates. Please refer to Management's Discussion and Analysis of Financial Condition and Results of Operations contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2011, for a complete discussion of our critical accounting policies and estimates.

Results of Operations

The following table sets forth our operating results and the related percentage of total revenues for the three months ended March 31, 2011 and 2012 (dollars in thousands):

	Three Months Ended March 31,			
	2011		2012	
Revenue:				
Commission	$30,760	82%	$31,464	85%
Other	6,795	18	5,611	15
Total revenue	37,555	100	37,075	100
Operating costs and expenses:				
Cost of revenue	2,651	7	1,675	5
Marketing and advertising	12,909	34	12,987	35
Customer care and enrollment	5,410	14	5,971	16
Technology and content	5,470	15	5,482	15
General and administrative	6,721	18	6,604	18
Amortization of intangible assets	427	1	447	1
Total operating costs and expenses	33,588	89	33,166	89
Income from operations	3,967	11	3,909	11
Other income (expense), net	(19)	(0)	21	0
Income before provision for income taxes	3,948	11	3,930	11
Provision for income taxes	1,967	5	1,805	5
Net income	$ 1,981	5%	$ 2,125	6%

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

	Three Months Ended March 31,	
	2011	2012
Marketing and advertising	$ 246	$ 240
Customer care and enrollment	107	79
Technology and content	455	333
General and administrative	1,053	973
Total stock-based compensation expense	$ 1,861	$ 1,625

Three Months Ended March 31, 2011 and 2012

Revenue

The following table presents our commission, other revenue and total revenue and the absolute dollar and percentage changes from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
Commission	$ 30,760	$ 31,464	$ 704	2%
Percentage of total revenue	82%	85%		
Other	$ 6,795	$ 5,611	$(1,184)	(17%)
Percentage of total revenue	18%	15%		
Total revenue	$ 37,555	$ 37,075	$ (480)	(1%)

Commission revenue increased $0.7 million, or 2%, in the three months ended March 31, 2012 compared to the three months ended March 31, 2011, due primarily to an increase in Medicare-related commission revenue. Partially offsetting this increase was a decrease in individual and family health insurance commission revenue due to a reduction in the commission rates we are paid on individual and family health insurance policies as a result of the implementation of the medical loss ratio requirements by insurance carriers as a result of healthcare reform legislation.

Other revenue decreased $1.2 million, or 17%, in the three months ended March 31, 2012 compared to the three months ended March 31, 2011, due primarily to a decrease in revenue we received related to our government systems business and a decrease in Medicare-related health insurance product lead referral revenue. The decrease in lead referral revenue was the result of our strategic decision to reduce the number of leads sold to third parties and to instead act as a health insurance agent to those leads. Partially offsetting these decreases was an increase in sponsorship and advertising revenue.

Operating Costs and Expenses

Cost of Revenue

The following table presents our cost of revenue and the dollar and percentage change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
Cost of revenue	$ 2,651	$ 1,675	$(976)	(37%)
Percentage of total revenue	7%	5%		

Cost of revenue decreased $1.0 million, or 37%, in the three months ended March 31, 2012 compared to the three months ended March 31, 2011, due primarily to a decrease of $1.8 million in costs related to a technology licensing contract with the federal government, which terminated in January 2012, partially offset by an increase of $1.0 million in amortization expense associated with the consideration paid in connection with several transactions in which we acquired broker of record status on a number of Medicare health insurance plans.

Marketing and Advertising

The following table presents our marketing and advertising expenses and the dollar and percentage change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
Marketing and advertising	$ 12,909	$ 12,987	$78	1%
Percentage of total revenue	34%	35%		

Marketing and advertising expenses increased relatively flat in the three months ended March 31, 2012 compared to the three months ended March 31, 2011.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses and the dollar and percentage change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
Customer care and enrollment	$ 5,410	$ 5,971	$561	10%
Percentage of total revenue	14%	16%		

Customer care and enrollment expenses increased $0.6 million, or 10%, in the three months ended March 31, 2012 compared to the three months ended March 31, 2011, due primarily to additional customer care center personnel hired since March 31, 2011 to service the increase in volume of Medicare leads serviced directly by us as a health insurance agent. As a result, compensation, benefits and other personnel costs increased $0.5 million and insurance licensing costs increased $0.1 million.

Technology and Content

The following table presents our technology and content expenses and the dollar and percentage change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
Technology and content	$ 5,470	$ 5,482	$12	0%
Percentage of total revenue	15%	15%		

Technology and content expenses remained relatively flat in the three months ended March 31, 2012 compared to the three months ended March 31, 2011.

General and Administrative

The following table presents our general and administrative expenses and the dollar and percentage change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
General and administrative	$ 6,721	$ 6,604	$(117)	(2%)
Percentage of total revenue	18%	18%		

General and administrative expenses remained relatively flat in the three months ended March 31, 2012 compared to the three months ended March 31, 2011.

Amortization of Intangible Assets

Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber were $0.4 million in each of the three months ended March 31, 2011 and 2012.

Other Income (Expense), Net

The following table presents our other income (expense), net, and the dollar and percentage change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		Change	
	2011	2012	$	%
Other income (expense), net	$ (19)	$ 21	$40	211%
Percentage of total revenue	(0)%	0%		

Other income (expense), net increased in the three months ended March 31, 2012 compared to the three months ended March 31, 2011 due primarily to a decrease in investment management fees. Administrative bank fees, management fees and interest expense on our capital lease obligations more than offset interest earned on our invested cash in the three months ended March 31, 2011.

Provision for Income Taxes

The following table presents our provision for income taxes and the dollar change from the comparable prior year quarter (dollars in thousands):

	Three Months Ended March 31,		
	2011	2012	Change $
Provision for income taxes	$ 1,967	$ 1,805	$ (162)
Percentage of total revenue	5%	5%	

In the three months ended March 31, 2012, we recorded a provision for income taxes of $1.8 million, representing an effective tax rate of 45.9%. Our effective tax rate in the three months ended March 31, 2012 was lower than our effective tax rate of 49.8% in the three months ended March 31, 2011, due primarily to a decrease in tax shortfalls related to share-based payments.

Liquidity and Capital Resources

At March 31, 2012, our cash and cash equivalents totaled $116.2 million. 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. At December 31, 2011, our cash and cash equivalents totaled $123.6 million.

On June 14, 2011, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to an additional $30 million of our common stock. In February 2012, we completed this stock repurchase program, having repurchased in the aggregate 2.2 million shares for approximately $30.0 million at an average price of $13.78 per share including commissions. Purchases under this repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

For accounting purposes, common stock repurchased under our stock repurchase programs was recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method. All shares repurchased under these programs are returned to the status of authorized but unissued shares of common stock.

Stock repurchase activity under our stock repurchase programs during the three months ended March 31, 2012 is summarized as follows (dollars in thousands, except share and per share amounts):

	Total Number of Shares Purchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2011 (1)	5,797,806	$ 14.07	$ 81,557
Repurchases of common stock	554,284	$ 15.23	8,441
Cumulative balance at March 31, 2012 (1)	6,352,090	$ 14.17	$ 89,998

(1) Cumulative balances at December 31, 2011 and March 31, 2012 include shares repurchased in connection with our stock repurchase programs announced on July 27, 2010 and June 14, 2011, as well as a previous stock repurchase plan announced in 2008.

(2) Average price paid per share includes commissions.

In addition to the 6.4 million shares repurchased under our repurchase programs as of March 31, 2012, we have in treasury 0.2 million shares that were surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2011 and March 31, 2012, we had a total of 5.9 million shares and 6.5 million shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the three months ended March 31, 2011 and 2012 (in thousands):

	Three Months Ended March 31,	
	2011	2012
Net cash provided by operating activities	$ 6,775	$ 5,093
Net cash used in investing activities	$ (1,270)	$ (4,576)
Net cash used in financing activities	$ (3,237)	$ (7,882)

The cash flow statement for the three months ended March 31, 2012 includes a $0.9 million cash flow benefit from deferred income taxes, of which approximately $0.4 million of tax benefit, primarily from the utilization of net operating loss carry forwards, is included in cash flow from operations and approximately $0.6 million of net operating loss carry forwards, from the utilization of excess tax benefits related to share-based payments. The utilization of excess tax benefits related to share-based payments is also shown in the cash flow statements for the three months ended March 31, 2012 as both a decrease in cash flow from operating activities and an increase in cash flow from financing activities.

The cash flow statement for the three months ended March 31, 2011 includes a $2.9 million cash flow benefit from deferred income taxes, of which approximately $1.8 million of tax benefit, primarily from the utilization of net operating loss carry forwards, is included in cash flow from operations and $1.1 million of net operating loss carry forwards, from the utilization of excess tax benefits related to share-based payments. The utilization of excess tax benefits related to share-based payments is also shown in the cash flow statements for the three months ended March 31, 2011 as both a decrease in cash flow from operating activities and an increase in cash flow from financing activities.

Operating Activities

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

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

Historically, we have experienced a reduction in operating cash flows during the first quarter of the year compared to the other quarters due to the payment of annual performance bonuses to employees in the first quarter of the year. Recently we have collected a substantial amount of lead referral payments in the first quarter related to Medicare leads sold during the annual enrollment period in the fourth quarter of the prior year. The seasonal impact of Medicare lead referral collections is expected to be minimal in 2013 as we transition away from lead referral transactions. A significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform. Since our marketing and advertising costs are expensed as incurred and the revenue from approved applications is recognized as commissions are subsequently reported to us, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter.

