eHealth, Inc.
Form 10-K
March 12, 2014

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2013

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	(I.R.S Employer
	incorporation or organization)	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)

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.001 per share	The NASDAQ Stock Market LLC (NASDAQ Global Select Market)

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ¨ NO

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. YES ¨ NO

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

Indicate by check mark whether the registrant has submitted electronically 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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

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

Based on the closing price of the registrant's common stock on the last business day of the registrant's most recently completed second fiscal quarter, which was June 28, 2013, the aggregate market value of its shares (based on a closing price of $22.72 per share) held by non-affiliates was $152,865,249. Shares of the registrant's common stock held by each executive officer and director and by each entity or person that owned five percent or more of the registrant's outstanding common stock were excluded in that such persons may be deemed to be affiliates. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

The number of shares of the registrant's common stock, par value $0.001 per share, outstanding as of February 28, 2014 was 18,875,297 shares.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Definitive Proxy Statement for the 2014 Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2013, are incorporated by reference into Part III of this Annual Report on Form 10-K to the extent stated herein.

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EHEALTH, INC. FORM 10-K

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PART I

ITEM 1. BUSINESS

In addition to historical information, this Annual Report on Form 10-K contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding an expected increase in individual and family submitted applications; increasing customer care center staff in the second and third quarters; our beliefs relating to collection issues with our customers; our expectations relating to average commission dollars per policy for individual and family policies that we sell in 2014; the impact of health care reform laws on the health insurance industry, on our business and on the adoption of the Internet for the purchase of health insurance; our ability to leverage our technology to expand our marketplace; our strategies; our expectations relating to submitted applications; the impact of open enrollment periods; seasonality, including the seasonality of our marketing and advertising expenses and their relation to the Medicare and individual and family health insurance open enrollment periods; expansion of the individual and family health insurance market and increase in demand for individual and family health insurance ; our ability to meet requirements to offer qualified health plans through state and federal health insurance exchanges; the impact of the technology and integration challenges of the health insurance exchanges on health insurance enrollment; expectations relating to revenue (including commission revenue, lead referral revenue, advertising revenue and other revenue), sources of revenue, cost of revenue, the collectability of our accounts receivable, profitability, operating expenses, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses and general and administrative expenses; our future commission rate structure; our overall individual and family health insurance commission rate structure; our expectations regarding the timing of our recognition of revenue; proposed changes relating to payments made to health insurance carriers and agents by the Centers of Medicare and Medicaid Services; the timing of accurate reporting of commission revenue and membership from health insurance carriers; an increase in our commission revenue in absolute dollars in 2014 relative to 2013; an increase in our average commission revenue per policy for individual and family policies in 2014; the amount of fees we pay to marketing partners; seasonal and absolute increases in our customer care and enrollment costs; increases in technology and content expenses; increases in general and administrative expenses; our estimate of the number of continuing members on all policies; the sufficiency of our cash generated from operations and our current cash and cash equivalents; the timing and amount of our future lease obligations; the timing of open enrollment periods including restrictions on changes outside of such periods and our readiness therefore; our 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; future capital requirements; expansion into new business areas and additional geographic regions; our need for additional regulatory licenses and approvals; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those discussed in this report, and in particular, the risks discussed under the heading “Risk Factors” in Part I, 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 audited consolidated financial statements and related notes contained therein that appear elsewhere in this report. 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.

General

eHealth, Inc. is the parent company of eHealthInsurance, America’s first and largest private health insurance exchange where individuals, families and small businesses can compare health insurance products from leading insurers side by side and purchase and enroll in coverage online. We offer thousands of individual, family and small business health plans underwritten by more than 200 of the nation's leading health insurance companies through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com and www.PlanPrescriber.com) and customer care centers. Our ecommerce platform can be accessed directly through our websites as well as through our network of marketing partners. We are licensed to sell health insurance in all 50 states and the District of Columbia. 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. In addition, through our eHealthTechnology solution (www.eHealthTechnology.com), we provide a suite of hosted e-commerce solutions that enable health plan providers and resellers to market and distribute health insurance products online. We also make available powerful online and pharmacy-based tools to help seniors navigate Medicare health insurance options, choose the right plan and enroll in select plans online through our wholly-owned subsidiary, PlanPrescriber, Inc., (www.planprescriber.com), and through our Medicare website (www.eHealthMedicare.com).

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We were incorporated in Delaware in November 1997. Our headquarters are located at 440 East Middlefield Road, Mountain View, California 94043, and our telephone number is (650) 584-2700. We make our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports, available free of charge on the Investor Relations page of our web site (www.ehealth.com) as soon as reasonably practicable after we file these reports with the Securities and Exchange Commission. The information on or that can be accessed through our websites is not part of this Annual Report on Form 10-K. Further, a copy of this Annual Report on Form 10-K is located at the SEC's Public Reference Room at 100 F Street, NE, Washington, D.C. 20549. Information on the operation of the Public Reference Room can be obtained by calling the SEC at 1-800-SEC-0330. The SEC maintains an Internet site that contains reports, proxy and information statements and other information regarding our filings at http://www.sec.gov.

Our Business Model

Individual, Family and Small Business Health Insurance Plans

Substantially all of our revenue is generated from customers located in the United States. We generate revenue primarily from commissions we receive from health insurance carriers whose individual, family and small business health insurance plans are purchased through our ecommerce platforms (www.eHealth.com and www.eHealthInsurance.com), as well as commission override payments we receive for achieving sales volume thresholds or other objectives. The commission payments we receive for individual and family and small business health insurance plans we sold that were effective in 2013 and prior years is typically a percentage of the premium our customers pay for those plans. For individual and family health insurance plans we sell that are effective in 2014, the commission payments we receive from many of our individual and family health insurance carriers are a flat amount per member per month, although many carriers still pay us on a percentage-of-premium basis. Commission payments are typically made to us on a monthly basis for as long as a policy remains active with us. As a result, much of our revenue for a given financial reporting period relates to policies 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 state regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

Medicare Health Insurance Plans

We began actively marketing the availability of Medicare-related insurance plans during 2010 through our online Medicare plan platforms (www.eHealthMedicare.com and www.PlanPrescriber.com). Our Medicare plan platforms enable consumers to research and compare Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. We also make available online application capabilities for certain Medicare plans and, through our customer care and enrollment centers, we offer telephonic enrollment capabilities. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, either online or telephonically, we generate revenue from commissions we receive from health insurance carriers. The commission payments we receive for Medicare Supplement plans are typically a percentage of the premium on the policy that was sold through us and are made to us on a monthly basis for as long as a policy remains active with us. In the first year of a Medicare Advantage and Medicare Part D prescription drug plan we are paid a fixed, full-year commission after the health insurance carrier approves the application. Additionally, these commission rates may be higher in the first twelve months of a policy if the policy is the first Medicare Advantage policy issued to the member. Beginning with and subsequent to the second plan year, we receive fixed, monthly commissions for Medicare Advantage plans or fixed, annual commissions for Medicare Part D prescription drug plans. We earn commission revenue for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically for a period of six years, or longer depending on the carrier arrangement, provided that the policy remains active with us. Through

May 2012 we also generated referral fee revenue by delivering and selling Medicare leads generated by our online platforms to third parties. We, however, have transitioned away from selling leads to providing health insurance agent services to our Medicare plan customers rather than referring them to other health insurance agents.

As part of our Medicare strategy we acquired PlanPrescriber, Inc., formerly Experion Systems, Inc. and a privately-held company, in April 2010. PlanPrescriber is a leading provider of online tools that help Medicare-eligible individuals navigate their Medicare-related health insurance options.

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 and allows Medicare plan carriers to purchase advertising on a separate website developed, hosted and maintained by us. In return, we are typically paid a flat fee or, with respect to individual and family health insurance plans, a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications.

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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. Health insurance carriers or agents that license our technology typically pay us implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications.

Commission revenue that we received from insurance carriers for individual, family and small business health insurance plans and Medicare health insurance plans represented 79%, 84% and 86% of our total revenue in the years ended December 31, 2011, 2012 and 2013, respectively. Additional financial information about our company is included in Part II, Item 8 “Financial Statements and Supplementary Data” of this Annual Report on Form 10-K.

Industry Background

The purchase and sale of health insurance has historically been a complex, time-consuming and paper-intensive process. This complexity can make it difficult to make informed health insurance decisions. In addition, the human error that arises from traditional paper-intensive distribution has historically resulted in a high number of incomplete and inaccurate applications being submitted to health insurance carriers. Incomplete and inaccurate paper applications often result in back-and-forth communications, delay and additional cost. The Internet’s convenient, information-rich and interactive nature offers the opportunity to provide consumers with more organized information, a broader choice of plans and a more efficient process than have typically been available from traditional health insurance distribution channels. We expect the ongoing implementation of the federal Patient Protection and Affordable Care Act will further accelerate the adoption of the Internet by consumers as a popular venue for researching and buying health insurance.

Individual, family and small business health insurance has historically been sold by independent insurance agents and, to a lesser degree, directly by insurance companies. Most of these agents are self-employed or part of small agencies, and they typically service only their local communities. In addition, many of these agents sell health insurance from a limited number of insurance carriers (in some cases only one), resulting in a reduced selection of plans for the consumer.

Medicare is a federal program that provides persons sixty-five years of age and over, and some persons under the age of sixty-five with certain conditions, with hospital and medical insurance benefits. The Centers for Medicare and Medicaid Services, or CMS, an agency of the United States Department of Health and Human Services, administers this original Medicare program. CMS also contracts with private health insurance carriers under the Medicare Advantage and Medicare Part D prescription drug programs for these health insurance carriers to provide health insurance and prescription drug benefits to Medicare-eligible individuals. Medicare Advantage plans replace original Medicare. Medicare Part D prescription drug plans provide prescription drug coverage that original Medicare does not provide. In addition, health insurance carriers offer Medicare Supplement health insurance plans, which help to

pay health care costs not covered through original Medicare. Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans, are typically marketed and sold by insurance carriers, also known as plan sponsors, through a combination of dedicated internal sales representatives and licensed independent brokers and agents. CMS also offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans.

Health Care Reform

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 and the regulations implementing them include a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer and contribute to their employees group health insurance coverage or face tax penalties; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; requirements for minimum individual and small business health insurance benefit levels, including prohibitions on lifetime coverage limits and limitations on annual coverage limits; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality; establishment of state and/or federal health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for the purchase of individual health insurance during specified times of the year; Medicaid expansion so that a greater number of individuals will be insured under Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels if they are eligible and purchase individual or small group health insurance through the state or federal health insurance exchange.

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The initial open enrollment period under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act began on October 1, 2013 and is scheduled to run through March 31, 2014. Individuals and families cannot purchase individual and family health insurance outside this period until the open enrollment period for the following year, unless they qualify for a special enrollment period as a result of certain events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance. Eligible individuals and families also must purchase qualified health insurance plans through a government-run health insurance exchange in order to receive health care reform subsidies and cost-sharing credits in connection with their purchase of individual and family health insurance. During the third quarter of 2013, we entered into an agreement with CMS to allow us to enroll subsidy-eligible individuals in qualified health insurance plans over the Internet in the 36 states where the federal government is operating the health insurance exchange during the initial open enrollment period. We are currently in the process of integration and testing with the federal exchange. The federal exchange is currently experiencing technological problems related to its ability to enroll individuals into qualified health plans. Our integration with the federal exchange to enroll individuals into qualified health plans over the Internet is dependent upon the resolution of these technological problems as well as the federal exchange devoting resources to technology development and implementation necessary for online health insurance agent and broker qualified health insurance plan enrollment. Although we are working to provide our customers with online enrollment into subsidy-eligible plans, the date on which we will be able to enroll customers in these plans online is uncertain. Additionally, we have not entered into a relationship to be able to enroll individuals into qualified health plans with any of the 14 states that are operating their own state-run health insurance exchanges.

Our Strategy

Our objective is to continue to strengthen our position as the leading online distribution platform for health insurance sold to individuals, families and small businesses and to enter new business areas where this platform may be leveraged.

Key elements of our strategy are to:

Increase Our Brand Awareness. We believe that building greater awareness of our brand is critical for our continued growth. A significant percentage of our website traffic is direct, and we intend to attempt to grow our direct website traffic by strengthening our brand awareness through a variety of marketing and public relations efforts.

Offer the Best Consumer Experience. We believe that providing the best consumer experience increases market adoption of our services, builds our brand awareness, drives word-of-mouth referrals and improves our visitor-to-member conversion rates. We intend to continue to further develop an online experience that empowers consumers with the knowledge, choice and services they need to select and purchase health insurance plans that best meet their needs.

Extend Our Technology Leadership. We believe that our technology infrastructure and online platforms give us a significant competitive advantage for the distribution of individual, family and small business health insurance. To extend our leadership position, we plan to continue to enhance our platforms and their capabilities to increase functionality, reliability, scalability and performance.

Broaden Our Carrier Network and Product Portfolio. Our goal is to continue to add new health insurance carriers and health insurance plans to our ecommerce platform. We seek to deepen our technology integration with health insurance carriers, allowing us to further streamline the sales, member fulfillment processes and increase revenue opportunities for us and health insurance carriers. We also seek to enter into relationships with carriers and government health insurance exchanges mandated as part of health care reform to be able to offer subsidy-eligible health insurance.