***Three Months Ended March 31, 2012*—**Our operating activities generated cash of $5.1 million during the three months ended March 31, 2012 and consisted of net income of $2.1 million, increased by non-cash items of $2.5 million and cash provided for working capital and other activities of $0.5 million. Adjustments for non-cash items primarily consisted of $0.4 million of deferred income taxes, $1.6 million of stock-based compensation expense and $1.0 million of depreciation and amortization, including amortization of intangible assets, partially offset by $0.6 million of excess tax benefits from stock-based compensation. Cash provided for working capital and other activities primarily consisted of a decrease of $1.8 million in accounts receivable, an increase of $1.3 million in deferred revenue, an increase of $1.3 million in other current liabilities and an increase of $0.8 million in accounts payable, partially offset by a decrease of $2.5 million in accrued marketing expenses and a decrease of $2.4 million in accrued compensation and benefits. Accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2011 and accounts payable decreased due to the timing of payments to our vendors.

***Three Months Ended March 31, 2011*—**Our operating activities generated cash of $6.8 million during the three months ended March 31, 2011 and consisted of net income of $2.0 million, increased by non-cash items of $3.6 million and cash provided for working capital and other activities of $1.2 million. Adjustments for non-cash items primarily consisted of $1.8 million of deferred income taxes, $1.9 million of stock-based compensation expense and $1.1 million of depreciation and amortization, including amortization of intangible assets, partially offset by $1.1 million of excess tax benefits from stock-based compensation. Cash provided for working capital and other activities primarily consisted of a decrease of $5.5 million in accounts receivable, partially offset by a decrease of $2.2 million in accrued compensation and benefits, a decrease of $1.4 million in accounts payable and a decrease of $0.9 million in other current liabilities. Accounts receivable decreased primarily due to collections of Medicare lead referral receivables recorded during the Medicare open enrollment period in the fourth quarter of 2010. Accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2010, and accounts payable decreased due to the timing of payments to our vendors.

Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software to enhance our website and to support our growth and includes consideration paid to a partner in connection with the transfer to us of certain Medicare plan members for whom we expect to earn future commissions.

Three Months Ended March 31, 2012—Net cash used in investing activities of $4.6 million during the three months ended March 31, 2012 was attributable to cash consideration of $4.4 million paid to a partner related to the transfer of a book-of-business in the three months ended March 31, 2012, whereby we became the broker of record on the underlying policies for certain Medicare insurance members that were transferred to us, and capital expenditures of $0.2 million.

Three Months Ended March 31, 2011—Net cash used in investing activities of $1.3 million during the three months ended March 31, 2011 was attributable to the final payment of $0.8 million related to the transfer of a book-of-business in the fourth quarter of 2010, whereby we became the broker of record on the underlying policies for certain Medicare insurance members that were transferred to us, and capital expenditures of $0.5 million.

Financing Activities

Three Months Ended March 31, 2012—Net cash used in financing activities of $7.9 million during the three months ended March 31, 2012 was due to $8.4 million used to repurchase 0.6 million shares of our common stock and $1.0 million used to net-share settle the tax obligation related to vesting equity awards, partially offset by $1.0 million of net proceeds from the exercise of common stock options and $0.6 million of excess tax benefits from stock-based compensation.

Three Months Ended March 31, 2011—Net cash used in financing activities of $3.2 million during the three months ended March 31, 2011 was due to $3.8 million used to repurchase 0.3 million shares of our common stock and $0.5 million used to net-share settle the tax obligation related to vesting equity awards, partially offset by $1.1 million of excess tax benefits from stock-based compensation.

Future Needs

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

Contractual Obligations and Commitments

Operating Lease Obligations

We lease certain of our office, operating facilities, equipment and furniture and fixtures under various operating leases, the latest of which expires in August 2018. 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.

On July 8, 2011, we entered into an agreement to extend the lease on our headquarter office in Mountain View, California, for an additional seven years through August 2018. On September 8, 2011, we entered into an agreement to extend the lease on an adjacent office in Mountain View, California, for an additional two years through August 2013.

In March 2012, we entered into a non-cancellable agreement to lease a building to be constructed in Mountain View, California, adjacent to our headquarters office. The term of the operating lease is ten years and the monthly base rent is approximately $0.6 million for the first year of the lease. The base rent increases annually by 3%. Future minimum payments related to this operating lease are estimated to total $6.8 million over the ten-year term of the lease, but may differ depending on actual rentable square footage. Lease payments are expected to begin in the second or third quarter of 2013, although the actual commencement of lease payments will depend upon the date of completion and delivery of the newly constructed building.

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

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.

In March 2012, we entered into a service agreement with a vendor to support our customer care center telephonic system and equipment. Service obligations related to this agreement total $0.7 million over the three-year term of the agreement.

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and certain contractual service and licensing obligations as of March 31, 2012 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2012 (nine months)	$ 2,721	$ 307	$ 3,028
2013	1,274	401	1,675
2014	909	325	1,234
2015	694	63	757
2016	691	—	691
Thereafter	1,189	—	1,189
Sub-Total	$ 7,478	$ 1,096	$ 8,574
New building - Mountain View, California (estimated commitment) (1)	6,833	—	6,833
Total (estimate)	$ 14,311	$ 1,096	$ 15,407

(1) Future minimum payments related to this operating lease are estimated to total $6.8 million over the ten-year term of the lease, but may differ depending on actual rentable square footage. Lease payments are expected to begin in the second or third quarter of 2013, although the actual commencement of lease payments will depend upon the date of completion and delivery of the newly constructed building. This lease is generally non-cancellable, except in the case of non-delivery of the newly constructed building.

Off-Balance Sheet Arrangements

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

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash and cash equivalents and accounts receivable. As of December 31, 2011 and March 31, 2012, our cash and cash equivalents were invested as follows (in thousands):

	December 31, 2011	March 31, 2012
Cash (1)	$ 17,256	$ 14,887
Money market funds (2)	106,351	101,354
Total cash and cash equivalents	$ 123,607	$ 116,241

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

(2) At December 31, 2011 and March 31, 2012 money market funds consisted of U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

We do not require collateral or other security for our accounts receivable. As of December 31, 2011, one customer represented 73%, or $5.9 million, of our $8.1 million accounts receivable. As of March 31, 2012, one customer represented 61%, or $3.8 million, of our $6.2 million outstanding accounts receivable. No other customers represented 10% or more of our total accounts receivable at December 31, 2011 and March 31, 2012. We believe the potential for collection issues with any of our customers is minimal as of March 31, 2012. Accordingly, our estimate for uncollectible amounts at March 31, 2012 was not material.

Significant Customers

Substantially all revenue for the three months ended March 31, 2011 and 2012 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three months ended March 31, 2011 and 2012 are presented in the table below:

	Three Months Ended March 31,	
	2011	2012
Humana	4%	16%
UnitedHealthcare (1)	13%	13%
WellPoint (2)	12%	12%
Aetna	11%	8%

(1) UnitedHealthcare includes other carriers owned by UnitedHealthcare.

(2) Wellpoint includes other carriers owned by Wellpoint.

Foreign Currency Exchange Risk

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

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

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

Based on management's evaluation, our chief executive officer and chief financial officer concluded that our disclosure controls and procedures are effective to provide reasonable assurance that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms, and that such information is accumulated and communicated to our management, including our chief executive officer and chief financial officer, as appropriate, to allow timely decisions regarding required disclosure.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the three months ended March 31, 2012 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, do not expect that our disclosure controls or our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of a simple error or mistake. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by management override of the controls. The design of any system of controls also is based in part upon certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions; over time, controls may become inadequate because of changes in conditions, or the degree of compliance with policies or procedures may deteriorate. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

PART II
OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

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

ITEM 1A. RISK FACTORS

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

Risks Related to Our Business

Changes and developments in the structure of the health insurance system in the United States could harm our business.

Our business depends upon the private sector of the United States health insurance system, its relative role in financing health care delivery and health insurance carriers' use of, and payment of commissions to, agents and brokers to market individual and family health insurance plans. In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the industry in which we operate in substantial ways. Among several other provisions, they include a mandate requiring individuals to be insured or face tax penalties; a mandate that certain employers offer their employees group health insurance coverage or face tax penalties; requirements relating to employer contribution to employee health coverage; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; prohibitions on rescission of health insurance; prohibitions on lifetime coverage limits; requirements for guaranteed renewability of health insurance plans; health insurance premium setting guidelines; limitations on deductibles and cost-sharing; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality and, if they do not, to provide rebates to policyholders; minimum benefit levels for health insurance plans; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for individual health insurance; assistance for member run health insurance issuers; creation of multi-state health insurance plans to be offered on the exchanges and with oversight from the Office of Personnel Management; requirements for uniform disclosure relating to the costs and benefits of health insurance; government subsidized high risk pools; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels. Many aspects of health care reform do not go into effect until 2014, although certain provisions currently are effective, such as medical loss ratio requirements for individual, family and small business health insurance, a prohibition against insurance companies using pre-existing health conditions as a reason to deny the application of children for health insurance and a requirement that persons 26 years of age and younger be able to stay on a parent's health insurance plan. Healthcare reform legislation requires various departments of the executive branch to adopt regulations implementing its provisions. In addition, state governments have adopted, and will continue to adopt, changes to their existing laws and regulations in light of federal healthcare reform legislation and regulations.