Grow Our Medicare Opportunity. We believe that our technology can be used to streamline and simplify the Medicare plan purchasing process. We seek to enhance the technology behind our online Medicare platforms and further develop demand generation programs in the Medicare market.

Expand Our Marketplace through Partners. We plan to leverage our platform by providing technology to power employer-based health insurance exchanges for defined contribution and other offerings. Private employer-based exchanges are expected to be a fast growing segment of the health insurance industry over the next several years. We believe that our expertise in providing efficient, consumer-friendly experience for researching and buying health insurance as well as our ability to offer a broad range of health insurance and related products positions us well to compete in this market.

Diversify Our Revenue. We plan to continue to diversify our revenue by entering into new business areas where our technology, experience and relationships can be leveraged.

Our Platforms and Technology

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Our ecommerce platforms organize and present voluminous and complex health insurance information in an objective format that empowers individuals, families and small businesses to research, analyze, compare and purchase a wide variety of health insurance plans. The plans we offer include major medical health insurance coverage such as preferred provider organization, health maintenance organization and indemnity plans, Medicare plans, short-term medical insurance, student health insurance, health savings account eligible health insurance plans and ancillary plans such as dental and vision insurance.

Elements of our platforms include:

Online Rate Quoting and Comprehensive Plan Information. Our ecommerce platforms instantly provide consumers online rate quotes and comprehensive plan benefit information from a large number of health insurance carriers. After entering a minimal amount of relevant information on our website, our platforms allow consumers to instantly receive a list of applicable health insurance plans and rate and benefit information in an easy-to-understand format. The consumer can sort through the quoted plans based on price, health insurance carrier or deductible amount, or search the list of quoted plans to obtain a subset based on certain consumer preferences. Medicare-eligible individuals may also obtain annualized cost comparisons that include out-of-pocket estimates for their prescription drugs.

Plan Comparison and Recommendations. We offer online comparison and recommendation tools that condense voluminous health insurance information. Our ecommerce platform enables consumers to compare and contrast health insurance plans in a side-by-side format based on plan characteristics such as price, plan type, deductible amount, co-payment amount and in-network and out-of-network benefits. To further assist consumers, our automated recommendation capability for individual and family health insurance presents a short series of questions and recommends up to four health insurance plans based on the consumer’s input. Our Medicare plan comparison tool enables Medicare-eligible individuals to compare plan premiums, deductibles, out-of-pocket drug expenses, coverage limitations on medications and other aspects of Medicare plans.

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

Electronic Processing Interchange. Our Electronic Processing Interchange, or EPI, technology integrates our online application process with health insurance carriers' technology systems, enabling us to electronically deliver our consumers' applications to health insurance carriers. This expedites the application process by eliminating manual delivery and reducing the need for data entry and human review. Through EPI, we also receive alerts and data from carriers, such as notification of underwriting approval or a request from a carrier for a consumer's medical records for underwriting purposes, which we then relay electronically to the consumer. These features of our service help prevent applications from becoming delayed or rejected through inactivity of the consumer or the carrier.

Back Office Systems. Our proprietary back office customer relationship management systems enable us to provide a full range of customer service tasks in an efficient, highly scalable and personalized manner. Using these tools, we can track each consumer throughout the application process, obtain real-time updates from the carrier, generate automated emails specific to each consumer and access a cross-sell engine and dashboard to identify and track cross-sell opportunities. Our auto-email system is feature-rich with HTML capability, customizable merge tags, granular segmentation and tracking capability.

Carrier Relationships

We have developed strategic relationships with leading health insurance carriers in the United States, enabling us to offer thousands of health insurance plans online. As of December 31, 2013, we had relationships with over 200 individual, family, Medicare and small business health insurance carriers, including large national carriers and well-established regional carriers. We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In addition, health insurance carriers often have the ability to terminate or amend our agreements unilaterally on short notice, including provisions in our agreements relating to our

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commission rates. The amendment or termination of an agreement we have with a health insurance carrier may adversely impact the commissions we are paid on health insurance plans that we have already sold through the carrier.

Revenue derived from Humana represented approximately 8%, 18% and 21% of our total revenue in 2011, 2012 and 2013, respectively. Revenue derived from carriers owned by WellPoint represented approximately 11%, 13% and 12% of our total revenue in 2011, 2012 and 2013, respectively. Revenue derived from carriers owned by UnitedHealthcare represented approximately 13%, 12% and 11% of our total revenue in 2011, 2012 and 2013, respectively. Revenue derived from carriers owned by Aetna represented approximately 8%, 8%, and 10% of our total revenue in 2011, 2012 and 2013, respectively.

Marketing

We focus on building brand awareness, increasing website visitors and converting visitors into buyers. Our marketing initiatives are varied and numerous. They include:

Direct Marketing. Our direct member acquisition channel consists of consumers who access our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.PlanPrescriber.com and www.eHealthMedicare.com) either directly or through algorithmic search listings on Internet search engines and directories.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our website 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.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our website through a network of affiliate partners and financial services and other companies. We have established a pay-for-performance network, comprised of hundreds of partners that drive consumers to our ecommerce platform. These partners generally fall into one of the following categories:

- Financial and online services partners in industries such as banking, insurance, mortgage and association partners.
- Affiliate programs, including our marketing programs managed through Commission Junction.
- Online advertisers and content providers that are specialists in paid and unpaid (algorithmic) search, as well as specialists in other types of Internet marketing.

We generally compensate our marketing partners for their individual, family and small business health insurance referrals based on the consumer submitting a health insurance application to us. If a marketing partner is licensed to sell health insurance, we may share a percentage of the commission revenue we earn from the health insurance carrier for each member referred by that partner.

Technology and Content

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

Government Regulation and Compliance

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

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In addition to state regulations, we also are subject to regulations and guidelines issued by CMS that place a number of requirements on health insurance carriers and agents and brokers in connection with the marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans. We are subject to similar requirements of state insurance departments with respect to our marketing and sale of Medicare Supplement plans. CMS and state insurance department regulations and guidelines include a number of prohibitions regarding the ability to contact Medicare-eligible individuals and place many restrictions on the marketing of Medicare plans. For example, our health insurance carrier partners are required to obtain CMS or state department of insurance approval of certain aspects of our platforms, call center scripts and other marketing materials used to market Medicare plans. In addition, the laws and regulations applicable to the marketing and sale of Medicare plans are ambiguous, complex and, particularly with respect to regulations and guidance issued by CMS for Medicare Advantage and Medicare Part D prescription drug plans, change frequently.

We are subject to various federal and state privacy and security laws, regulations and requirements. These laws govern our collection, use, disclosure, protection and maintenance of the individually-identifiable information that we collect from consumers. For example, we are subject to the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA and regulations adopted pursuant to HIPPA require us to maintain the privacy of individually-identifiable health information that we collect on behalf of health insurance carriers, implement measures to safeguard such information and provide notification in the event of a breach in the privacy or confidentiality of such information. The use and disclosure of certain data that we collect from consumers is also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act, or GLBA, and state statutes implementing GLBA, which generally require brokers to provide customers with notice regarding how their non-public personal health and financial information is used and the opportunity to “opt out” of certain disclosures before sharing such information with a third party, and which generally require safeguards for the protection of personal information. Violations of these federal and state privacy and security laws may result in significant liability and expense.

Intellectual Property

We rely on a combination of trademark, copyright and trade secret laws in the United States and other jurisdictions as well as confidentiality procedures and contractual provisions to protect our proprietary technology and our brand. Our eHealth and eHealthInsurance trademarks have reached incontestability status with the U.S. Patent and Trademark Office, which means the marks have been in use for over five years and, subject to certain limited exceptions, no third party can contest the validity of the marks or our ownership of them. We also have filed patent applications that relate to certain of our technology and business processes.

Competition

The market for selling health insurance plans is highly competitive. 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. In addition to the direct competition from health insurance carriers, we compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our current competitors include the tens of thousands of local insurance agents across the United States who sell health insurance plans in their communities. There are a number of agents that operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. Some agents also use "lead aggregator" services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to the agent.

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

As a part of health care reform, each state was required to establish a health insurance exchange by October 2013 where individuals and small business can purchase health insurance. For states that did not implement a health insurance exchange, the federal government has implemented and is operating the exchange for that state. The Federally-Facilitated Marketplace, or FFM, is operating some part of the health insurance exchange in 36 states during the initial open enrollment period that began in October 2013 and is currently scheduled to run through March 2014. Among other things, the government exchanges have websites where individuals and businesses can shop for and purchase health insurance, and they also have offline customer support and enrollment capabilities. We began competing with government health insurance exchanges for the enrollment of individuals and small businesses in health insurance in October 2013 for enrollment in health insurance

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plans effective in January 2014. Qualified health insurance plans that individuals and small businesses must purchase in order to receive health care reform related financial assistance in the form of subsidies to purchase health insurance and cost sharing reductions must be purchased through government health insurance exchanges. We have entered into an agreement with the CMS to allow us to enroll subsidy-eligible individuals in qualified health insurance plans through the health insurance exchange in the 36 states where the federal government is operating an exchange during the initial open enrollment period. We are currently in the process of development, integration and testing with the federal exchange to sell plans through it online. We also are able to enroll a limited number of individuals into qualified health plans through the federal exchange using our call centers.

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.

Seasonality

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

In addition to the initial open enrollment period scheduled to end in March 2014, the annual open enrollment period for individual and family health insurance is proposed to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates of annual open enrollment period are unknown. Individuals and families generally will not be able to purchase individual and family health insurance outside of these open enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance. We expect that open enrollment periods will change the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. Because we have not operated our individual and family health insurance business under these circumstances, the impact of open enrollment periods on that business is unclear. We do expect that applications submitted for individual and family health insurance to decline outside of the annual open enrollment periods.

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

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by seasonal submitted application patterns. As a result, in years prior to 2013 marketing and advertising expenses related to individual and family health insurance plans were highest in our first and third quarters. This changed during the fourth quarter of 2013 during which marketing and advertising expense related to individual and family health insurance plans increased significantly as a result of the increase in the number of applications submitted during the initial open enrollment period under the federal Patient Protection and Affordable Care Act. The future impact of annual open enrollment periods for individual and family health insurance on our submitted applications and marketing and advertising expenses is unclear.

Marketing and advertising expenses related to our selling Medicare plans are highest in our third and fourth quarters. Additionally, in preparation for the Medicare annual enrollment period, we begin ramping up our temporary customer care center staff during our second and third quarters and employ our temporary customer care center staff until the end of the Medicare annual enrollment period in December. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters.

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Based on these seasonal trends, our revenue has historically been highest in the fourth quarter of the year. In years prior to 2013, our profitability was relatively higher in the first and fourth quarters and substantially lower in the third quarter of the year. During the fourth quarter of 2013, our profitability was adversely impacted by the increase in marketing and advertising expenses associated with individual and family health insurance plans related to the increase in submitted applications. The impact of open enrollment periods and other aspects of the Patient Protection and Affordable Care Act that became effective in 2014 on our profitability in future periods is uncertain.

Employees

As of December 31, 2013, we had 972 full-time employees, of which 48 were in marketing and advertising, 419 were in customer care and enrollment, 348 were in technology and content and 157 were in general and administrative. None of our employees are represented by a labor union. We have not experienced any work stoppages and consider our employee relations to be good.

ITEM 1A. RISK FACTORS

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

Risks Related to Our Business

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

Our business depends upon the private sector of the United States health insurance system, its relative role in financing health care delivery and health insurance carriers' use of, and payment of commissions to, agents and brokers to market health insurance plans. In March 2010, the federal Patient Protection and Affordable Care Act and related

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

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businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause a substantial reduction in our membership and commission revenue; and cause health insurance carriers to reduce our commissions and other amounts they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. In addition, various aspects of health care reform have and could continue to cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to exit the business of selling insurance plans in a particular jurisdiction, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower or no commissions, any of which could materially harm our business, operating results and financial condition.

Beginning in 2014, health insurance carriers offering coverage in the individual or small business health insurance market must ensure that such coverage meets certain actuarial value standards, includes certain minimum health benefits, is not subject to lifetime or, for most health insurance benefits, annual dollar amount coverage limits and cannot deny individuals health insurance for health reasons. Individuals also are required to hold plans providing minimum essential coverage to meet the mandate for health insurance and avoid a tax penalty. The cost of health insurance plans with effective dates in 2014 has generally increased as a result of the new standards for increased health insurance benefits, among other things. While the individual and family health insurance plans that we sold and that were effective in 2013 and prior to 2013 may not be as expensive, many of these plans do not have post-healthcare reform benefits or meet other standards under health care reform. Moreover, certain health insurance companies determined to terminate these 2013 plans or modified them effective January 1, 2014 with an increase in the cost of the plan in response to health care reform implementation. Any of these circumstances could cause us to suffer a substantial reduction in our membership, which would materially harm our business, operating results and financial condition. Moreover, compared to the increased cost of individual and family health insurance plans, government subsidies to purchase health insurance and the healthcare reform tax penalty may not be sufficient enough to drive a substantial number of new entrants into the individual and family health insurance market or incentivize existing holders of individual and family health insurance to maintain their policies, which could contribute to a decline in our membership and materially harm our business, operating results and financial condition.

As a part of healthcare reform, each state was required to implement a health insurance exchange by October 2013 where individuals and small businesses can purchase health insurance. For states that did not implement a health insurance exchange, the federal government has implemented and is operating the exchange for that state. The Federally-Facilitated Marketplace, or FFM, is operating some part of the health insurance exchange in 36 states during the initial open enrollment period that began in October 2013 and is currently scheduled to run through March 2014. It may operate the health insurance exchange for a fewer or greater number of states in the future. Among other things, the exchanges have websites where individuals and small businesses can shop for and purchase health insurance, and they also have offline customer support and enrollment capabilities. Individuals who are eligible for government subsidies must purchase qualified health plans through a government exchange to receive their subsidy. The exchanges are a new source of competition for us. In the event our existing members purchase health insurance directly through health insurance exchanges without using us as their health insurance agent, as a result of their being eligible for a subsidy or otherwise, we will no longer receive commission revenue as a result of our sale of health insurance to them. Moreover, the exchanges will compete with us for new members. Competitive pressure from health insurance exchanges may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, and may otherwise harm our business, operating results and financial condition.

A federal regulation promulgated under the Patient Protection and Affordable Care Act has been issued that clarifies that states may, but are not required to, allow agents and brokers such as us to market the qualified health plans offered on government-run health insurance exchanges and that are the plans that subsidy-eligible individuals must purchase in order to receive their subsidies. In order to offer qualified health plans, agents and brokers must meet certain conditions, such as receiving permission to do so from the health insurance exchange, entering into an agreement with the health insurance exchange, ensuring that the enrollment and subsidy application is completed through the state's health insurance exchange (or the FFM in states without individual health insurance enrollment capability) and complying with privacy, security and other standards, some of which have been recently issued and contain requirements that are new to us. In the event Internet-based agents and brokers such as us use the Internet for completion of qualified health plan selection purposes, their websites are required to meet certain additional conditions, such as compliance with standards for display of health plan and related information; providing consumers the ability to view all health plans offered on the government-run exchange; displaying certain health plan and other data available on the exchange; and providing a mechanism for consumers to withdraw from the application process on the agent or broker's website. A substantial number of our existing members are likely eligible for subsidies in connection with their purchase of health insurance. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members. If we are not able to satisfy these conditions and requirements as well as enter into functioning relationships with

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government-run health insurance exchanges to offer qualified health insurance plans that are required for individuals to receive a subsidy, we may lose existing members and new members, which would harm our business, operating results and financial condition.

During the third quarter of 2013, we entered into agreements with the CMS, relating to our ability to enroll individuals in qualified health plans through the FFM. The agreements contain comprehensive privacy and security and other requirements that we must meet and maintain. In order to be able to enroll individuals into qualified health plans, we also must satisfy several other regulatory requirements and comply with additional laws and regulations. While we have entered into these agreements, we have not been able to integrate with the FFM to offer individuals and families the ability to enroll online in subsidy-qualifying health insurance through the FFM, due to technology and other issues the FFM is experiencing. There are risks and uncertainties relating to our ability to enroll individuals into qualified health plans through the FFM in the future. Among other things, we must satisfy the requirements contained in the relevant agreements as well as applicable laws and regulations; complete development of a compliant web platform incorporating those requirements; maintain qualified health plan information from health insurance carriers and CMS and incorporate it into our web platform; maintain a privacy and security program to conform to the privacy and security requirements of our agreement with CMS as well as applicable laws and regulations; and successfully integrate with the FFM so that information may be passed to and from us relating to enrollment and qualified health plan and subsidy eligibility. We also depend upon the federal government for a number of things relating to our ability to enroll individuals into qualified health plans through the FFM, including certain qualified health plan information that is required under the applicable regulations to be displayed on our website. In addition, the FFM may at any time cease allowing agents and brokers to enroll individuals in qualified health plans and must allocate resources to ensuring, and otherwise, ensure that its technology platform functions properly to enroll individuals online with an adequate customer experience and that results in our receiving credit for enrollments so that we may be paid a commission. If we are not successful in integrating with the FFM in these ways, or if after integrating with the FFM the FFM experiences technical or other problems in connection with the enrollment of individuals in health insurance, we may lose existing members and new members or may not receive commissions for the plans that we sell through the FFM, which would harm our business, operating results and financial condition. Moreover, it is unlikely that we will be able to enroll individuals and families into qualified health plans in an online process during the current initial open enrollment period and cannot guarantee that we will be able to do so within any other specific timeframe. If we are not able to enroll individuals into qualified health plans over the Internet, our business, operating results and financial condition would be harmed.

Individuals and families whose incomes are between 133% and 400% of the federal poverty level are generally entitled beginning in 2014 to subsidies in connection with their purchase of health insurance. These qualified health plans are required to be purchased during an initial open enrollment period that began in October 2013 and is currently scheduled to run through March 2014, and qualified individuals can thereafter purchase or change their qualified health plan only during subsequent annual enrollment periods of shorter duration, subject to states extending the period and exceptions for special enrollment periods for certain qualifying events. States and health insurance carriers also have generally adopted these open enrollment periods for the purchase of both subsidy-eligible and non-subsidy eligible health insurance outside of government-run health insurance exchanges. It may be difficult for us to handle as a business any increased volume of health insurance transactions that would occur in a short period of time during the enrollment periods. In the aggregate, a shift to open enrollment periods of limited duration in the individual and family and small business health insurance markets may result in a reduction in our membership and revenue; increase

in our expenses, particularly during certain periods of the year; and otherwise may harm our business, operating results and financial condition, particularly given that the open enrollment period for qualified health plans and other health plans will overlap with the annual enrollment period for Medicare plans. In addition, we depend upon health insurance carriers and government-run health insurance exchanges to adopt systems and processes than can handle sales of individual and family health insurance outside of the open enrollment period to those who qualify for special enrollment periods, which may include systems and processes that verify whether individuals and families are permitted to purchase individual and family health insurance outside of the open enrollment period. If these systems and processes are not timely developed or are not compatible with our platform for selling individual and family health insurance, our ability to sell individual and family health insurance outside of the open enrollment period would be negatively impacted, which would harm our business, operating results and financial condition.

We depend upon health insurance companies to allow us to sell qualified health plans and to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to sell individual and family qualified health insurance plans, or if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans, we could lose a substantial number of existing and potential members and commission revenue we receive as a result of the sale of individual and family and small business health insurance products, which would materially harm our business, operating results and financial condition. In part to attempt to satisfy conditions necessary for us to use our Internet technology platform to enroll individuals into qualified health plans as a health insurance agent, and assist individuals in applying for subsidies, through government-run health insurance exchanges, we have incurred increased

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operating expenses and expect to continue to do so. These past and expected increased operating expenses may not result in increased revenue for a number of reasons both within and outside of our control. If our revenues do not increase to offset these expected increases in costs and operating expenses, our financial condition and results of operations could be negatively affected.

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

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

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

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

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

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

We typically enter into contractual agency relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In many cases, health insurance carriers also may amend the terms of our agreements unilaterally on short notice. Carriers may be unwilling to allow us to sell their existing or new health insurance plans, or desire to amend our agreements with them, for a variety of reasons, including for competitive or regulatory reasons, or because they do not want to be associated with our brand. In addition, many aspects of health care reform implemented in 2014 may cause carriers to modify their relationship with us given the substantial changes in the industry in which we operate. For instance, in addition to the medical loss ratio requirements, health care reform contains taxes and assessments on health insurance carriers that may make their businesses less profitable. In the future, and as a result of health care reform or for other reasons, an increasing number of health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels, including traditional in-house agents and carrier websites, to sell their own plans and, in turn, could limit or prohibit us from selling their plans on our ecommerce platform. Carriers may choose to exclude us from their most profitable or popular plans or may determine not to distribute insurance plans in the individual and family and small business markets in certain geographies or altogether. The termination or amendment of our relationship with a carrier could reduce the variety of health insurance plans we offer, which could harm our business, operating results and financial condition. It also could adversely impact, or cause the termination of, commissions for past

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and future sales, which would materially harm our business, operating results and financial condition. Our business could also be harmed if in the future we fail to develop new carrier relationships and are unable to offer consumers a variety of health insurance plans in each jurisdiction.

The health insurance industry in the United States has experienced a substantial amount of consolidation, resulting in a decrease in the number of health insurance carriers. In the future, we may be forced to offer insurance policies from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. We derived 18% and 21% of our total revenue in the years ended December 31, 2012 and 2013, respectively, from Humana. We derived 13% and 12% of our total revenue in the years ended December 31, 2012 and 2013, respectively, from carriers owned by Wellpoint. We derived 12% and 11% of our total revenue in the years ended December 31, 2012 and 2013, respectively, from carriers owned by UnitedHealthcare. We derived 8% and 10% of our total revenue in the years ended December 31, 2012 and 2013, respectively, from carriers owned by Aetna. We have several agreements that govern our sale of health insurance plans with these health insurance carriers. They may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact or cause the termination of the commission payments that we receive from these health insurance carriers, which would harm our business, operating results and financial condition. The termination, amendment or consolidation of our relationship with these and other health insurance carriers could materially harm our business, operating results and financial condition.

Our revenues and earnings may decline.

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

Our revenue will be adversely impacted if our membership does not grow. The individual and family commission rates that we receive are typically higher in the first twelve months of a policy. After the first twelve months, they generally decline significantly. The Medicare-related commission rates that we receive may be higher in the first

twelve months of a policy if the policy is the first Medicare-related policy issued to the member. Accordingly, to the extent that our net addition of new members slows, our revenue would be adversely impacted due to a decline in commissions we receive for members whose policies have been active for less than twelve months in addition to the reduction in revenue growth that would occur solely as a result of a decline in our membership.

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

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

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

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citizens over the age of 65. The sale of Medicare Advantage and Medicare Part D prescription drug plans are subject to an annual enrollment period during the fourth quarter of each year, when a substantial percentage of the annual sales of these plans occur. We sell Medicare plans as a health insurance agent using our websites and customer care centers.

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

In addition, we may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carrier partners. For instance, a carrier may terminate our relationship. Moreover, CMS heavily regulates the sale of Medicare Advantage and Medicare Part D prescription drug plans and has and will continue to penalize health insurance carriers for certain regulatory violations by not allowing them to market and sell Medicare plans for significant periods of time. Given the 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. The agreements that we have with health insurance carriers to sell Medicare plans may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact, or cause the termination of, the commission payments that we receive for selling their Medicare plans, including commissions on plans that we have already sold, which would harm our business operating results and financial condition.

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

CMS recently proposed regulations relating to health insurance agent compensation in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans. The proposed regulations would change the maximum compensation structure for agent compensation for new enrollments in renewal years from 50% of the initial-year compensation payment to 35% of a fair market value determined by CMS each year. This value is

currently used to determine only the initial-year agent compensation an agent would receive in connection with the sale of a Medicare Advantage or prescription drug plan. In addition, the proposed regulation would permit health insurance carriers to pay agents 35% of the annually-determined fair market value for all of the renewal years that the member stayed on the plan, while in previous years there were restrictions placed on renewal year agent compensation that would not permit payment of health insurance agent compensation after 6 years. CMS also proposed regulations that would prohibit payment of agent compensation until the beginning of the plan year that an enrollment is effective, while we are currently paid agent compensation prior to that time for some enrollments that occur during the Medicare annual enrollment period. It is unclear whether these proposed regulations will become final regulations or whether they will be modified, but if the final regulations have the effect of reducing the compensation that we receive in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans, our business, operating results and financial condition would be harmed. In addition, the impact these proposed regulations would have on the timing of our revenue recognition is unclear, but they could have the impact of delaying our recognition of revenue.

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

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

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

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

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

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

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

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

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

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

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

upon state departments of insurance and health insurance carriers for their licensing, certification and appointment of our health insurance agent employees. We may not be successful in timely hiring a sufficient number of additional licensed agents or other employees for the Medicare annual enrollment period, and even if we are successful, these employees may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments with our health insurance carrier partners. If we and our health insurance agent employees are not successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the annual enrollment period, which would harm our business, operating results and financial condition.

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

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

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

The marketing and sale of Medicare plans are subject to numerous, complex and frequently changing laws and regulations, and noncompliance with or changes to 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. For instance, CMS rules currently prohibit health insurance agents from enrolling individuals into Medicare Advantage and Medicare Part D prescription drug plans online. Individuals are currently able to enroll in these plans online after shopping for these plans on our website given that we have established relationships with health insurance carriers to complete the enrollment on a platform owned or licensed by the carrier. CMS is currently reviewing its rules in this regard, and if CMS determines to change them to prohibit enrollment in that manner, it could harm our business, operating results and financial condition.

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

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

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

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

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

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

A significant component of our marketing and advertising expenses consists of expenses incurred in search engine advertising at the time a consumer clicks on an advertisement and payments owed to our marketing partners in connection with applications submitted on our ecommerce platform by potential members referred to us by our marketing partners. As a result of this timing difference between expense and associated revenue recognition, our operating results and cash flows may be adversely affected in periods where we experience a significant increase in new applicants, which could occur in connection with the implementation of health care reform. The implementation of healthcare reform caused in the fourth quarter of 2013 and could in the future cause a substantial number of health insurance applications to be submitted through us, which could cause us to incur a substantial amount of marketing and advertising expense over a limited period of time and harm our business, operating results and financial condition. In addition, if we incur other unanticipated or one-time expenses in a particular quarter, lose a significant amount of our member base for any reason or our commission rates are reduced, the impact of our incurring increased marketing and advertising expenses would be especially pronounced and we would likely be unable to offset these expenses by increasing sales within that quarter or to replace lost revenue in the quarter with revenue from new members and our business, operating results and financial condition would be harmed.