Challenges to the constitutionality of health care reform legislation have been initiated in the federal courts. The challenges center upon the constitutionality of the mandate in the Patient Protection and Affordable Care Act requiring individuals to have health insurance or face a penalty. Decisions in lower courts on the issue have been inconsistent. The United States Supreme Court has decided to review the constitutionality of health care reform. The Supreme Court could determine that health care reform is constitutional; could determine that just certain aspects, such as the mandate to have health insurance, are unconstitutional and uphold the remainder of the law; could determine that certain aspects are unconstitutional and strike down portions beyond the unconstitutional provisions; or could determine that certain aspects are unconstitutional and strike down the whole law. It is not possible for us to predict how the Supreme Court will rule, but its decision and any legislative response to the decision could harm our business, operating results and financial condition.

The implementation of health care reform could increase our competition; reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals, families or small businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause health insurance carriers to apply more rigorous underwriting standards (until provisions in health care reform legislation limiting underwriting go into effect in 2014) or change the benefits and/or premiums for the plans they sell; or cause health insurance carriers to reduce the amount 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. For instance, cost and benefit information relating to the health insurance plans we sell will become more readily accessible, which could facilitate additional

competition beyond the competition we would face from health insurance exchanges themselves. Various aspects of health care reform also could cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to exit the business of selling insurance plans in a particular jurisdiction, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower commissions, any of which would materially harm our business, operating results and financial condition.

Assuming health care reform legislation is constitutional, individuals and families whose incomes are at or below 400% of the federal poverty level will generally be entitled beginning in 2014 to subsidies in connection with their purchase of health insurance. A federal regulation promulgated under the Patient Protection and Affordable Care Act has been issued that clarifies that states may, but are not required to, allow agents and brokers such as us to market the plans that below poverty level individuals must purchase in order to receive subsidies. While there are details that need to be clarified by the federal government, states and health insurance carriers, it is clear that, in order to offer subsidy eligible health insurance plans, agents and brokers must meet certain conditions, such as entering into an agreement with the state health insurance exchange, ensuring that the enrollment and subsidy application is completed through the state's health insurance exchange and complying with privacy, security and conflict of interest standards. In the event Internet-based agents and brokers such as us use the Internet for plan selection purposes, their websites are required to meet certain additional conditions, such as compliance with standards for display of health plan and related information; providing consumers the ability to view all subsidy eligible plans offered on the state's exchange; displaying all subsidy eligible health plan data on the state's exchange and providing a mechanism for consumers to withdraw from the application process. We may experience difficulty in satisfying the conditions to be able offer plans to individuals and families who are entitled to subsidies under health care reform, and even if we are able to satisfy them, we depend upon states to permit us to offer these plans and upon health insurance companies to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to sell individual and family health insurance products to health care reform subsidy eligible individuals, we could lose a substantial number of existing and potential members and the related commission revenue we receive as a result of the sale of individual, family and small business health insurance products to them, which would materially harm our business, operating results and financial condition.

The medical loss ratio requirements that are a part of health care reform have and will continue to harm our business.

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

Carrier reaction to the individual and family medical loss ratio requirements has been to significantly reduce the commissions we receive in connection with the sale of these plans. These commission rate reductions have and will continue to significantly impact our business and operating results. We previously estimated the amount by which our average individual and family plan base commission rate changed to be a decline from just over 10% of premium to just below 7%. The estimate of the change in the average rate was calculated by applying the changes in the first and subsequent year commission rates to our membership as of the end of the third quarter of 2010, as if all changes were effective immediately for all individual and family health insurance plan members. The commission rate changes applied prospectively to applicable commissions earned on or after January 1, 2011 and the majority of the changes applied only to commissions earned on new members approved in 2011 and thereafter. For the majority of members that were approved prior to the effective date of the commission rate changes, we continue to be paid commissions at the rates in effect prior to the changes. As a result, the new estimated average base commission rate is phasing in over time. Health insurance carriers may determine to further reduce our commissions as a result of the medical loss ratio requirements or other aspects of health care reform, which would harm our business, operating results and financial condition. In addition, if health insurance companies fail to meet medical loss ratio requirements, we may be required to pay back commissions that are related to any premium amounts the carriers are required to rebate policy holders as a result, which would harm our business, operating results and financial condition. The medical loss ratio requirements also may cause certain health insurance carriers to limit the geographies in which they sell health insurance or exit certain markets altogether, place less reliance on agents to distribute their plans, apply stricter underwriting standards (until provisions in health care reform registration limiting underwriting go into effect in 2014) or limit their health insurance offerings in any number of other ways, each of which would harm our business, operating results and financial condition. The implementation of medical loss ratio requirements

has caused and could further cause health insurance carriers to reduce the amount they are willing to spend in connection with our sponsorship and technology licensing businesses, which also could harm our business, operating results and financial condition.

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

We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers also may amend the terms of our agreements unilaterally on short notice. Carriers may be unwilling to allow us to sell their existing or new health insurance plans, or desire to amend our agreements with them, for a variety of reasons, including for competitive or regulatory reasons, as a result of health care reform, as a result of a reluctance to distribute their plans over the Internet or because they do not want to be associated with our brand. 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 rely on their own internal distribution channels, including traditional in-house agents and carrier websites, to sell their own plans and, in turn, could limit or prohibit us from selling their plans on our ecommerce platform. For instance, carriers may choose to exclude us from their most profitable or popular plans or may determine not to distribute insurance plans in the individual, family and small business markets in certain geographies or altogether. The termination or amendment of our relationship with a carrier could reduce the variety of health insurance plans we offer, which could harm our business, operating results and financial condition. We also could lose a source of or be paid reduced commissions for future sales and for past 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 wide variety of health insurance plans.

The health insurance industry in the United States has experienced a substantial amount of consolidation over the past several years, resulting in a decrease in the number of health insurance carriers. In the future, we may be forced to offer insurance policies from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. We derived 12% of our total revenue in each of the three months ended March 31, 2011 and 2012 from carriers owned by Wellpoint. We derived 13% of our total revenue in the each of three months ended March 31, 2011 and 2012 from carriers owned by UnitedHealthcare. We derived 4% and 16% of our total revenue in the three months ended March 31, 2011 and 2012, respectively, from Humana. We derived 11% and 8% of our total revenue in the three months ended March 31, 2011 and 2012, respectively, from Aetna. We have several agreements that govern our sale of individual health insurance plans with these health insurance carriers. Many of them may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact or cause the termination of the commission payments that we receive from these health insurance carriers, which would harm our business, operating results and financial condition. Notwithstanding our separate agreements with various carriers directly or indirectly owned by the same entity, certain carriers have attempted and may continue to attempt to consolidate our relationship with them, which could increase the impact of carrier concentration on us, decrease the commission rates we receive and adversely affect our financial results, particularly in states where we offer health insurance from a relatively smaller number of carriers or where a small number of carriers dominates the market. The termination, amendment or consolidation of our relationship with these and other health insurance carriers could harm our business, operating results and financial condition.

Our revenues and earnings may continue to decline.

We have recently experienced a significant reduction in the commission rates that health insurance carriers pay us on the individual and family health insurance plans that we sell. We also have in the past and may in the future continue to make significant expenditures related to the development of our business, including expenditures relating to marketing, website technology development, the development of our business selling Medicare-related health insurance plans and the expansion of our technology licensing business to governmental entities. Our ability to resume revenue and earnings per share growth on a consistent basis will be dependent upon a number of factors, including the success of our Medicare plan marketing and sales business, our ability to attract individuals, families and small businesses to purchase health insurance through our ecommerce platform, our maintaining our relationships with health insurance carriers and the commission rates we receive for our sale of health insurance plans, our ability to maintain our relationship with existing members within historical levels and our success in entering into relationships with government entities to perform services and license our technology for use in the implementation of health insurance exchanges and other health care reform-related endeavors. If we are not successful in these areas, our business, operating results and financial condition will be harmed.

Our revenue will be adversely impacted if our membership does not grow. The 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.

Accordingly, to the extent that our net addition of new members slows or we experience a reduction in the number of our members, our revenue would be adversely impacted due to a decline in commissions we receive for members whose policies have been active for more than twelve months in addition to the reduction in revenue growth that would occur solely as a result of a decline in our membership growth rate. The commission rates we receive are impacted by a variety of other factors, including the particular health insurance policies chosen by our members, the carriers offering those policies, our members' states of residence, the laws and regulations in those jurisdictions and health care reform. Our commission rate per member has, and could in the future, decrease as a result of either reductions in contractual commission rates or unfavorable changes in health insurance carrier override commission programs, each of which may be beyond our control and may occur on short notice. To the extent these and other factors cause our commission rate per member to decline, our rate of revenue growth may decline and our business, operating results and financial condition would be harmed.

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

We recently determined to actively market the availability of Medicare-related health insurance plans using our ecommerce platforms, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We refer to these plans as Medicare plans. We market Medicare plans to Medicare-eligible individuals, who are predominately senior citizens over the age of 65. The sale of Medicare Advantage and Medicare Part D prescription drug plans are subject to an annual enrollment period during the fourth quarter of each year, when a substantial percentage of the annual sales of these plans occur. We do not have significant experience in marketing Medicare plans. The Medicare-related revenue we have generated is primarily referral fees paid to us based on Medicare leads generated by our online platforms that are delivered and sold to third parties. However, our strategy is to sell a greater percentage of these products directly as a health insurance agent using our websites and customer care centers.

We have a limited number of relationships with health insurance carriers to sell Medicare plans, and our Medicare plan related revenue is concentrated in a small number of health insurance carriers. The success of our entry into the market for Medicare plans as a health insurance agent will depend upon our ability to enter into and maintain relationships with health insurance carriers on favorable economic terms. We may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carrier partners. For instance, a carrier may terminate our relationship. In addition, the Centers for Medicare and Medicaid Services, or CMS, has and will continue to penalize health insurance carriers for certain regulatory violations by not allowing them to market and sell Medicare plans for significant periods of time. Given the small number of our Medicare carrier relationships, if we lose a relationship with a health insurance carrier to market their Medicare plans temporarily or permanently for this or any other reason, our sales as a health insurance agent and Medicare plan related revenue could suffer significantly, and our business, operating results and financial condition would be harmed. In addition, 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, which would harm our business operating results and financial condition.

CMS must approve our websites and call center scripts for us to be able to generate Medicare plan leads and sell Medicare plans to those leads as a health insurance agent. Moreover, we and our subsidiary PlanPrescriber use Medicare plan cost and benefit data collected and made publicly available by CMS. In the event that CMS disapproves, or delays approval, of our websites or call center scripts, or does not timely release Medicare plan cost and benefit data for the following year's Medicare plans prior to the annual enrollment period, we could lose a significant source of Medicare plan leads and our ability to sell Medicare plans would be adversely impacted, each of which would harm our business, operating results and financial condition.

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

- our ability to continue to adapt our ecommerce platform to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the modification of our existing user experience for new plans targeted at a different demographic;
- our success in marketing our ecommerce platform to Medicare-eligible individuals and in entering into business development relationships to drive Medicare-eligible individuals to our ecommerce platform;

- our effectiveness in entering into and maintaining relationships with marketing partners, including existing pharmacy chain partners that refer Medicare-eligible individuals to us;
- our ability to hire and retain additional employees with experience in Medicare, including our ability to timely implement Medicare sales expertise into our customer care centers;
- our ability to comply with the numerous, complex and changing laws and regulations and CMS guidelines relating to the marketing and sale of Medicare plans, including continuing to conform our online and offline sales processes to those laws and regulations; and
- the effectiveness with which our competitors market the availability of Medicare plans from sources other than our ecommerce platform.

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

Our ability to sell Medicare-related health insurance plans as a health insurance agent is dependent upon our ability to timely hire, train and retain licensed health insurance agents.

In addition to our websites, we rely upon our customer care centers to sell Medicare plans. The success of our customer care center operations is largely dependent on licensed health insurance agents. In order to sell Medicare-related health insurance plans, our health insurance agent employees must first be licensed by the state in which they are selling the plan and certified and appointed with the health insurance carrier that offers the plan in each state that the Medicare-related health insurance product is being sold. Because the vast majority of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we are required to hire and train a significant number of additional employees on a temporary or seasonal basis in a limited period of time. We must also ensure that these employees are timely licensed in a significant number of states and certified and appointed with the health insurance carriers whose products we sell. We may not be successful in timely hiring a sufficient number of additional licensed agents for the Medicare annual enrollment period, and even if we are successful, these employees may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments with our health insurance carrier partners. If we and our health insurance agent employees are not successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the annual enrollment period, which would harm our business, operating results and financial condition.

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

We determined to enter into the Medicare plan market because we believe the number of individuals becoming eligible for Medicare is increasing and these individuals are increasingly using the Internet to shop for health insurance plans. We also believe that, on average, member retention rates and the commissions that health insurance carriers pay in connection with the sale of Medicare plans compare favorably to the member retention rates and commissions we receive in connection with our sale of individual and family health insurance. Should we prove to be wrong, or should these circumstances reverse, our success in marketing Medicare plans would be materially and adversely impacted, which could harm our business, operating results and financial condition. For instance, portions of health care reform impose significant changes to original Medicare and the Medicare Advantage program by, among other things, increasing the benefits original Medicare provides, reducing payments to Medicare Advantage plans and imposing medical loss ratio requirements for Medicare Advantage plans. In the event health care reform or other circumstances decrease the demand for Medicare Advantage plans or other alternatives to original Medicare, or cause a reduction in the amount paid to agents in connection with the sale of these plans, our business operating results and financial condition could be harmed.

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws and regulations, and any noncompliance with them could harm our business, operating results and financial condition.

The marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. The marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans are principally

regulated by CMS. The marketing and sale of Medicare Supplement plans are principally regulated on a state-by-state basis by state departments of insurance. The laws and regulations applicable to the marketing and sale of Medicare plans are numerous, ambiguous and complex, and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently. As a result of these laws, regulations and guidelines, we have altered, and likely will have to continue to alter, our websites and sales process to comply with several requirements that are not applicable to our sale of non-Medicare-related health insurance plans. For instance, many aspects of our online platforms and our marketing material and processes, as well as changes to these platforms, materials and processes, including call center scripts, must be approved on a regular basis by CMS and by health insurance carriers in light of CMS requirements. In addition, certain aspects of our Medicare plan marketing partner relationships with pharmacy chains have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. Changes to the laws, regulations and guidelines relating to Medicare plans, their interpretation or the manner in which they are enforced could be incompatible with these relationships, our platforms or our sale of Medicare plans. Due to changes in CMS guidance or enforcement or interpretation of existing guidance, or as a result of new regulations and guidelines, CMS, state departments of insurance or health insurance carriers may determine to object to or not to approve aspects of our online platforms or marketing material and processes and may determine that certain existing aspects of our Medicare-related business are not in compliance. As a result, the progress of our Medicare operations could be slowed or we could be prevented from operating aspects of our Medicare revenue generating activities altogether, which would harm our business, operating results and financial condition, particularly if it occurred during the Medicare annual enrollment period. It could also result in the write-down of the value of assets acquired in our PlanPrescriber acquisition.

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

Our Medicare-related health insurance plan lead referral revenue may continue to decline.

One of our strategies is to service a greater number of Medicare plan leads ourselves as a health insurance agent rather than refer them to third parties and generate referral revenue. As a result, we have experienced a reduction in Medicare referral revenue during the three months ended March 31, 2012 and may continue to experience a reduction in Medicare referral revenue in future periods, as we recognize lead referral revenue at the time of delivery and sale of the leads to third parties, but we recognize commission revenue from the sale of Medicare plans for which we serve as an agent over the term of the sold policies. Our generation of Medicare plan lead referral revenue also is dependent upon many of the factors that could impact our ability to generate Medicare plan commission revenue, including our ability to generate Medicare plan leads, and is subject to other risks and uncertainties. For instance, we depend upon CMS to permit us to use Medicare plan data collected by CMS for significant aspects of our PlanPrescriber platform, which has generated the majority of our Medicare plan related leads, and we rely upon a single purchaser of Medicare plan related leads. We also generate a significant number of Medicare plan leads through a limited number of marketing partner relationships with pharmacy chains. A delay in our ability to use CMS plan data, the termination our relationship with our lead purchasing partner, the inability of our lead purchasing partner to pay for the leads we generate or the termination of our relationship with our marketing partners could harm our ability to generate Medicare plan lead referral revenue and our business, operating results and financial condition.

We have reduced our cost of acquisition and other expenses in connection with the sale of our individual and family health insurance plans, which may harm our operating results.

As a result of the reduction in the commission rates we receive for selling individual and family health insurance plans, we have reduced our marketing and advertising and other expenses in this area of our business, which has adversely impacted the number of individual and family health insurance plan approved members for which we will receive commission revenue. The maintenance of a lower cost of acquisition depends significantly on the rate at which visitors to our website submit health insurance applications, particularly with respect to paid search advertising, as our paid search costs are incurred on the referral of a potential member rather than on the submission of a health insurance application. As a result, we may not be successful in maintaining an acceptable individual and family health insurance cost of acquisition in the event we experience a decline in the rate at which visitors to our platform submit individual and family health insurance applications, which would harm our business, operating results and financial condition.

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

Our operating results are likely to fluctuate as a result of a variety of factors, including the factors described elsewhere in this "Risk Factors" section, many of which are outside of our control. As a result, comparing our operating results on a period-to-period basis may not be meaningful and you should not rely on our past results as an indication of our future performance, particularly as a result of the commission rate reductions that we have experienced in our individual and family health insurance business, which began impacting our financial results in 2011. If our revenue or operating results fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially.

Our business model is characterized primarily by revenue based on commissions we receive from insurance carriers whose policies are purchased by our members. We receive commissions and record related revenue for an individual, family, small business or Medicare Supplement health insurance policy, typically on a monthly basis, until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. For both Medicare Advantage and Medicare Part D prescription drug plans, we record commission revenue on an annual basis but may receive commission payments from insurance carriers on either a monthly or annual basis typically for a period of up to six years, or longer depending on the carrier arrangement, provided that the policy remains active with us.