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

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

We believe that demand for the health insurance and services we offer are impacted by prevailing economic conditions. We cannot be certain of the future impact that the economic conditions will have on our business. A softening of demand for health insurance and services offered by us, whether caused by changes in customer preferences or a weak U.S. economy, including as a result of disruptions in the global financial markets or a decrease in general consumer confidence, could adversely impact our operating results. Consumers may attempt to reduce expenses by cancelling existing health insurance purchased through us, determine not to purchase new health insurance through us, or purchase health insurance plans 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 or take other actions that would negatively impact our sale of health insurance as well as our sponsorship and technology licensing businesses.

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

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

•changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers' ability or willingness to pay for health insurance, availability of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business, including health care reform;

•the quality of and changes to the consumer experience on our ecommerce platform or with our customer care center;

•regulatory requirements, including those that make the experience on our online platforms cumbersome or difficult to navigate;

•the variety, competitiveness and affordability of the health insurance plans that we offer;

•system failures or interruptions in the operation of our ecommerce platform or call center operations;

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

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

•health insurance carrier guidelines applicable to applications submitted by consumers and the amount of time a carrier takes to make a decision on that application; and

•competitive offerings.

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

We are in the process of attempting to integrate with the FFM so that we may sell qualified health insurance plans to health care reform subsidy eligible individuals and families over the Internet in the 36 states in which the FFM operates the state's health insurance exchange. Pursuant to health care reform laws and regulations, the purchase of qualified health plans must occur through a health insurance exchange, which means that a part of the purchasing process will occur on the FFM website and through its systems. We are also dependent on these systems to convey to health insurance carriers that we are the agent in connection with the purchase of health insurance and should receive commissions for a sale. To date the FFM's website, technology and systems have not worked properly, and we have encountered problems in integrating with it to provide a stable, easy to use and scalable solution. Assuming we complete integration with the FFM and are permitted to enroll individuals into qualified health plans through the FFM, we would be dependent upon FFM systems and its website experience for individuals to be able to complete the process of purchasing a qualified health plan and to convert into members for which we receive commission revenue. If the FFM website experience remains unstable, the experience of applying for qualified health plans and subsidies remains cumbersome, or we are not properly identified by FFM systems as

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the agent of record on health insurance plan sales, we will suffer a reduction in our membership and our commission revenue and our business, operating results and financial condition will be harmed.

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

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

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

The demand for health insurance marketed through our ecommerce platform is impacted by, among other things, the variety, quality and price of the health insurance plans we offer. Some health insurance carriers have exited certain state insurance markets where we have historically represented their insurance plans. If health insurance carriers do not continue to allow us to sell a variety of high-quality, affordable health insurance plans in the individual and family, small business, ancillary and Medicare markets, or if their offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform or otherwise, our sales may decrease and our business, operating results and financial condition could be harmed. For example, the cost of health insurance has increased substantially in many states as a result of health care reform implementation and some health insurance carriers have exited the individual and family health insurance business in certain states. These circumstances have and may continue to adversely impact demand for individual health insurance, and if individuals do not purchase health insurance through us as a result of these circumstances, our business, operating results and financial condition could be harmed.

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

Our commission rates, and the commission override payments we receive from health insurance carriers for achieving sales volume thresholds or other objectives, are either set by each carrier or negotiated between us and each carrier. Carriers have altered, and may in the future alter, the contractual relationships we have with them on short notice, either by renegotiation or unilateral action. If these contractual changes result in reduced commissions, our business may suffer and our operating results and financial condition would be harmed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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, or if pharmacy partners otherwise decided to no longer utilize aspects of our platform and tools, we would experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and customer care centers, which would harm our business, operating results and financial condition and could result in a write-down of the value of intangible assets acquired in our PlanPrescriber acquisition.

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

For individual and family, small business, ancillary and Medicare Supplement health insurance plans, many health insurance carriers pay us a flat amount per member per month or a percentage of the paid health insurance premium on a health insurance policy that we have sold during the period that a member maintains coverage under the policy. For both

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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 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. There have been instances where we have determined that policy cancellation data reported to us by a health insurance carrier has not been accurate. Although we recognize commissions reported to us net of estimated cancellations, the extent to which health insurance carriers are inaccurate in their reporting of policy cancellations could cause us to change our cancellation estimates, which could adversely impact our revenues. We apply judgment and make estimates based on historical data and current trends to independently determine whether or not carriers are accurately reporting commissions due to us. To the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, we will not recognize revenue to which we are entitled, which would harm our business, operating results and financial condition.

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

A substantial number of our existing members may become eligible for health care reform subsidies in connection with their purchase of health insurance. We may experience difficulty in satisfying the conditions required to offer plans to individuals and families who are entitled to subsidies under health care reform, and even if we are able to satisfy them, we depend upon government run health insurance exchanges to permit us to offer these plans and to have systems and a website that allows us to effectively do so. While we have entered into agreements with the health insurance exchange operated in 36 states by the Federal government, we have not been able to enroll individuals in subsidy-eligible qualified health insurance plans as a result of the federal health insurance exchange technical difficulties. We also depend upon health insurance carriers to allow us to sell these plans and to pay us commissions in connection with their sale. In the event we are not successful in gaining the ability to effectively sell individual and family health insurance products to health care reform subsidy-eligible individuals, or if health insurance carriers pay us no commissions or reduced commissions in connection with the sale of these plans, we could lose a substantial number of existing and potential members and the related commission revenue we receive as a result of the sale of individual and family and small business health insurance products to them, which would materially harm our business, operating results and financial condition. We could also lose a substantial number of existing and potential members as a result of individuals who are not eligible for subsidies shopping for new health care reform health insurance plans and using other sources, including a government-run health insurance exchange, to do so. In addition, a substantial amount of individual and family health insurance purchasing activity is expected to occur over a limited

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

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

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

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

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

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

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

The market for selling health insurance plans is highly competitive. We compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our competitors include local insurance agents across the United States who sell health insurance plans in their communities. There are a number of agents that operate websites and provide an online shopping experience for consumers interested in

purchasing health insurance. Some local agents use “lead aggregator” services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to the traditional agent. In addition to health insurance brokers and agents, many health insurance carriers directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. We also compete with state and federal health insurance exchanges implemented as a result of health care reform. Health care reform also will result in health insurance plan cost and benefit data being more readily accessible, which could facilitate additional competition. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. In addition, CMS offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans. To remain competitive against our current and future competitors, we will need to continue to invest and improve the online shopping experience and functionalities of our website and other platforms that our current and future customers may access to purchase health insurance products from us. If we cannot predict, develop and deliver the right shopping experience and functionality in a timely and cost-effective manner, we may not be able to compete successfully against our current or future competitors and our business, operating results and financial condition may be adversely affected.

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

•undertake more extensive marketing campaigns for their brands and services;

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•devote more resources to website and systems development;

•negotiate more favorable commission rates and commission override payments; and

•make more attractive offers to potential employees, marketing partners and third-party service providers.

In addition, CMS has the ability to regulate our marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans, and government run health insurance exchanges, including CMS with respect to the federal health insurance exchange, have the ability to regulate our marketing and sale of qualified health plans under health care reform. CMS and the exchanges could impact the commissions we receive in connection with the sale of these plans and impose other restrictions and limitations that make it difficult for us to sell them.

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

There are many risks associated with our operations in China.

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

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

Our participation and success in the insurance market in China may be impacted by additional factors given that outside of Xiamen city, the insurance products offered on our website are offered directly by insurance carriers. As a result, our success in selling insurance outside of Xiamen city depends on many factors, including our dependence on insurance

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

Our sponsorship and advertising business may not be successful.

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

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

We may not be 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

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offer health insurance carriers and other third parties a reliable platform to cost-efficiently offer their plans over the Internet, our technology licensing business will be unsuccessful.

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

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

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

There are a large number of patents, copyrights, trademarks and trade secrets applicable to the internet and technology industries and entities frequently enter into litigation based on allegations of infringement or other violations of intellectual property rights. We have received, and may in the future receive, notices that claim we have misappropriated, infringed or misused other parties’ intellectual property rights, and, to the extent we gain greater visibility, we face a higher risk of being the subject of intellectual property infringement claims. There may be third-party intellectual property rights, including issued or pending patents that cover significant aspects of our technologies or business methods or that cover third-party technology that we use as a part of our websites. Any intellectual property claim against us, with or without merit, could be time consuming, expensive to settle or litigate and could divert our management’s attention and other resources. These claims also could subject us to significant liability for damages and could result in our having to stop using technology found to be in violation of a third party’s

rights. We might be required to seek a license for third-party intellectual property, which may not be available on reasonable terms or at all. Even if a license is available, we could be required to pay significant royalties, which would increase our operating expenses. We may also be required to develop alternative non-infringing technology, which could require significant effort and expense. If we cannot license or develop technology for any infringing aspect of our business, we would be forced to limit our services and may be unable to compete effectively. Any of these results would harm our business, operating results and financial condition.

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

We provide information on our website, through our customer care centers and in other ways regarding health insurance in general and the health insurance plans we market and sell, including information relating to insurance premiums, coverage, benefits, provider networks, exclusions, limitations, availability, plan comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our website. Separately, from time to time, we use the information provided on our website and otherwise collected by us to publish reports designed to educate consumers, facilitate public debate, and facilitate reform at the state and federal level relating to the accessibility and affordability of health insurance. If the information we provide on our website, through our customer care centers or otherwise is not accurate or is construed as misleading, or if we do not properly assist individuals and businesses in purchasing health insurance, members, health insurance carriers and others could attempt to hold us liable for damages, our relationships with health insurance carriers could be terminated and regulators could attempt to subject us to penalties, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which

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could result in our loss of our commission revenue. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints without significant financial cost, we cannot guarantee that we will be able to do so in the future. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

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

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

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

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

We have expanded our operations significantly and have recently entered into the business of selling Medicare plans. Our entering into this new area of business places increasing and significant demands on our management, our operational and financial systems and infrastructure and our other resources. If we do not effectively manage this expansion, the quality of our services could suffer, which could harm our business, operating results and financial condition. In order to successfully expand our business, we need to hire, integrate and retain highly skilled and

motivated employees. We also need to continue to improve our existing systems for operational and financial management, including our reporting systems, procedures and controls. These improvements could require significant capital expenditures and place increasing demands on our management. We may not be successful in managing or expanding our operations or in maintaining adequate financial and operating systems and controls. If we do not successfully implement improvements in these areas, our business, operating results and financial condition will be harmed.

Seasonality may cause fluctuations in our financial results.

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

In addition to the initial open enrollment period scheduled to end in March 2014, the annual open enrollment period for individual and family health insurance is proposed to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates of annual open enrollment period are unknown. Individuals and families generally will not be able to purchase individual and family health insurance outside of these open enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their

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health insurance. We expect that open enrollment periods will change the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. Because we have not operated our individual and family health insurance business under these circumstances, the impact of open enrollment periods on that business is unclear. We do expect that applications submitted for individual and family health insurance to decline outside of the annual open enrollment periods.

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

Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by seasonal submitted application patterns. As a result, in years prior to 2013 marketing and advertising expenses related to individual and family health insurance plans were highest in our first and third quarters. This changed during the fourth quarter of 2013 during which marketing and advertising expense related to individual and family health insurance plans increased significantly as a result of the increase in the number of applications submitted during the initial open enrollment period under the federal Patient Protection and Affordable Care Act. The future impact of annual open enrollment periods for individual and family health insurance on our submitted applications and marketing and advertising expenses is unclear. Marketing and advertising expenses related to our selling Medicare plans are highest in our third and fourth quarters. Additionally, in preparation for the Medicare annual enrollment period, we begin ramping up our temporary customer care center staff during our second and third quarters and employ our temporary customer care center staff until the end of the Medicare annual enrollment period in December. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters.

Based on these seasonal trends, our revenue has historically been highest in the fourth quarter of the year. In years prior to 2013 our profitability was relatively higher in the first and fourth quarters and substantially lower in the third quarter of the year. During the fourth quarter of 2013 our profitability was adversely impacted by the increase in marketing and advertising expenses associated with individual and family health insurance plans related to the increase in submitted applications. The impact of open enrollment periods and other aspects of the Patient Protection and Affordable Care Act that became effective in 2014 on our profitability in future periods is uncertain.

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;

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

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

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

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

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

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

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

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

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

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

Significant judgment is required to determine the recognition and measurement attribute prescribed in U.S. generally accepted accounting principles (“U.S. GAAP”) relating to accounting for income taxes. In addition, U.S. GAAP applies to all income tax positions, including the potential recovery of previously paid taxes, which if settled unfavorably could adversely impact our provision for income taxes or additional paid-in capital. In addition, we are subject to examinations of

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our income tax returns by the Internal Revenue Service and other tax authorities. We assess the likelihood of adverse outcomes resulting from these examinations to determine the adequacy of our provision for income taxes. There may be exposure that the outcomes from these examinations will have an adverse effect on our operating results and financial condition.