A significant component of our marketing and advertising expenses consists of expenses incurred in search engine advertising at the time a consumer clicks on an advertisement and payments owed to our marketing partners in connection with applications submitted on our ecommerce platform by potential members referred to us by our marketing partners. As a result of this timing difference between expense and associated revenue recognition, our operating results and cash flows may be adversely affected in periods where we experience a significant increase in new applicants. In addition, if we incur other unanticipated or one-time expenses in a particular quarter or if we lose a significant amount of our member base for any reason, we would likely be unable to offset these expenses by increasing sales within that quarter or to replace lost revenue in the quarter with revenue from new members. As a result, our quarterly results may suffer due to unanticipated expenses, one-time charges or significant member turnover.

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

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

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

Economic conditions have caused interest rates to decline. We have experienced a significant reduction in the rate of return on our investments both as a result of the decline in interest rates and as a result of our implementation of more conservative investment policies. Economic conditions could materially and adversely impact our investments in the future, including loss of our principal investment, despite our implementation of more conservative investment policies.

Our business may not grow if consumers are not informed about the availability and accessibility of affordable health insurance.

Numerous health insurance plans are available to consumers in any given market. Most of these plans vary by price, benefits and other policy features. Health insurance terminology and provisions are often confusing and difficult to understand. As a result, researching, selecting and purchasing health insurance can be a complex process. We believe that this complexity has contributed to a perception held by many consumers that individual health insurance is prohibitively expensive and difficult to obtain. We attempt to make the health insurance research and application process on our website understandable and user-friendly. We also attempt to use our website and other means to educate consumers about the accessibility and affordability of health insurance. If consumers are not informed about the availability and accessibility of affordable health insurance or our ecommerce platform is difficult to navigate, our business may not grow and our operating results and financial condition would be harmed.

If we are not successful in cost-effectively converting visitors to our website into members, our business and operating results would be harmed.

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

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers' ability or willingness to pay for health insurance, extension of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business;
- the quality of and changes to the consumer experience on our ecommerce platform or with our customer care center;
- regulatory requirements, including those that make the experience on our online platforms cumbersome or difficult to navigate;
- the variety 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;
- the 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 underwriting practices and guidelines applicable to applications submitted by consumers and the amount of time a carrier takes to make a decision on that application; and
- competitive offerings.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels. For example, our conversion rates have historically been lower with respect to consumers referred to us by Internet lead aggregators and relatively higher with respect to consumers coming to us through our direct member acquisition channel. In addition, we may make changes to our ecommerce platform or undertake other initiatives in an attempt to improve consumer experience or for other reasons. These changes in the past, and may in the future, have the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platform and are converted into members could cause an increase in our cost of acquiring members on a per member basis. To the extent the rate at which we convert consumers visiting our ecommerce platform into members suffers, our membership growth rate may decline, which would harm our business, operating results and financial condition.

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

We receive revenue from commissions health insurance carriers pay to us for health insurance policies sold through our ecommerce platform. When one of these policies is cancelled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission revenue. Individuals, families and small businesses may choose to discontinue their health insurance policies for a variety of reasons. For example, individuals and families may replace a health insurance policy purchased through us with a health insurance policy provided by a new or existing employer or may determine that they cannot afford health insurance. In addition, our members may choose to purchase new policies using a different agent if, for example, they are not satisfied with our customer service or the health insurance plans that we offer. Consumers may also purchase health insurance policies from state health insurance exchanges after their implementation as a result of health care reform. Health insurance carriers may also terminate health insurance plans purchased and held by our members. If we are not successful in transferring members covered under a terminated plan to another policy that we offer, we will lose these members and associated commission revenue. Our cost in acquiring a new member is substantially greater than the cost involved in maintaining our relationship with an existing member. If we are not able to successfully retain existing members and limit member turnover, our revenue and operating margins could be adversely impacted and our business, operating results and financial condition would be harmed.

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

The demand for health insurance marketed through our ecommerce platform is impacted by, among other things, the variety, quality and price of the health insurance plans we offer. If health insurance carriers do not continue to allow us to sell a variety of high-quality, affordable health insurance plans in the individual, family and small business and Medicare markets, or if their offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform legislation or otherwise, our sales may decrease and our business, operating results and financial condition could be harmed.

Health insurance carriers could determine to reduce the commissions paid to us or change their underwriting practices in ways that reduce the number of insurance policies sold through our ecommerce platform, which could harm our business and operating results.

Our commission rates, and the commission override payments we receive from health insurance carriers for achieving sales volume thresholds or other objectives, are either set by each carrier or negotiated between us and each carrier. Carriers have altered, and may in the future alter, the contractual relationships we have with them on short notice, either by renegotiation or unilateral action. If these contractual changes result in reduced commissions, our business may suffer and our operating results and financial condition would be harmed. In addition, carriers periodically change the criteria they use for determining whether they are willing to insure individuals as well as other underwriting practices. At various times, carriers have applied more stringent underwriting criteria and practices to applications for health insurance. These practices result in a decrease in the rate at which insurance applications submitted through our ecommerce platform are approved. Changes in carrier underwriting criteria or practices could negatively impact sales of insurance policies on our ecommerce platform and could 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, the number of consumers visiting our platform could decrease, and our cost of acquiring members could increase as a result of a reduction in the number of members coming from our direct member acquisition channel, both of which could harm our business, operating results and financial condition.

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

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

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

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

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

Our success depends in part upon widespread consumer and health insurance carrier acceptance of the Internet as a marketplace for the purchase and sale of health insurance. Consumers and health insurance carriers may choose to depend more on traditional sources, such as individual agents, or alternative sources may develop, including as a result of health care reform legislation. Our future growth, if any, will depend in part upon:

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

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

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

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

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

We purchase paid advertisements on search engines in order to attract consumers to our website. We typically pay a search engine for prominent placement of our name and website when particular health insurance-related terms are searched for on the search engine, regardless of the algorithmic search result listings. In some circumstances, 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, have greater resources with which to bid and better brand recognition than we do. We have experienced increased competition from health insurance carriers and some of our marketing partners for both algorithmic search result listings and for paid advertisements, which has increased our marketing and advertising expenses. If this competition increases further, or if the fees associated with paid search advertisements increase as a result of algorithm changes or other factors, our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which could harm our business, operating results and financial condition.

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

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

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

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

- the compliance of our marketing partners, and of the manner marketing partners refer consumers to our platforms, with applicable laws, regulations and guidelines;
- the interest of the marketing partner's customers in the health insurance plans that we offer on our ecommerce platform;
- the contractual terms we negotiate with the marketing partner, including the marketing fees we agree to pay a marketing partner;
- the percentage of the marketing partner's customers that submit applications or purchase health insurance policies through our ecommerce platform;
- the ability of a marketing partner to maintain efficient and uninterrupted operation of its website; and
- our ability to work with the marketing partner to implement website changes, launch marketing campaigns and pursue other initiatives necessary to maintain positive consumer experiences and acceptable traffic volumes.

For instance, we partner with Internet lead aggregators who refer a significant number of consumers to our online platforms. Major search engines have in the past and may in the future determine not to list lead aggregator websites prominently in search result listings for various reasons, which would cause a significant reduction in the number of consumers referred to us through our marketing partner channel. If we are unable to maintain successful relationships with our existing marketing partners or fail to establish successful relationships with new marketing partners, our business, operating results and financial condition will be harmed.

The impact that health care reform will have on our relationships with marketing partners is unclear. To the extent that health care reform makes it less profitable or desirable for marketing partners to promote us to their customers, we may lose relationships with existing marketing partners and may have difficulty entering into relationships with new marketing partners. We may also need to reduce the compensation that we pay to marketing partners to the extent that health care reform has the effect of reducing commissions for individual and family health insurance. There is no guarantee that we will be able to amend our agreements to reduce the compensation that we pay to acceptable levels in light of the commission rates that we receive. If we are not able to do so, our business, operating results and financial condition could be harmed. In addition, the promulgation of laws, regulations or guidelines, or the interpretation of existing laws, regulations and guidelines, by state departments of insurance or by CMS, could cause our relationships with our marketing partners to be in noncompliance with those laws, regulations and guidelines. For instance, as a result of our acquisition of PlanPrescriber, we have marketing partner relationships with pharmacy chains that utilize aspects of our platform and tools. Our relationships with these pharmacy chains result in the referral of a significant number of individuals to us who are interested in purchasing Medicare plans. If CMS or state departments of insurance were to change existing laws, regulations or guidelines, or interpret existing laws, regulations or guidelines, to prohibit these arrangements, we would experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and call center, which would harm our business, operating results and financial condition and could result in a write-down of the value of assets acquired in our PlanPrescriber acquisition.

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

For individual, family and small business health insurance plans, health insurance carriers typically pay us a specified percentage of the premium amount on a health insurance policy that we have sold during the period that a member maintains coverage under the policy. For both Medicare Advantage and Medicare Part D prescription drug policies, health insurance carriers typically pay us a fixed commission amount during the period the policy remains active, typically for up to six years, or longer depending on carrier the arrangement, provided that the policy remains active with us. We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission revenue, prepare our financial reports, projections and budgets and direct our marketing and other operating efforts based on the reports we receive from health insurance carriers. It is often difficult for us to independently determine whether or not carriers are accurately reporting commissions due to us. To the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, we will not recognize revenue to which we are entitled, which would harm our business, operating results and financial condition.

We also are dependent on health insurance carriers and others for data related to our membership. For instance, with respect to health insurance plans other than small business group health insurance, health insurance carriers do not directly report member cancellations to us, resulting in the need for us to determine cancellations using payment data that carriers provide. We infer cancellations from this payment data by analyzing whether payments from members have ceased for a period of time, and we may not learn of a cancellation for several months, given that some of our members pay on a schedule less frequently than monthly (e.g., quarterly). With respect to our small business group 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. Additionally, health insurance carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be different from our estimates, perhaps materially. Total revenue per estimated member for the period would also change if our estimated membership changed. Our estimate regarding the average amount of time our members maintain their health insurance plans also could be inaccurate as it is dependent upon the accuracy of our membership estimates.

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

The timing of our revenue depends upon the timing of our receipt of commission reports and associated payments from health insurance carriers. There have been instances where their report of commissions and payment have been delayed, such as during holiday periods. Any delay could materially impact our financial results for a given quarter as we would not be able to recognize the related commission revenue in that quarter. In addition, much of our commission override revenue is not reported and paid to us in accordance with a scheduled pattern, and some is only reported and paid to us once per year. This could result in a large amount of commission revenue from a carrier being recorded in a given quarter that is not indicative of the amount of revenue we may receive from that carrier in subsequent quarters, causing fluctuations in our operating results. We could report revenue below the expectations of our investors or securities analysts in any particular period if a material report or payment from a health insurance carrier were delayed or not received within the time frame required for revenue recognition.

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 the tens of thousands of local insurance agents across the United States who sell health insurance plans in their communities. There are a number of agents that operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. Some local agents use "lead aggregator" services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to the traditional agent. In addition to health insurance brokers and agents, many health insurance carriers directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. We will also compete with state health insurance exchanges implemented as a result of healthcare reform. Healthcare reform also will result in health insurance plan cost and benefit data being more readily accessible, which could facilitate additional competition. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. In addition, CMS offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans.

In licensing our health insurance purchasing platform, we compete with companies providing technology that automates premium quoting, research and analysis of health insurance plans, member enrollment and other tools that support online sales efforts by health insurance carriers and their agents and brokers. We anticipate that in licensing our technology to government entities for health insurance exchange and other purposes, we will compete with these entities as well as system integrators, software companies, employee benefit service providers, technology consulting companies and others that have experience providing technology and services to the federal or state governments.

We may not be able to compete successfully against our current or future competitors. Some of our current and potential competitors have longer operating histories, larger customer bases, greater brand recognition and significantly greater financial, technical, marketing and other resources than we do. As compared to us, our current and future competitors may be able to:

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

In addition, CMS has the ability to regulate our marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans.

Competitive pressures may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, or may otherwise harm our business, operating results and financial condition.

There are many risks associated with our operations in China.

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

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

availability of our ecommerce platform, competition, the regulatory environment and the manner in which health care delivery is financed and changes to such environment or manner, our ability to attract and retain qualified personnel and network security.

Our participation and success in the insurance market in China may be impacted by additional factors given that outside of Xiamen city, the insurance products offered on our website are offered directly by insurance carriers. As a result, our success in selling insurance outside of China is dependent upon many factors, including our dependence on insurance carriers for the products on our website, the insurance carriers' relationship with consumers, our relationship with the insurance carriers, the insurance carriers' ability to maintain licenses and regulatory approvals, and the number, quality and attractiveness of the insurance products offered by the insurance carriers through our platform. While there is no certainty that we would be able to expand our presence in the insurance industry in China, we may attempt to do so. If we decide to do so, we will need to receive additional government licenses and approvals or enter into additional relationships and we may face disadvantages in doing so as a result of our subsidiary in China being wholly foreign owned.

Our sponsorship and advertising business may not be successful.

We sell advertising space to health insurance carriers on our website through our sponsorship and advertising program. Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. Health insurance carriers have and may continue to determine to eliminate or reduce spending on our sponsorship and advertising program as a result of various aspects of health care reform, including the medical loss ratio requirements that became effective in 2011. As a result, our business, operating results and financial condition could be harmed. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for advertising on our ecommerce platform, our sponsorship and advertising program will be adversely impacted. The success of our sponsorship and advertising program is dependent upon a number of other factors, including the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer and health insurance carrier adoption of the Internet and our ecommerce platform as a medium for the purchase and sale of health insurance, our ability to attract consumers visiting our ecommerce platform and convert those consumers into members, the existence of a relationship between us and a diverse group of carriers that offer a number of health insurance plans in the markets in which we attempt to sell advertising, the cost, benefit and brand recognition of the health insurance plan that is the subject of the advertising, the impact the advertising has on the sale of the health insurance plan that is the subject of the advertising and the effectiveness of the carrier's other means of advertising. In addition, while our practice of selling advertising is described on our ecommerce platform, it could cause consumers to perceive us as not objective, which could harm our brand and result in a decline in our health insurance sales. It also could adversely impact our relationship with health insurance carriers that do not purchase our advertising. As a result, our business, operating results and financial condition could be harmed.

We also develop, host and maintain carrier dedicated Medicare plan websites through our advertising program. Our success in doing so is dependent upon the same factors that could impact our sponsorship program. In addition, since we maintain relationships with a limited number of health insurance carriers to sell their Medicare plans, our Medicare plan-related sponsorship 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 of any of these relationships. Moreover, in light of the regulations applicable to the marketing and sale of Medicare plans, and given that these regulations are often unclear, change frequently and are subject to changing interpretations, we may in the future not be permitted to sell Medicare plan related advertising. If we are not successful in generating Medicare plan related advertising revenue, our business operating results and financial condition could be harmed.

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

We license the use of our ecommerce technology to health insurance carriers and agents. Carriers use our platform to offer their own health insurance policies on their websites, and agents use it to power their quoting and online content. If we do not grow our revenue from the license of our technology, or if the rate of growth declines, our business, operating results and financial condition may be harmed. The impact that health care reform may have on our technology licensing business is unclear. Health care reform could reduce health insurance carrier and agent demand for our technology licensing platform as a result of the medical loss ratio requirements that became effective in 2011 or for other reasons, and health insurance carriers who currently use the platform could determine to cease using it, reduce the number and type of plans offered on the platform or renegotiate the fees that they pay, any of which would reduce the revenue we receive from our technology licensing business.

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

We may not be successful in licensing the use of our technology or performing services pursuant to federal or state government contracts.

An element of our strategy is to license the use of our technology and provide services to government entities in connection with health care reform and its requirement that states establish health insurance exchanges. While we have been a party to a small number of government contracts as a prime contractor or as a subcontractor, we are new to government contracting. Generally, government contracts are offered through a competitive bidding process. A number of entities may compete for the award of any particular government contract or related subcontract, and we may not be able to outbid our competitors. Even if we are awarded a contract, unsuccessful bidders may protest or challenge the contract award, which could result in our losing the contract. Complicated rules apply to doing business with the federal and state governments, including without limitation procurement laws and regulations. In addition, socio-economic obligations, including various restrictions relating to those of our employees that may perform under the government contract, may accompany government contracts. These requirements may require us to restructure aspects of our operations to perform under a contract, which may be difficult or impossible. As a government contractor, we are subject to audits, cost reviews and investigations by oversight agencies. We may not be successful in our effort to enter into government contracts, and even if we are, we may face difficulty and unanticipated expense in adapting our platform and software, and complying with applicable laws, regulations and contractual requirements. If we are not successful in our government contracting efforts, our business, operating results and financial condition could be harmed. In addition, if we fail to comply with the terms of one or more of our government contracts or applicable laws and regulations, we could be suspended or barred from future government projects for a significant period of time, as well as face civil or criminal fines and penalties, which would harm our business, operating results and financial condition.

Government contracts that we have entered into for the use of our services or licensing the use of our technology have short terms. Our government contracts may not be renewed for any reason, including as a result of performance of the contract, competing solutions or a change in the governmental entity’s preferences. Furthermore, the contracts may be terminated as a result of our performance or as a result of the performance or actions of third parties involved in the contracts, such as a subcontractor or the prime contractor where we are a subcontractor. The termination or nonrenewal of any of our government contracts could harm our business, operating results and financial condition and make it more difficult to successfully bid on future government contracting opportunities.

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

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

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

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

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

We provide information on our website, through our customer care centers and in other ways regarding health insurance in general and the health insurance plans we market and sell, including information relating to insurance premiums, coverage, benefits, provider networks, exclusions, limitations, availability, plan comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our website. Separately, from time to time, we use the information provided on our website and otherwise collected by us to publish reports designed to educate consumers, facilitate public debate, and facilitate reform at the state and federal level relating to the accessibility and affordability of health insurance. We also regularly provide health insurance plan information in our customer care centers. If the information we provide on our website, through our customer care centers or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, health insurance carriers and others could attempt to hold us liable for damages, our relationships with health insurance carriers could be terminated and regulators could attempt to subject us to penalties, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which could result in our loss of our commission revenue. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints without significant financial cost, we cannot guarantee that we will be able to do so in the future. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations, we could lose our relationship with health insurance carriers and be subject to various fines and penalties, including revocation of our licenses to sell insurance, and our business, operating results and financial condition would be materially harmed. We would also be harmed to the extent that related publicity damages our reputation as a trusted source of information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome.