Risks Related to State Insurance Regulation

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

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

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

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

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

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

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

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· impose continuing education requirements.

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

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

Risks Related to the Internet and Electronic Commerce

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

Our services involve the collection and storage of confidential information of consumers and the transmission of this information to their chosen health insurance carriers. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers in connection with their applications for health insurance. As a result, we are subject to various federal, state and international laws and regulations

regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We cannot guarantee that our facilities and systems, and those of our third party service providers, will be free of security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance with privacy and security laws, requirements and regulations may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by us or third party service providers, and enforcement actions. We may be required to expend significant amounts and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, techniques used to obtain unauthorized access or to sabotage systems change frequently. As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures. Additionally, our third party service providers may cause security breaches for which we are responsible.

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

Government regulation of the Internet could adversely affect our business.

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

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

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

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

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

Risks Related to the Ownership of Our Common Stock

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

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

· price and volume fluctuations in the overall stock market from time to time;

· significant volatility in the market price and trading volume of technology companies in general, and companies in our industry;

· actual or anticipated changes in our results of operations or fluctuations in our operating results;

· actual or anticipated changes in the expectations of investors or securities analysts, including changes in financial estimates or investment recommendations by securities analysts who follow our business and changes in perceptions relating to the economy;

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- speculation in the press or investment community;
- technological advances or introduction of new products by us or our competitors;
- actual or anticipated developments in our competitors' businesses or the competitive landscape generally;
- litigation involving us, our industry or both;
- actual or anticipated regulatory developments in the United States or foreign countries, including health care reform legislation in the United States;
- major catastrophic events;
- announcements or developments relating to the economy;
- our sale of common stock or other securities in the future;
- the trading volume of our common stock, as well as sales of large blocks of our stock; or
- departures of key personnel.

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

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

A small number of greater than 5% stockholders and their affiliated entities beneficially owned more than 50% percent of our outstanding common stock as of December 31, 2013. 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;

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- 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.

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ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

The following table sets forth the location, approximate square footage and primary use of each of the principal properties we occupied at December 31, 2013:

Location	Approximate Square Footage	Primary Use
Mountain View, California – 340 and 440 East Middlefield Road	36,012	Corporate headquarters, marketing and advertising, technology and content and general and administrative
Gold River, California	38,897	Customer care and enrollment, technology and content and general and administrative
South Jordan, Utah	27,830	Customer care and enrollment
Xiamen, China	52,930	Technology and content, customer care and enrollment, marketing and advertising and general and administrative

We lease all of the principal properties. In addition, we also lease office facilities in San Francisco, California and Westford, Massachusetts for our marketing and advertising, technology and content, customer care and enrollment, and general and administrative personnel. All of our properties are fully used for current operations. We believe our existing facilities are adequate for our current needs and that suitable additional space will be available in the future to accommodate the expansion of our operations, if necessary.

ITEM 3. LEGAL PROCEEDINGS

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

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

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PART II

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

Our common stock has been quoted on The NASDAQ Global Market under the symbol "EHTH" since our initial public offering on October 13, 2006. Prior to that time, there was no public market for our stock. As of February 28, 2014, there were 35 stockholders of record of our common stock (which does not include the number of stockholders holding shares of our common stock in "street name") and the closing price of our common stock was $48.00 per share on February 28, 2014 as reported by The NASDAQ Global Market.

The following table sets forth for the indicated period the closing high and low sales prices for our common stock as reported on The NASDAQ Global Market.

1

	High	Low
First Quarter 2013	$ 27.34	$ 15.02
Second Quarter 2013	$ 25.28	$ 17.68
Third Quarter 2013	$ 33.93	$ 22.72
Fourth Quarter 2013	$ 46.49	$ 33.00
Year 2013	$ 46.49	$ 15.02

	High	Low
First Quarter 2012	$ 16.85	$ 14.07
Second Quarter 2012	$ 17.72	$ 15.12
Third Quarter 2012	$ 18.77	$ 16.12
Fourth Quarter 2012	$ 27.76	$ 19.21
Year 2012	$ 27.76	$ 14.07

Dividend Policy

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

Unregistered Sales of Equity Securities

During the quarter ended December 31, 2013, we did not issue or sell any shares of our common stock or other equity securities pursuant to unregistered transactions in reliance upon an exemption from the registration requirements of the Securities Act of 1933, as amended.

Issuer Purchases of Equity Securities

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. Purchases under the repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. 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. 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. Repurchases under this program began in the third quarter of 2011. Purchases under the repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. In February 2012, we completed this stock repurchase program, having repurchased in aggregate 2.2 million shares for approximately $30.0 million at an average price of $13.78 per share including commissions. The cost of the repurchased shares was funded from available working capital.

On September 10, 2012, 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. On March 5, 2013, we announced that our board of directors approved an additional $30 million of stock repurchases, bringing the total approved under this program to $60 million. Purchases under this program may be made in the open market or unsolicited negotiated transactions and are expected to comply with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The timing of the purchases and the exact number of shares to be purchased will depend upon market conditions. We completed repurchasing common

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stock under this program in June 2013 having repurchased 2,957,179 shares for $60.0 million at an average price of $20.29 per share.

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.

Stock repurchase activity under our stock repurchase programs during the years ended December 31, 2012 and 2013 is summarized as follows (in thousands, except share and per share amounts):

	Total Number of Shares Purchased	Average Price Paid per Share (1)	Amount of Repurchase
Cumulative balance at December 31, 2011	5,797,806	$ 14.07	$ 81,557
Repurchases of common stock during 2012	599,997	$ 15.72	9,434
Cumulative balance at December 31, 2012	6,397,803	$ 14.22	90,991
Repurchases of common stock during 2013	2,911,466	$ 20.27	59,007
Cumulative balance at December 31, 2013	9,309,269	$ 16.11	$ 149,998

(1) Average price paid per share includes commissions

In addition to the 9.3 million shares repurchased under our repurchase programs as of December 31, 2013, we have in treasury an additional 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, 2012 and 2013, we had a total of 6.6 million shares and 9.5 million shares, respectively, held in treasury.

STOCK PERFORMANCE GRAPH

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

The graph below compares the cumulative total stockholder return on our common stock with the cumulative 5-year total returns on the NASDAQ Composite index and the Research Data Group (“RDG”) Internet Composite index for the five-year period between December 31, 2008 and December 31, 2013, assuming an investment of $100 at the beginning of such period and the reinvestment of any dividends.

	12/31/08	12/31/09	12/31/10	12/31/11	12/31/12	12/31/13
eHealth, Inc.	$ 100.00	$ 123.72	$ 106.85	$ 110.69	$ 206.93	$ 350.08
NASDAQ Composite	100.00	144.84	170.58	171.34	200.00	283.43
RDG Internet Composite	100.00	175.07	202.22	209.97	253.14	344.69

The stock price performance included in this graph is not necessarily indicative of future stock price performance.

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ITEM 6. SELECTED CONSOLIDATED FINANCIAL DATA

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

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Consolidated Statements of

Income Data:	Year Ended December 31,				
	2009	2010	2011	2012	2013
	(in thousands, except per share amounts)				
Revenue:					
Commission	$119,259	$ 135,366	$ 120,321	$ 130,663	$ 153,383
Other	15,631	25,038	31,327	24,810	25,797
Total revenue	134,890	160,404	151,648	155,473	179,180
Operating costs and expenses:					
Cost of revenue	4,581	5,499	8,340	4,783	5,461
Marketing and advertising (1)	53,987	60,102	56,877	57,789	71,660
Customer care and enrollment (1)	14,769	17,810	22,898	30,282	35,099
Technology and content (1)	15,685	19,241	21,657	21,406	32,579
General and administrative (1)	20,028	24,055	26,593	26,169	29,235
Amortization of intangible assets	—	1,138	2,046	1,615	1,414
Total operating costs and expenses	109,050	127,845	138,411	142,044	175,448
Income from operations	25,840	32,559	13,237	13,429	3,732
Other income (expense), net	938	9	(53)	23	(92)
Income before provision for income taxes	26,778	32,568	13,184	13,452	3,640
Provision for income taxes	11,431	15,086	6,460	6,370	1,917
Net income	$15,347	$ 17,482	$ 6,724	$ 7,082	$ 1,723
Net income per share:					
Basic	$0.63	$ 0.76	$ 0.32	$ 0.36	$ 0.09
Diluted	$0.61	$ 0.73	$ 0.31	$ 0.34	$ 0.09
Weighted average number of shares used in per share amounts:					
Basic	24,309	23,118	20,947	19,867	19,145
Diluted	25,201	23,873	21,703	20,753	19,846

(1) Includes stock-based compensation as follows:

	Year Ended December 31,				
	2009	2010	2011	2012	2013
Marketing and advertising	$ 803	$ 808	$ 962	$ 1,215	$ 2,112
Customer care and enrollment	325	384	344	321	342
Technology and content	1,194	1,622	1,669	1,021	1,641
General and administrative	2,513	3,581	4,121	3,065	3,707
Total	$ 4,835	$ 6,395	$ 7,096	$ 5,622	$ 7,802

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	As of December 31,				
	2009	2010	2011	2012	2013
Consolidated Balance Sheet Data:	(in thousands)				
Cash and cash equivalents	$ 131,339	$ 128,074	$ 123,607	$ 140,849	$ 107,055
Marketable securities	22,184	—	—	—	—
Working capital	148,891	128,395	121,310	135,249	97,220
Total assets	169,708	185,845	177,945	196,301	166,426
Non-current liabilities	2,997	3,451	3,920	4,625	6,165
Retained earnings (accumulated deficit)	(2,545)	14,937	21,661	28,743	30,466
Total stockholders' equity	151,451	162,197	155,674	170,867	133,017

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

Overview

We are the leading online source of health insurance for individuals, families and small businesses. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com 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 member acquisition programs, obtaining necessary regulatory approvals of our websites and establishing relationships and appointments with leading health insurance carriers, enabling us to offer thousands of health insurance plans online. Our ecommerce platforms can be accessed directly through our website as well as through our network of marketing partners.

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platform. Commission revenue represented 79%, 84% and 86% of total revenue in the years ended December 31, 2011, 2012 and 2013, respectively. Historically, the commission payments we receive on individual and family, small business and ancillary health insurance policies we sold were a percentage of the premium on the policy. During 2013, we received communications from many carriers indicating that in 2014 our individual and family health insurance commissions will change from being calculated on a percentage-of-premium basis to a flat amount per-member-per-month. The commission payment that we receive for individual and family, small business and ancillary health insurance policies are typically made to us on a monthly basis for as long as the policy remains active with us.

We actively market the availability of Medicare-related health insurance plans through our online Medicare plan platforms www.eHealthMedicare.com 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 six years, or longer depending on the carrier arrangement, and are paid to us either monthly or annually.

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

In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have changed and will continue to change, the health insurance industry in substantial ways. Among several other provisions, these laws and the regulations implementing them include a mandate requiring individuals to maintain health insurance or face tax penalties; a mandate that certain employers offer and contribute to their employees group health insurance coverage or face tax penalties if they do not do so in 2015 and thereafter; prohibitions against insurance companies using pre-existing health conditions as a reason to deny an application for health insurance; requirements for minimum individual and small business health insurance benefit levels, including prohibitions on lifetime coverage limits and limitations on annual coverage limits; medical loss ratio requirements that require each health insurance carrier to spend a certain percentage of their premium revenue on reimbursement for clinical services and activities that improve health care quality; establishment of state and/or federal government-run health insurance exchanges to facilitate access to, and the purchase of, health insurance; open enrollment periods for the purchase of individual health insurance during specified times of the year; Medicaid expansion so that a greater number of individuals will be insured under Medicaid programs; and subsidies and cost-sharing credits to make health insurance more affordable for those below certain income levels if they are eligible and purchase individual or small group health insurance through the state or federal health insurance exchange.

While many aspects of health care reform became effective in 2014, health insurance carriers have been required as a part of health care reform to maintain medical loss ratios of eighty percent in their individual and family health insurance business since the beginning of 2011. The implementation of the medical loss ratio requirements by health insurance

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carriers resulted in a reduction in the commission rates that we are paid for selling individual and family health insurance plans. These commission rate changes began to impact our individual and family plan commission revenue in 2011. Under health care reform an eighty-five percent medical loss ratio requirement for Medicare Advantage plans became effective in 2014.

The initial open enrollment period under health care reform began in October 2013 and is scheduled to run through March 2014. Individuals and families cannot purchase individual and family health insurance outside this period until the open enrollment period for the following year, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance. Moreover, in order to be eligible for a subsidy, qualified individuals must purchase subsidy-qualifying health plans through a government-run health insurance exchange during the open enrollment period or special enrollment period. A substantial number of our existing members are likely eligible for subsidies in connection with their purchase of health insurance. During the third quarter of 2013, we entered into two agreements with the Centers for Medicare and Medicaid Services, or CMS to allow us to enroll subsidy-eligible individuals in qualified health insurance plans online in the 36 states where the federal government is operating an exchange during the initial open enrollment period. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members. If we are not able to satisfy these conditions and requirements as well as enter into functioning relationships with government-run health insurance exchanges to offer qualified health insurance plans that are required for individuals to receive a subsidy, we may lose existing members and new members. We are currently in the process of integration and testing with the federal exchange, and the federal government is in the process of completing development of this capability. Our integration with the federal exchange to enroll individuals and families online through the federal exchange so that they may receive a subsidy is dependent upon completion of integration and development as well as the federal government's resolution of technological problems. Although we are working to provide consumers with access to subsidy-eligible plans, the date on which we will be able to do so is uncertain and it is unlikely we will be able to enroll individuals and families into qualified health plans in our online process during the current initial open enrollment period that is scheduled to end on March 31, 2014. Additionally, we have not entered into a similar relationship with any of the other 14 states that are operating their own exchanges.