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

Our success is dependent upon the performance of our senior management and key personnel. Our management and employees can terminate their employment at any time. Many of our senior management and key employees have sold shares of our common stock in the open market, and some have sold a significant portion of their vested holdings. These employees may be more likely to leave us given that they have liquidated some or a substantial percentage of their holdings. The loss of the services of any of our executive officers or key employees could harm our business. For example, we appoint a single writing agent with each insurance carrier.

If we lose the service of our appointed writing agent, the duties of writing agent will need to be transitioned to other company personnel. Due to our national reach and the large number of carrier partners whose policies are purchased by our members, this transition may be difficult and requires a significant period of time to complete. If the transition is not successful or takes too long to complete, our agency relationship with particular insurance carriers may be terminated, our commission payments could be discontinued or delayed and, as a result, our business, operating results and financial condition would be harmed. Our success is also dependent upon our ability to attract additional personnel for all areas of our organization. We may not be successful in attracting and retaining personnel on a timely basis, on competitive terms or at all. If we are unable to attract and retain the necessary personnel, our business would be harmed.

We recently hired a new president and chief operating officer, and the employment of our executive vice president of business and corporate development and the employment of our chief technology officer recently terminated. We are likely to experience change in our operations as a result. If we are not effective in managing this transition in our leadership and changes in our operations, our business could be adversely impacted and our operating results and financial condition could be harmed.

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

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

Seasonality may cause fluctuations in our financial results.

The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by these patterns. The reasons for these seasonal patterns are not entirely clear.

The vast majority of Medicare plans are sold in the fourth quarter of each year during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, we have generated the majority of our Medicare plan-related revenue in the fourth quarter of the year. Additionally, we recognize a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year.

In 2011, we significantly increased our temporary customer care center staff during the third quarter in preparation for the Medicare annual enrollment period. We employed our temporary customer care center staff until the end of the Medicare annual enrollment period in December 2011. As a result, our customer care center staffing costs were significantly higher in the third and fourth quarters of 2011 compared to the first and second quarters of 2011. We expect this seasonal trend to occur again in 2012. We also incurred significantly greater Medicare plan-related online advertising expenses during the third and fourth quarters of 2011 compared to the first and second quarters of 2011. We expect this seasonal trend to occur again in 2012. Because the majority of our Medicare plan-related revenue is not generated until the fourth quarter, our temporary customer care center staffing costs and Medicare-related online advertising expenses incurred in the third quarter have had a significant negative impact on our profitability during the third quarter.

Based on these seasonal trends, we expect our revenue to be highest in the fourth quarter of the year and we expect our profitability to be relatively higher in the second and fourth quarters and relatively lower in the third quarter of the year.

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

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

- an acquisition may negatively impact our results of operations because it will require us to incur transaction expenses, and after the transaction, may require us to incur charges and substantial debt or liabilities, may require the amortization, write down or impairment of amounts related to deferred compensation, goodwill and other intangible assets, or may cause adverse tax consequences, substantial depreciation or deferred compensation charges;
- an acquisition undertaken for strategic business purposes may negatively impact our results of operations;
- we may encounter difficulties in assimilating and integrating the business, technologies, products, personnel or operations of companies that we acquire, particularly if key personnel of the acquired company decide not to work for us;
- an acquisition may disrupt our ongoing business, divert resources, increase our expenses and distract our management;
- we may be required to implement or improve internal controls, procedures and policies appropriate for a public company at a business that prior to the acquisition lacked these controls, procedures and policies;
- the acquired businesses, products or technologies may not generate sufficient revenue to offset acquisition costs or to maintain our financial results;
- we may have to issue equity securities to complete an acquisition, which would dilute our stockholders' ownership and could adversely affect the market price of our common stock; and
- acquisitions may involve the entry into geographic or business markets in which we have little or no prior experience.

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

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

We have a complex business organization, and we recently expanded our business operations into the areas of the sale of Medicare plans and government contracting. Ensuring that we have adequate internal financial and accounting controls and procedures in place to help ensure that we can produce accurate financial statements on a timely basis is a costly and time-consuming effort that needs to be re-evaluated frequently and is complicated by the expansion of our business operations. Our management, including our chief executive officer and chief financial officer, does not expect that our internal control over financial reporting will prevent all errors or all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time, controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

As a result, we cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations, or result in material misstatements in our financial statements.

Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002 and the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

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

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections, changes in the valuation of our deferred tax assets and liabilities, expiration of or lapses in the research and development tax credit laws, tax effects of share-based compensation or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. For instance, in October 2010, the state of California approved budget legislation which substantially limited the utilization of net operating losses. The new law did not affect the amount of net operating losses and tax credits that we expect to ultimately use to offset future California taxes, but limited the amount we could utilize in 2010 and 2011, resulting in our paying higher cash taxes. To the extent that our provision for income taxes is subject to volatility or adverse outcomes as a result of tax examinations, our operating results could be harmed.

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

Any expansion of our business into foreign countries involves significant risks.

We currently do not sell health insurance or license our technology platform outside the United States other than in China. We may attempt to expand aspects of our business to additional geographic regions. We face significant challenges in connection with expanding our business into any foreign country, since we have no prior experience marketing or selling insurance in any foreign jurisdiction. Additionally, demand for private health insurance is not significant in many foreign countries as a result of government-sponsored health care systems. In addition to facing many of the same challenges we face domestically, we also would have to overcome other obstacles such as:

- legal, political or systemic restrictions on the ability of United States companies to market insurance or otherwise do business in foreign countries;
- varied, unfamiliar and unclear legal and regulatory restrictions;
- less extensive adoption of the Internet as a commerce medium or information source and increased restriction on the content of websites; and
- the adaptation of our website and distribution model to fit the particular foreign country.

As a result of these obstacles, we may find it impossible or prohibitively expensive to expand our services internationally or we may be unsuccessful should we attempt to do so, either of which could harm our business, operating results and financial condition.

Risks Related to Insurance Regulation

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

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

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

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

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

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

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

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New insurance laws, regulations and guidelines also may not be compatible with the sale of health insurance over the Internet or with various aspects of our platform or manner of marketing or selling health insurance plans. Failure to comply with insurance laws, regulations and guidelines or other laws and regulations applicable to our business could result in significant liability, additional department of insurance licensing requirements, the revocation of licenses in a particular jurisdiction and/or our inability to sell health insurance plans, which could significantly increase our operating expenses, result in the loss of our commission revenue and otherwise

harm our business, operating results and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand. Because some consumers, marketing partners and health insurance carriers may not be comfortable with the concept of purchasing health insurance using the Internet, any negative publicity may affect us more than it would others in the health insurance industry and would harm our business, operating results and financial condition. Changes in insurance laws, regulations and guidelines may also be incompatible with various aspects of our business and require that we make significant modifications to our existing technology or practices, which may be costly and time-consuming to implement and could also harm our business, operating results and financial condition.

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

Risks Related to the Internet and Electronic Commerce

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

Our services involve the collection and storage of confidential information of consumers and the transmission of this information to their chosen health insurance carriers. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers in connection with their applications for health insurance. As a result, we are subject to various federal, state and international laws and regulations regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We cannot guarantee that our facilities and systems, and those of our third party service providers, will be free of security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with privacy and security laws, requirements and regulations may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by third party service providers, and enforcement actions. We may be required to expend significant capital 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, although our third party service providers are required to implement appropriate security measures, we have limited control over their actions and practices.

Any compromise or perceived compromise of our security could damage our reputation and our relationship with our members, marketing partners and health insurance carriers, could reduce demand for our services and could subject us to significant liability and expense as well as regulatory action or private privacy-related lawsuits, which would harm our business, operating results and financial condition. In addition, in the event that data security laws are implemented, or our health insurance carrier or other partners determine to impose new requirements on us relating to data security, we may not be able to timely comply with such requirements or such requirements may not be compatible with our current processes. Changing our processes could be time consuming and expensive, and failure to timely implement required changes could result in our inability to sell health insurance plans in a particular jurisdiction or for a particular health insurance carrier or subject us to liability for non-compliance, any of which would damage our business, operating results and financial condition.

Government regulation of the Internet could adversely affect our business.

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

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

We use email to market our services to potential members and as the primary means of communicating with our existing members. The laws and regulations governing the use of email for marketing purposes continue to evolve and the growth and development of the market for commerce over the Internet may lead to the adoption of additional legislation. If new laws or regulations are adopted, or existing laws and regulations are interpreted, to impose additional restrictions on our ability to send email to our members or potential members, we may not be able to communicate with them in a cost-effective manner. In addition to legal restrictions on the use of email, Internet service providers, e-mail service providers and others attempt to block the transmission of unsolicited email, commonly known as "spam." Many Internet and e-mail service providers have relationships with organizations whose purpose it is to detect and notify the Internet and e-mail service providers of entities that the organization believes is sending unsolicited e-mail. If an Internet or e-mail service provider identifies email from us as "spam" as a result of reports from these organizations or otherwise, we can be placed on a restricted list that will block our email to members or potential members. If we are unable to communicate by email with our members and potential members as a result of legislation, blockage or otherwise, our business, operating results and financial condition would be harmed.

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

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

Risks Related to the Ownership of Our Common Stock

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

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

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

- actual or anticipated regulatory developments in the United States or foreign countries, including health care reform legislation in the United States;
- major catastrophic events;
- announcements or developments relating to the economy;
- our sale of common stock or other securities in the future;
- the trading volume of our common stock, as well as sales of large blocks of our stock; or
- departures of key personnel.