While aspects of health care reform may positively impact our business, the aggregate future impact of the implementation of health care reform on our business and financial results is uncertain. For instance, it is unclear how our existing members will react to health care reform and whether they will seek or be forced to purchase new health insurance products or change existing plans in response to health care reform requirements. Our ability to continue to act as a health insurance agent for our members who switch to a new health insurance product will be dependent upon a number of factors, including health insurance company practices, individual financial circumstances, our members' existing health insurance plans, the price of health insurance and our ability to expand our offering to include subsidy-eligible health insurance plans. While a large number of consumers may enter the market for individual health insurance in response to health care reform given the requirement that individuals maintain health insurance or face a tax penalty, it is unclear whether the tax penalty will have this intended effect, particularly given that the cost of health insurance has generally increased in response to health care reform. Moreover, we are facing new competition in the form of government run health insurance exchanges and our ability to act as a health insurance agent to health care reform subsidy eligible individuals is dependent upon our ability to successfully enter into agreements and integrate with those government-run exchanges. In order to enroll individuals in subsidy-eligible plans, we also need to meet a number of requirements relating to the display of information on our websites as well as new and comprehensive privacy and security requirements. Our ability to meet and maintain compliance with these and other requirements

could present significant challenges for us. The implementation of open enrollment periods for the purchase of individual health insurance also presents challenges to our ability to enroll a significant number of individuals into health insurance over a limited period of time. The restriction on individuals being able to make plan changes outside of open enrollment periods could result in a reduction in the number of health insurance policies purchased through us outside of the open enrollment period. The impact of health care reform on our health insurance carrier partners and their reaction is also unclear. For instance, health insurance carriers have the ability to unilaterally change their relationship with us, including the commission rates we receive for acting as a health insurance agent and may reduce the amount they pay us, alter the manner and geographic areas in which they permit us to sell their products and change our relationship with them in any number of ways. Given the disruption that the implementation of health care reform may have on the health insurance market, health care reform could in the aggregate have a material adverse effect on our business and results of operations.

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

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and maintained by us. In these instances, we are typically paid a fixed, up-front fee, which we recognize as revenue over the service period.

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

In the past we also derived a significant amount of revenue from referral fees paid to us based on leads generated by our online platforms that are delivered and sold to third parties. In early 2012 we began directly servicing most of the Medicare leads we generated as a health insurance agent, while significantly reducing the number of Medicare leads we sold to third parties. As a result, our lead referral revenue declined significantly in 2013 compared to 2012. 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 and family, small business and ancillary health insurance policies, such as stand-alone dental, life, student, vision, accident and short-term insurance plan offerings, have generally represented a percentage of the insurance premium and, to a much lesser extent, commission override payments that insurance carriers pay us for achieving sales volume thresholds or other objectives. Commission rates vary by carrier and by the type of plan purchased by a member. Commission rates can vary based upon the amount of time that the policy has been active, with commission rates for individual and family plans typically being higher in the first twelve months of the policy. After the first twelve months, commission rates generally decline significantly. As a result, if we do not add a sufficient number of members on new policies, our revenue growth will be negatively impacted. Individuals, families and small businesses purchasing health insurance through us typically pay their premiums on a monthly basis. Insurance carriers typically pay commissions to us on these policies monthly, after they receive the premium payment from the member. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. As a result, the majority of our commission revenue is recurring in nature.

During 2013 we received communication from many health insurance carriers indicating that in 2014 our commissions will change from a percentage of premium to a flat amount per-member-per-month. The amount paid per-member-per-month will generally decline after the initial policy year. To date, we have received commission rate schedules applicable to 2014 coverage from substantially all of our individual and family health insurance carriers.

These rate schedules are generally effective for policies with 2014 effective dates, although existing policies for some carriers have also been affected. Based on our analysis, we determined that the average commission dollars per policy for individual and family policies under the new rates are equal to, or slightly higher than, our average commission dollars per policy for policies we sold during the period from July 2011 to June 2012. This period was selected because it was after the medical loss requirements went into effect at the beginning of 2011 and allowed for enough time to generate both first year and renewal commissions on the policies analyzed. Assuming the ratio of flat amount per member per month commissions to percentage of premium commissions as well as average policy premiums remain constant; our analysis was performed by applying the changes in both the first year and renewal year commissions to the individual and family plan members and comparing commission revenues that were actually generated by these members to what these commission revenues would have been under the new rates.

We generally recognize individual and family, small business and ancillary 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

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reported to us in a more irregular pattern than premium commissions. As a result, our revenue for a particular quarter could be higher or lower than expectations due to the timing of the reporting of commission override revenue to us.

Historically, the number of individual and family health insurance applications submitted through our ecommerce platform generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. This trend changed in the fourth quarter of 2013 as a result of an increase in the number of individual and family applications submitted during the initial open enrollment period under health care reform which began on October 1, 2013 and is scheduled to run through March 31, 2014. The number of submitted individual and family plan applications increased significantly, relative to historical levels, during the fourth quarter of 2013.

In addition to the initial open enrollment period scheduled to end in March 2014, the annual open enrollment period for individual and family health insurance is proposed to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates of annual open enrollment period are unknown. Individuals and families generally will not be able to purchase individual and family health insurance outside of these open enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance. We expect that open enrollment periods will change the seasonality of our individual and family health insurance business and individual and family health insurance submitted applications. Because we have not operated our individual and family health insurance business under these circumstances, the impact of open enrollment periods on that business is unclear. We do expect that applications submitted for individual and family health insurance to decline outside of the annual open enrollment periods.

We actively market the availability of Medicare-related insurance plans through our online Medicare plan platforms, including 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. Additionally, these commission rates may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. We may earn commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans typically for a period of 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 consolidated balance sheets. We continue to receive the commission payments from the relevant insurance carrier until the earlier of the cancellation of the policy, our no longer remaining the agent on the policy, or our commission term with the carrier expires, typically for a period of six years from the effective date of the policy, or longer depending on the carrier arrangement. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier. Our services are complete when a carrier has approved an application in the initial year and when a member has renewed in a renewal year. The seller's price is fixed or determinable and collectability is reasonably assured when a carrier has approved an application and the carrier reports to us the annual or first monthly renewal commission amount for each policy year.

The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, we generate a significant amount of Medicare plan-related revenue in the fourth quarter resulting from the sale of new Medicare plans. 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.

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Commission revenue attributable to major medical individual and family health insurance plans was 86%, 75% and 69% of commission revenue in the years ended December 31, 2011, 2012 and 2013, respectively. The decline in the percentage of commission revenue attributable to major medical individual and family health insurance plans in 2012 compared to 2011 was due primarily to an increase in commission revenue attributable to Medicare-related insurance plans. The decline in the percentage of commission revenue attributable to major medical individual and family health plans in 2013 compared to 2012 was due primarily to increases in commission revenue attributable to both ancillary health insurance plans, consisting primarily of dental, accident and vision insurance plan offerings, and Medicare-related insurance plans.

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

Other Revenue

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

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

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

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. Prior to 2012, the majority of our lead referral revenue was generated during the Medicare annual enrollment period, which occurs during the fourth quarter of the calendar year. In the second quarter of 2012, we began to perform services for substantially all Medicare leads ourselves as a health insurance agent, for which we are entitled to receive commissions. As a result, our Medicare lead referral revenue declined substantially. In the future, we intend to continue to perform services for substantially all Medicare leads ourselves as a health insurance agent.

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

Member Acquisition

An important factor in our revenue growth is the growth of our member base. Our marketing initiatives are an important component of our strategy to grow our member base and are focused on three primary member acquisition channels: direct, marketing partners and online advertising. Our marketing initiatives are primarily designed to encourage consumers to complete an application for health insurance. Our marketing channels are as follows:

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Direct. Our direct member acquisition channel consists of consumers who access our website addresses including 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 years ended December 31, 2011, 2012 and 2013, applications submitted through us for individual and family health insurance from our direct channel constituted 44%, 47% and 47%, 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 years ended December 31, 2011, 2012 and 2013, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 32%, 32% and 36%, 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 years ended December 31, 2011, 2012 and 2013, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 24%, 21% and 18%, respectively, of all individual and family health insurance applications submitted on our website.

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

Operating Costs and Expenses

Cost of Revenue

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

policy is sold. Costs related to revenue-sharing arrangements are expensed as the related revenue is recognized.

Additionally, cost of revenue includes the amortization of consideration we paid to certain broker partners in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies. These transfers include primarily Medicare plan members. Total consideration paid in connection with these transfers amounted to$13.9 million. Consideration for all book-of-business transfers is being amortized to cost of revenue as we recognize commission revenue related to the transferred members over a period of up to five years for each arrangement.

We expect cost of revenue to increase in absolute dollars in 2014 compared to 2013 due to an increase in payments for referrals to our website by marketing partners with whom we have revenue-sharing arrangements.

Marketing and Advertising

Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct, marketing partner and online advertising member acquisition channels, in addition to compensation and other expenses related to marketing, business development, partner management, public relations and carrier relations personnel who support our offerings. Our direct channel expenses primarily consist of costs for 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. Since a significant portion of our marketing and advertising expenses are driven by the number

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of health insurance applications submitted on our ecommerce platform, those expenses are influenced by seasonal submitted application patterns. As a result, marketing and advertising expenses related to individual and family health insurance plans has historically been highest in our first and third quarters, while marketing and advertising expenses related to Medicare-related plans has historically been highest in our third and fourth quarters. However, with the implementation of the initial open enrollment period for individual and family plans in October 2013, we experienced an increase in marketing and advertising expenses related to individual and family plans during the fourth quarter of 2013. The future impact of annual open enrollment periods for individual and family health insurance on our submitted applications and marketing and advertising expenses is unclear.

The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our website, those expenses are influenced by these patterns. In addition, because the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. An 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 2013, we experienced a significant increase in online advertising expenses during the fourth quarter of 2013 compared to the other quarters of 2013. We also increased our discretionary spending for Medicare plan-related online advertising in the third and fourth quarters of 2013, compared to the first and second quarters, in conjunction with the Medicare annual enrollment period in the fourth quarter of each year. 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 2013. These seasonal patterns also occurred in 2012 and we expect them to occur again in 2014.

We expect our marketing and advertising expenses to increase in absolute dollars in 2014 compared to 2013 due primarily to increases in submitted individual and family plan applications from our marketing partners and in our Medicare-related online marketing and advertising expenditures during 2014, 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 preparation for the Medicare annual enrollment period and to a lesser extent the initial open enrollment period for individuals and family plans, we begin ramping up our customer care center staff during our second and third quarters to handle the anticipated increased volume of health insurance transactions during the fourth quarter. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to the first and second quarters. Because the majority of our Medicare plan-related revenue related to new sales is not generated until the fourth quarter, our temporary customer care center staffing costs incurred in the third quarter has had a significant negative impact on our profitability during that quarter. These seasonal trends are expected to continue in 2014.

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

Technology and Content

Technology and content expenses consist primarily of compensation and benefits costs for personnel associated with developing and enhancing our website technology as well as maintaining our website. A majority of our technology and

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content group is located at our wholly-owned subsidiary in China, where technology development costs are generally lower than in the United States.

In order for us to offer and sell subsidy-eligible health insurance plans on our websites, we are required to meet certain 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 to the state exchange. We increased our technology and content spending throughout 2013 in order to increase functionality to meet the conditions required to offer and sell subsidy-eligible health insurance plans and to enhance the user experience. We expect that technology and content spending will be impacted in future years by additional infrastructure necessary to maintain compliance with these conditions.

We expect technology and content expenses to increase in absolute dollars and as a percentage of total revenue in 2014 compared to 2013 as a result of an increase in labor and personnel costs in our product management and engineering departments as we increase our investment in our technology platform to further enhance the user experience, increase functionality and meet the requirements to offer and sell subsidy-eligible health insurance plans. We also expect to invest in certain platform features which will allow us to provide technology to employer-based health insurance exchanges for defined contribution offerings.

General and Administrative

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

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

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Summary of Selected Metrics

The following table shows certain selected quarterly metrics for 2012 and 2013:

Key Metrics:	Three Months Ended							
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012	March 31, 2013	June 30, 2013	September 30, 2013	D 2
Operating cash flows (1)	$ 5,093,000	$ 7,632,000	$ 6,928,000	$ 5,238,000	$ (538,000)	$ 6,635,000	$ 8,678,000	$
IFP submitted applications (2)	115,400	103,400	120,100	113,600	126,900	110,600	123,300	
IFP approved members (3)	100,300	87,900	99,500	93,600	114,400	100,700	112,300	
Total approved members (4)	151,900	148,500	174,500	186,700	206,600	190,400	210,700	
Commission revenue (5)	$ 31,464,000	$ 30,603,000	$ 31,291,000	$ 37,305,000	$ 38,251,000	$ 34,942,000	$ 36,000,000	$
Commission revenue per estimated member for the period (6)	$ 37.82	$ 35.47	$ 34.7	$ 39.07	$ 37.56	$ 32.58	$ 32.39	$
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012	March 31, 2013	June 30, 2013	September 30, 2013	D 2
IFP estimated membership (7)	686,800	684,000	698,600	709,700	738,900	748,000	765,500	
Medicare estimated	35,200	42,900	48,400	70,600	75,300	80,400	85,300	

membership (8)							
Other estimated membership (9)	126,600	150,000	179,600	202,600	239,600	263,000	296,300
Total estimated membership (10)	848,600	876,900	926,600	982,900	1,053,800	1,091,400	1,147,100

Other Metrics:	Three Months Ended							
	March 31, 2012	June 30, 2012	September 30, 2012	December 31, 2012	March 31, 2013	June 30, 2013	September 30, 2013	D 2
Source of IFP submitted applications (as a percentage of total IFP applications for the period):								

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Direct (11)	44	%	47	%	48	%	49	%	48	%	49	%	51	%	41	%
Marketing partners (12)	33	%	31	%	32	%	33	%	32	%	32	%	33	%	42	%
Online advertising (13)	23	%	22	%	20	%	18	%	20	%	19	%	16	%	17	%
Total	100	%	100	%	100	%	100	%	100	%	100	%	100	%	100	%

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Notes:

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

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

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

- For ancillary insurance policies (such as short-term, dental, vision, accident and student), we take the sum of (i) the number of members for whom we have received or applied a commission payment for the month that is one to three months prior to the date of estimation (after reducing that number using historical experience for assumed member cancellations over the one to three-month period); and (ii) the number of approved members over the one to three-month period prior to the date of estimation (after reducing that number using historical experience for an assumed number of members who do not accept their approved policy and for estimated member cancellations through the date of the estimate). The one to three-month period varies by insurance product and is largely dependent upon the timeliness of commission payment and related reporting from the related carriers.

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

- For small business health insurance policies, we estimate the number of members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier in the period it is reported. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us.

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Additionally, our carrier partners often do not communicate this information to us. We often are made aware of policy cancellations at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

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

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

Critical Accounting Policies and Estimates

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

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

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

During the year ended December 31, 2013, there were no significant changes to our critical accounting policies and estimates.

Revenue Recognition

Commission Revenue

We recognize revenue for our services when each of the following four criteria is met: persuasive evidence of an arrangement exists; delivery has occurred or services have been rendered; the seller’s price to the buyer is fixed or determinable; and collectability is reasonably assured. Our revenue is primarily comprised of compensation paid to us by health insurance carriers related to insurance policies that have been purchased by a member who used our service. We define a member as an individual currently covered by an insurance plan, including individual and family, Medicare-related, small business and ancillary plans, for which we are entitled to receive compensation from an insurance carrier.

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Commission Revenue—For individual and family, Medicare Supplement, small business and ancillary plans, our compensation generally represents a flat amount per member per month or a percentage of the premium amount collected by the carrier during the period that a member maintains coverage under a policy (commissions) and, to a much lesser extent, override commissions that health insurance carriers pay us for achieving certain objectives. Premium-based commissions are reported to us after the premiums are collected by the carrier, generally on a monthly basis. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. We recognize commission revenue for individual and family, Medicare Supplement, small business and ancillary plans as the commissions are reported to us by the carrier, net of an estimate for future forfeiture amounts due to policy cancellations. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier, a carrier reports to us that it has approved an application submitted through our ecommerce platform and the applicant starts making payments on the policy. Our services are complete when a carrier has approved an application. The seller's price is fixed or determinable and collectability is reasonably assured when commission amounts have been reported to us by a carrier.

We recognize individual and family, small business and ancillary commission override revenue when reported to us by a carrier based on the actual attainment of predetermined target sales levels or other objectives as determined by the carrier. Commission override revenue, which we recognize on the same basis as individual and family, small business and ancillary commissions, is generally reported to us in a more irregular pattern than such commissions.

For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission payment from insurance carriers once the policy is approved by the carrier and either a fixed, monthly commission payment beginning with and subsequent to the second policy year for a Medicare Advantage policy or a fixed, annual commission payment beginning with and subsequent to the second policy year for a Medicare Part D prescription drug policy. Additionally, these commission rates may be higher in the first twelve months of a policy if the policy is the first Medicare-related policy issued to the member. We 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 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 six years from the effective date of the policy, or longer depending on the carrier arrangement. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier. Our services are complete when a carrier has approved an application in the initial year and when a member has renewed in a renewal year. The seller's price is fixed or determinable and collectability is reasonably assured when a carrier has approved an application and the carrier reports to us the annual or first monthly renewal commission amount for each policy year.

Commissions for all health insurance plans we sell 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 following the end of the accounting period. If the second corroborating communication is not received shortly following 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 future forfeiture amounts due to policy cancellations. As a result, we recognize the net amount of compensation earned as the agent in the transaction.

Certain commission amounts are subject to forfeiture when the policy is subsequently cancelled and either the carrier takes back all or a portion of the commission they have paid to us or we will no longer receive monthly commission payments for the remainder of the policy year. We record an estimate for these forfeitures based on our historical cancellation experience using data provided on commission statements. Policy cancellations and the commission amounts, if any, to be taken back by the carrier are typically reported to us by health insurance carriers several months after the policy's cancellation date. Our estimate for forfeitures payable to a carrier, which is included in Other Current Liabilities in the consolidated balance sheets, includes an estimate of both the reporting time lag and the forfeiture amount, based on our historical experience by policy type. Similarly, our estimate for commission amounts not expected to be collected due to policy cancellations, which is recorded as a reduction of Accounts Receivable in the consolidated balance sheets, includes an estimate of the annual policy cancellation rate, based on our historical experience by policy type. Changes in our historical trends would result in changes to our estimated forfeitures in future periods. There were no changes in our average

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forfeiture rates or reporting time lag during the years ended December 31, 2011, 2012 and 2013 which had a material impact on our estimate for forfeitures.

We rely on health insurance carriers to report accurately and in a timely manner the amount of commissions earned by us, and we calculate our commission revenues, prepare our financial reports, projections and budgets, and direct our marketing and other operating efforts based on the reports we receive from them. Each month we analyze the reports we receive from health insurance carriers by comparing such data to the database we maintain on our members. It is often difficult for us to independently determine whether or not carriers are reporting all commissions due to us, primarily because members on individual, family and small business policies typically terminate their policies by discontinuing their premium payments to the carrier instead of by informing us of the cancellation. Also, some of our individual, family and small business members pay their premiums less frequently than monthly. This results in our having to identify underpayment or non-payment of commissions on a policy and follow up with a carrier to obtain an explanation and/or request correction of the amount of commissions paid to us.

Other Revenue

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

Technology Licensing Revenue—Our commercial technology licensing business allows carriers the use of our ecommerce platform to offer their own health insurance policies on their websites and agents to utilize our technology to power their online quoting, content and application submission processes. Typically, we are paid a one-time implementation fee, which we recognize on a straight-line basis over the estimated term of the customer relationship (generally the initial term of the agreement), commencing once the technology is available for use by the third party, and a performance fee based on metrics such as submitted health insurance applications. The metrics used to calculate performance fees for both sponsorship and advertising and technology licensing are based on performance criteria that are either measured based on data tracked by us, or based on data tracked by the third party. In instances where the performance criteria data is tracked by us, we recognize revenue in the period of performance. In instances where the performance criteria data is tracked by the third party, we recognize revenue when the amounts earned are either fixed or determinable and collection is reasonably assured. Typically, this occurs through our receipt of a cash payment from the third party along with a detailed statement containing the data that is tracked by the third party.

Medicare Lead Referral Revenue—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 sell our leads to a limited number of purchasers, and until May 2012 the majority of our lead referral revenue was generated during the Medicare annual enrollment period, which occurs during the fourth quarter of the calendar year. We recognize lead referral revenue when persuasive evidence of an arrangement exists, delivery of a lead has occurred, the fee is fixed or determinable and collectability is reasonably assured. Delivery is deemed to have occurred at the time a lead is delivered to the customer.

Multiple-element Arrangements—We allocate revenue to all units of accounting within an arrangement with multiple deliverables at the inception of the arrangement using the relative selling price method. The relative selling price method allocates any discount in an arrangement proportionally to each deliverable on the basis of each deliverable's relative selling price. The relative selling price established for each deliverable is based on vendor-specific objective evidence of fair value ("VSOE") if available, third-party evidence of selling price if VSOE is not available, or best estimate of selling price if neither VSOE nor third-party evidence is available. When used, the best estimate of selling price reflects our best estimates of what the selling prices of certain deliverables would be if they were sold regularly on a stand-alone basis. Our process for determining best estimate of selling price for deliverables without VSOE or third-party evidence of selling price considers multiple factors that may vary depending upon the unique facts and circumstances related to each deliverable. Key factors considered by us in developing the relative selling prices for our technology licensing fees include prices charged by us for similar offerings and our historical pricing practices. We may also consider additional factors as appropriate, including competition.

Deferred Revenue—Deferred revenue includes deferred technology licensing implementation fees and amounts billed for deliverables in multiple element arrangements that do not have stand-alone value from other, undelivered elements as well as amounts billed or collected from sponsorship or technology licensing customers in advance of our performing our service for such customers. It also includes the amount by which both unbilled and billed services provided under our

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technology licensing arrangements exceed the straight-line revenue recognized to date. We defer commission amounts that have been paid to us related to transactions where our services are complete, but where we cannot currently estimate future forfeitures related to those amounts.

A deliverable constitutes a separate unit of accounting when it has stand-alone value and there are no customer-negotiated right of refunds for the delivered elements. If the arrangement includes a customer-negotiated right of refund relative to the delivered item, and the delivery and performance of the undelivered item is considered probable and substantially in our control, the delivered element constitutes a separate unit of accounting. In circumstances when the aforementioned criteria are not met, the deliverable is combined with the undelivered elements, and the allocation of the arrangement consideration and revenue recognition is determined for the combined unit as a single unit. Allocation of the consideration is determined at the inception of the arrangement on the basis of each unit's relative selling price. After the arrangement consideration has been allocated to each unit of accounting based on their relative selling prices, we apply revenue recognition criteria separately to each respective unit of accounting in the arrangement in accordance with applicable accounting guidance.

Stock-Based Compensation

We recognize stock-based compensation expense in the accompanying consolidated statements of comprehensive income based on the fair value of our stock-based awards over their respective vesting periods, which is generally four years. The estimated grant date fair value of our stock options is determined using the Black-Scholes-Merton pricing model and a single option award approach. The weighted-average expected term for stock options granted is calculated using historical option exercise behavior. The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through December 31, 2013, we had not declared or paid any cash dividends, and we do not expect to pay any in the foreseeable future. We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options. The estimated attainment of performance-based awards and related expense is based on the expectations of revenue target achievement. The assumptions used in calculating the fair value of stock-based payment awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected term and volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions could significantly impact the valuation of such instruments.

Future stock-based compensation expense is dependent upon the fair value of each option at the date each option is granted and the number of awards issued and outstanding during each period. We expect stock-based compensation expense will increase in the future to the extent the number of equity awards issued and outstanding increases.

Realizability of Long-Lived Assets

We assess the realizability of our long-lived assets, including intangible assets and goodwill, whenever events or changes in circumstances indicate the carrying value of such assets may not be recoverable. Factors that we consider in deciding when to perform an impairment review include significant negative industry or economic trends or significant changes or planned changes in our use of the assets. Additionally, we test goodwill for impairment on an annual basis on or about November 30 of each year. When performing the annual goodwill impairment test we first

assess qualitative factors to determine whether it is “more likely than not” that the fair value of our reporting unit is less than its carrying amount as a basis for determining whether it is necessary to perform the two-step goodwill impairment test.

If events or changes in circumstances indicate the carrying value of such assets may not be recoverable, for long lived assets other than goodwill, including intangible assets with finite useful lives, which include purchased technology, pharmacy and customer relationships, trade names, trademarks and website addresses, we measure the recoverability of assets that will continue to be used in our operations by comparing the carrying value of the asset grouping to our estimate of the related total future undiscounted net cash flows. For assets related to our book-of-business transfers, we compare the carrying amount of each asset to the commission revenue expected to be generated by the policies included in each respective book-of-business. Our estimates of commission revenue expected to be generated by each book-of-business include subjective judgments regarding expected policy cancellations. If an asset grouping’s carrying value is not recoverable through the related undiscounted cash flows, the asset grouping is considered to be impaired. The impairment charge is calculated as the amount by which the asset grouping’s carrying value exceeds its fair value, which is defined as the price that would be received from selling an asset in an orderly transaction between market participants at the measurement date.

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

Accounting for Income Taxes

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

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

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

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

Future changes in various factors, such as the amount of stock-based compensation we record during the period and the related tax benefit we realize upon the exercise of employee stock options, potential limitations on the use of our federal and state net operating loss credit carry forwards, pending or future tax law changes including rate changes and the tax benefit from or limitations on our ability to utilize research and development credits, the amount of non-deductible lobbying and acquisition-related costs, changes in our valuation allowance and state and foreign taxes,

would impact our estimates, and as a result, could affect our effective tax rate and the amount of income tax expense we record, and pay, in future periods.