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

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

A small number of greater than 5% stockholders and their affiliated entities beneficially owned more than 75% percent of our outstanding common stock as of March 31, 2012. These stockholders, if they act together, could exert substantial influence over matters requiring approval by our stockholders, including the election of directors, the amendment of our certificate of incorporation and bylaws and the approval of mergers or other business combination transactions. This concentration of ownership may discourage, delay or prevent a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their stock as part of a sale of our company and might reduce our stock price. These actions may be taken even if they are opposed by other stockholders.

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

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

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;
- cumulative voting in the election of directors is prohibited, which limits the ability of minority stockholders to elect director candidates;
- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or the resignation, death or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors;
- the ability of our board of directors to determine to issue shares of preferred stock and to determine the price and other terms of those shares, including preferences and voting rights, without stockholder approval, which could be used to significantly dilute the ownership of a hostile acquiror;
- a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders;

- the requirement that a special meeting of stockholders may be called only by the chairman of the board of directors, the chief executive officer or the board of directors, which may delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; and
- advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquiror from conducting a solicitation of proxies to elect the acquiror's own slate of directors or otherwise attempting to obtain control of us.

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

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

On June 14, 2011, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to an additional $30 million of our common stock. In February 2012, we completed this stock repurchase program, having repurchased in the aggregate 2.2 million shares for approximately $30.0 million at an average price of $13.78 per share including commissions. Purchases under this repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The cost of the repurchased shares was funded from available working capital.

For accounting purposes, common stock repurchased under our stock repurchase programs was recorded based upon the settlement date of the applicable trade. Such repurchased shares are held in treasury and are presented using the cost method. All shares repurchased under these programs are returned to the status of authorized but unissued shares of common stock.

	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Program	Approximate Dollar Amount of Shares that May Yet be Repurchased (in thousands)
January 1 - 31, 2012	493,791	$ 15.14	493,791	$ 29,035
February 1 - 29, 2012	60,493	$ 15.95	60,493	$ —
March 1 - 31, 2012	—	$ —	—	$ —
	554,284	$ 15.23	554,284	

ITEM 6. EXHIBITS

(a) Exhibits

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

Exhibit Number	Description of Exhibit
10.15	Lease Agreement, effective as of March 23, 2012, between eHealth, Inc. and 340 Middlefield, LLC (filed by incorporation by reference to Exhibit 10.15 to the Current Report on Form 8-K filed with the Securities and Exchange Commission on March 27, 2012)
10.18*†	Executive Bonus Plan
31.1†	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2†	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1‡	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2‡	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

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

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized on the 8th day of May 2012.

/s/ GARY L. LAUER

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

/s/ STUART M. HUIZINGA

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

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EHEALTH, INC.
EXECUTIVE BONUS PLAN
2012

1. **Plan Objectives.**

- Reward management for achieving stated business objectives
- Build long-term stockholder value
- Provide competitive compensation for senior management

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

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

Eligible senior management hired during the Plan year will have their Target Incentive Percentage and Maximum Incentive Percentage set by the Compensation Committee (see Item 5 below). Such Participant's incentive payout will be pro-rated from the first day of employment; provided that the Compensation Committee determines that the Participant is eligible to participate. Employees hired after September 30, 2012 are not eligible for incentive payout for the 2012 Plan year, unless the Compensation Committee determines otherwise.

4. **Term**. 12 months, commencing on January 1, 2012 and ending on December 31, 2012.

5. **Target Incentive Payout**. The Compensation Committee will approve a Target Incentive Percentage and a Maximum Incentive Percentage for each Participant. The incentives under this Plan are expressed as a percentage of annual base salary as of the time the Compensation Committee approves a Participant's participation in the Plan (the "Annual Salary"). Attached, as Exhibit A, is a schedule of the Annual Salary, Target and Maximum Incentive Percentages and aggregate incentive for each 2012 Plan Participant. The aggregate "Target Incentive Award" for each Participant is equal to that Participant's Annual Salary multiplied by the Target Incentive Percentage for that Participant.

6. **Incentive Determination**. 100% of each Participant's potential Target Incentive Award is based upon achievement of the 2012 Revenue, Non-GAAP Operating Earnings (without

stock compensation and amortization of acquired intangibles) and EBITDA (GAAP Operating Income without stock compensation, depreciation and amortization) performance goals of the Company (each, a "Goal") as approved by the Compensation Committee in connection with the adoption of this Plan and subject to adjustment as set forth elsewhere in this Plan. The Revenue Goal comprises 40% of the total potential Target Incentive Award. The Non-GAAP Operating Earnings Goal and the EBITDA Goal each comprise 30% of the total potential Target Incentive Award. In order to determine payouts based upon Goal performance achievement between whole percentages, the Compensation Committee shall apply straight-line interpolation.

On-Target Performance Payout. In the event the Company meets the Revenue Goal, a Participant shall receive 40% of the product determined by multiplying the Target Incentive Percentage of the Participant by the Participant's Annual Salary; in the event the Company meets the Non-GAAP Operating Earnings Goal or the EBITDA Goal, a Participant shall receive 30% (for each goal) of the product determined by multiplying the Target Incentive Percentage of the Participant by the Participant's Annual Salary (respectively, for each of the three Goals, a "Goal Target Payout").

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

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

Above 100% Performance Payout – 2012 Revenue Goal. Subject to the other provisions of this Plan, for each percent achieved above 100% of the 2012 Revenue Goal, the Participant will receive an additional 5% of the Goal Target Payout for the Revenue Goal up to a maximum additional payment equal to 50% of the Goal Target Payout.

Above 100% Performance Payout – 2012 Non-GAAP Operating Earnings Goal. If and only if the 2012 Revenue Goal is achieved at a level of 100% or more, then for each percent achieved above 100% of the 2012 Non-GAAP Operating Earnings Goal, the Participant will receive an additional 2.5% of the Goal Target Payout up to a maximum additional Goal Target Payout of 50%.

Above 100% Performance Payout – 2012 Non-GAAP EBITDA Goal. If and only if the 2012 Revenue Goal is achieved at a level of 100% or more, then for each percent achieved above 100% of the 2012 EBITDA Goal, the Participant will receive an additional 2.5% of the Goal Target Payout up to a maximum additional Goal Target Payout of 50%.

The Company must be profitable on an operating basis (excluding non-cash charges) for a Participant to qualify for their maximum payout under the Plan for any specific Goal. If the

Company is not profitable on an operating basis (excluding non-cash charges), the maximum possible payout for the achievement of all three Goals shall be no more than 100% of the Participant's Target Incentive Award.

The 2012 Revenue Goal, Non-GAAP Operating Earnings Goal and EBITDA Goal and performance may exclude, at the Compensation Committee's sole discretion, (i) the effect of mergers and acquisitions closing in 2012 (if any), (ii) any extraordinary non-recurring items as described in Accounting Principles Board Opinion No. 30 or as otherwise determined by the Compensation Committee to be extraordinary or non-recurring in its sole discretion, (iii) the effect of any changes in accounting principles affecting the Company's or a business units' reported results, and (iv) any non-recurring expenses specified by the Compensation Committee.

7. **Payment**. Payments under the Plan will be made following the release of the Company's earnings to the public, but in no event later than March 15, 2013. The Compensation Committee must approve all executive officer incentive awards prior to payment. All Plan payments will be made net of applicable withholding taxes.

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

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

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EXHIBIT A

Salaries, Incentives and Incentive Percentages for 2012 Plan Participants

OFFICERS	SALARY	TITLE	INCENTIVE% TARGET	INCENTIVE% MAX	INCENTIVE $ TARGET	INCENTIVE $ MAX
Gibbs, Sam	$250,000	President, Govt Systems	60%	90%	$150,000	$225,000
Huizinga, Stuart	$280,000	CFO	60%	90%	$168,000	$252,000
Hurley, Robert	$250,000	SVP	60%	90%	$150,000	$225,000
Shaughnessy, Bill	$500,000	President & COO	60%	90%	$300,000*	$450,000*

* Per employment agreement, to be pro-rated for partial year.

Exhibit 31.1

CERTIFICATION

I, Gary L. Lauer, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 8, 2012

/s/ GARY L. LAUER
Gary L. Lauer
Chief Executive Officer

Exhibit 31.2

CERTIFICATION

I, Stuart M. Huizinga, certify that:

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

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

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

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

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

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

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

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

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

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

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

Date: May 8, 2012

/s/ STUART M. HUIZINGA

Stuart M. Huizinga
Chief Financial Officer

Exhibit 32.1

Certification of Chief Executive Officer, Pursuant to

18 U.S.C. Section 1350,

As Adopted Pursuant to

Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarterly period ended March 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Gary L. Lauer, Chief Executive Officer of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

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

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

/s/ GARY L. LAUER

Gary L. Lauer
Chief Executive Officer
May 8, 2012

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

Exhibit 32.2

Certification of Chief Financial Officer, Pursuant to

18 U.S.C. Section 1350,

As Adopted Pursuant to

Section 906 of the Sarbanes-Oxley Act of 2002

In connection with the Quarterly Report of eHealth, Inc. on Form 10-Q (the "Form 10-Q") for the quarterly period ended March 31, 2012, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), I, Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that, to my knowledge:

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

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

/s/ STUART M. HUIZINGA

Stuart M. Huizinga
Chief Financial Officer
May 8, 2012

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.