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Results of Operations

The following table sets forth our operating results and related percentage of total revenues for the years ended December 31, 2011, 2012 and 2013 (dollars in thousands):

	Year Ended December 31,								
	2011			2012			2013		
Revenue:									
Commission	$ 120,321	79	%	$ 130,663	84	%	$ 153,383	86	%
Other	31,327	21		24,810	16		25,797	14	
Total revenue	151,648	100		155,473	100		179,180	100	
Operating costs and expenses:									
Cost of revenue	8,340	5		4,783	3		5,461	3	
Marketing and advertising	56,877	38		57,789	37		71,660	40	
Customer care and enrollment	22,898	15		30,282	19		35,099	20	
Technology and content	21,657	14		21,406	14		32,579	18	
General and administrative	26,593	18		26,169	17		29,235	16	
Amortization of intangible assets	2,046	1		1,615	1		1,414	1	
Total operating costs and expenses	138,411	91		142,044	91		175,448	98	
Income from operations	13,237	9		13,429	9		3,732	2	
Other income (expense), net	(53)	0		23	0		(92)	(0)	
Income before provision for income taxes	13,184	9		13,452	9		3,640	2	
Provision for income taxes	6,460	4		6,370	4		1,917	1	
Net income	$ 6,724	4	%	$ 7,082	5	%	$ 1,723	1	%

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

	Year Ended December 31,		
	2011	2012	2013
Marketing and advertising	$ 962	$ 1,215	$ 2,112
Customer care and enrollment	344	321	342
Technology and content	1,669	1,021	1,641
General and administrative	4,121	3,065	3,707
	$ 7,096	$ 5,622	$ 7,802

Years Ended December 31, 2011, 2012 and 2013

Revenue

The following table presents our commission, other revenue and total revenue for the years ended December 31, 2011, 2012 and 2013 and the dollar and percentage changes from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Change %	Year Ended December 31, 2012	Change $	Change %	Year Ended December 31, 2013
Commission	$ 120,321	$ 10,342	9%	$ 130,663	$ 22,720	17%	$ 153,383
Percentage of total revenue	79%			84%			86%
Other	31,327	(6,517)	(21)%	24,810	987	4%	25,797
Percentage of total revenue	21%			16%			14%

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Total revenue	$ 151,648	$ 3,825	3%	$ 155,473	$ 23,707	15%	$ 179,180

2013 compared to 2012—Commission revenue increased $22.7 million, or 17%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, due to a $13.8 million increase in non-Medicare commission revenue, consisting primarily of individual and family health insurance commission revenue and ancillary product commission revenue, and an $8.9 million increase in Medicare-related commission revenue. The increase in revenue of both Medicare-related and non-Medicare commission revenue is due to increased membership for the year ended December 31, 2013 compared to the year ended December 31, 2012.

Other revenue increased $1.0 million, or 4%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, due primarily to a $1.7 million increase in online sponsorship and advertising revenue and a $0.5 million increase in technology licensing revenue, partially offset by a $1.2 million decrease in revenue related to our Medicare lead referral revenue. The increase in online sponsorship and advertising revenue was primarily related to individual and family health insurance plan carriers. The decrease in lead referral revenue was the result of our strategic decision to reduce the number of Medicare leads sold to third parties and to instead act as a health insurance agent to those leads.

2012 compared to 2011—Commission revenue increased $10.3 million, or 9%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due primarily to a $12.6 million increase in Medicare-related commission revenue. Partially offsetting this increase was a $2.2 million decrease in non-Medicare commission revenue, primarily 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 beginning in 2011.

Other revenue decreased $6.5 million, or 21%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due primarily to a $10.8 million decrease in Medicare lead referral revenue and a $5.9 million decrease in revenue related to our government systems business. The decrease in lead referral revenue was the result of our strategic decision to reduce the number of Medicare leads sold to third parties and to instead act as a health insurance agent to those leads. Our government systems business revenue was adversely impacted by the expiration of our technology licensing contract with the federal government in January 2012. These decreases in other revenue were partially offset by a $10.3 million increase in online sponsorship and advertising revenue, primarily related to Medicare plan carriers.

Operating Costs and Expenses

Cost of Revenue

The following table presents our cost of revenue for the years ended December 31, 2011, 2012 and 2013 and the dollar and percentage changes from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Change %	Year Ended December 31, 2012	Change $	Change %	Year Ended December 31, 2013
Cost of revenue	$ 8,340	$ (3,557)	(43)%	$ 4,783	$ 678	14%	$ 5,461
Percentage of total revenue	5%			3%			3%

2013 compared to 2012—Cost of revenue increased $0.7 million, or 14%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, due primarily to an increase of $0.4 million in amortization expense associated with the consideration we paid to a broker partner in connection with the transfer of several Medicare plan books-of-business to us whereby we became the broker of record on the underlying policies, an increase of $0.1 million due to revenue-sharing with partners, and an increase of $0.1 million in direct costs associated with technology licensing revenue.

2012 compared to 2011—Cost of revenue decreased $3.6 million, or 43%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due primarily to a decrease of $4.9 million in costs related to our technology licensing contract with the federal government, which expired in January 2012, and a $0.5 million decrease in revenue-sharing expenses with partners. Partially offsetting these decreases was an increase of $1.4 million in amortization expense associated with the consideration we paid to a broker partner in connection with the transfer of several Medicare

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plan books-of-business to us whereby we became the broker of record on the underlying policies, and an asset impairment charge of $0.4 million related to one of the transferred Medicare plan books-of-business.

Marketing and Advertising

The following table presents our marketing and advertising expenses for the years ended December 31, 2011, 2012 and 2013 and the dollar and percentage changes from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Change %	Year Ended December 31, 2012	Change $	Change %	Year Ended December 31, 2013
Marketing and advertising	$ 56,877	$ 912	2%	$ 57,789	$ 13,871	24%	$ 71,660
Percentage of total revenue	38%			37%			40%

2013 compared to 2012—Marketing and advertising expenses increased $13.9 million, or 24%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, primarily due to an increase of $6.6 million in fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website, an increase of $2.7 million in online advertising costs, and an increase of $1.8 million in direct marketing costs. Also contributing to the increase was an increase of $2.0 million in compensation, benefits, stock-based compensation and other personnel costs associated with an increase in employee headcount.

2012 compared to 2011—Marketing and advertising expenses increased $0.9 million, or 2%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due to an increase of $1.0 million in compensation, benefits, stock-based compensation and other personnel costs associated with an increase in employee headcount, and a $1.3 million increase in fees we paid to marketing partners for referrals that result in the submission of a health insurance application on our website. Partially offsetting these increases was a decrease in online advertising costs of $1.3 million as we directed a portion of our online advertising spending to performance partners while decreasing our overall level of online spending.

Customer Care and Enrollment

The following table presents our customer care and enrollment expenses for the years ended December 31, 2011, 2012 and 2013 and the dollar and percentage changes from the prior year (dollars in thousands):

		Change			Change	

	Year Ended December 31, 2011	$	%	Year Ended December 31, 2012	$	%	Year Ended December 31, 2013
Customer care and enrollment	$ 22,898	$ 7,384	32%	$ 30,282	$ 4,817	16%	$ 35,099
Percentage of total revenue	15%			19%			20%

2013 compared to 2012—Customer care and enrollment expenses increased $4.8 million, or 16%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, due primarily to additional customer care center personnel hired to service the increased enrollment in individual and family health insurance plans and Medicare-related health insurance plans. As a result, compensation, benefits, stock-based compensation, licensing and other personnel costs increased $4.2 million.

2012 compared to 2011—Customer care and enrollment expenses increased $7.4 million, or 32%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due primarily to additional customer care center personnel hired to service the increase in volume of Medicare leads serviced directly by us as a health insurance agent. As a result, compensation, benefits, stock-based compensation and other personnel costs increased $5.8 million and insurance licensing costs increased $0.8 million. Additionally, costs related to customer call center telephonic equipment, as well as telephone expense, increased $0.7 million.

Technology and Content

The following table presents our technology and content expenses for the years ended December 31, 2011, 2012 and 2013 and the dollar and percentage changes from the prior year (dollars in thousands):

Year Ended	Change	Year Ended	Change	Year Ended

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	December 31, 2011	$	%	December 31, 2012	$	%	December 31, 2013
Technology and content	$ 21,657	$ (251)	(1)%	$ 21,406	$ 11,173	52%	$ 32,579
Percentage of total revenue	14%			14%			18%

2013 compared to 2012—Technology and content expenses increased $11.2 million, or 52%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, due primarily to an increase of $8.9 million in compensation, benefits, stock-based compensation, and other personnel costs, as a result of an increase in technology and content personnel. Additionally, data center infrastructure maintenance costs and depreciation expense increased $0.7 million and $0.5 million, respectively. The remainder of the increase is due to increased spending to support website operations.

2012 compared to 2011—Technology and content expenses decreased $0.3 million, or 1%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due primarily to a decrease of $0.9 million in compensation, benefits, stock-based compensation and other personnel costs. Partially offsetting this decrease was a $0.5 million increase in internet and data center infrastructure costs associated with an increase in employee headcount.

General and Administrative

The following table presents our general and administrative expenses for the years ended December 31, 2011, 2012 and 2013 and the dollar and percentage changes from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Change %	Year Ended December 31, 2012	Change $	Change %	Year Ended December 31, 2013
General and administrative	$ 26,593	$ (424)	(2)%	$ 26,169	$ 3,066	12%	$ 29,235
Percentage of total revenue	18%			17%			16%

2013 compared to 2012—General and administrative expenses increased $3.1 million, or 12%, in the year ended December 31, 2013 compared to the year ended December 31, 2012, due primarily to an increase of $3.0 million in compensation, benefits, stock-based compensation and other personnel costs as a result of an increase in general and administrative personnel as we add infrastructure to support company growth.

2012 compared to 2011—General and administrative expenses decreased $0.4 million, or 2%, in the year ended December 31, 2012 compared to the year ended December 31, 2011, due primarily to a decrease of $0.2 million in compensation, benefits, stock-based compensation and other personnel costs in 2012 and a decrease of $0.5 million in lobbying fees. Partially offsetting these decreases was an increase of $0.3 million in rent expense and equipment costs.

Amortization of Intangible Assets

The following table presents our intangible asset amortization expense for the years ended December 31, 2011, 2012 and 2013 and the dollar change from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Year Ended December 31, 2012	Change $	Year Ended December 31, 2013
Amortization of intangible assets	$ 2,046	$ (431)	$ 1,615	$ (201)	$ 1,414
Percentage of total revenue	1%		1%		1%

2013 compared to 2012—Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber decreased for the year ended December 31, 2013 compared to the year ended December 31, 2012 due to certain acquired intangible assets becoming fully amortized in May 2012.

2012 compared to 2011—Amortization expense related to intangible assets purchased through our acquisition of PlanPrescriber decreased for the year ended December 31, 2012 compared to the year ended December 31, 2011 due to certain acquired intangible assets becoming fully amortized in May 2012.

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Other Income (Expense), Net

The following table presents our other income (expense), net for the years ended December 31, 2011, 2012 and 2013 and the dollar change from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Year Ended December 31, 2012	Change $	Year Ended December 31, 2013
Other income (expense), net	$ (53)	$ 76	$ 23	$ (115)	$ (92)
Percentage of total revenue	0%		(0)%		0%

Other income (expense), net, in 2011, 2012 and 2013 primarily consisted of interest income earned on our invested cash, cash equivalents and marketable securities balances, offset by administrative bank fees, investment management fees and interest expense on capital lease obligations.

2013 compared to 2012 and 2012 compared to 2011—Other income (expense), net decreased in 2013 compared to 2012 due primarily to a decrease in investment interest income due to lower cash balances and declining average yields as well as higher bank fees. Other income (expense) increased in 2012 compared to 2011 due primarily to a decrease in investment management fees, which we negotiated lower as a result of a decline in the average yield we earn on our invested cash.

Provision for Income Taxes

The following table presents our provision for income taxes for the years ended December 31, 2011, 2012 and 2013 and the dollar change from the prior year (dollars in thousands):

	Year Ended December 31, 2011	Change $	Year Ended December 31, 2012	Change $	Year Ended December 31, 2013
Provision for income taxes	$ 6,460	$ (90)	$ 6,370	$ (4,453)	$ 1,917
Percentage of total revenue	4%		4%		1%

2013 compared to 2012—In 2013, we recorded a provision for income taxes of $1.9 million, representing an effective tax rate of 52.7%. Our effective tax rate in 2013 was higher than our effective tax rate in 2012 of 47.4%, due primarily to a decrease in pre-tax income, which resulted in non-deductible expenses having a more significant impact on the effective tax rate during 2013.

2012 compared to 2011—In 2012, we recorded a provision for income taxes of $6.4 million, representing an effective tax rate of 47.4%. Our effective tax rate in 2012 was less than our effective tax rate in 2011 of 49.0%, due primarily to a decrease in non-deductible lobbying expenses, partially offset by an increase in tax shortfalls related to share-based payments. Tax shortfalls in 2012 were primarily a result of certain options expiring unexercised.

Our effective tax rates for the years ended December 31, 2011, 2012 and 2013 were higher than statutory federal and state tax rates due primarily due to non-deductible lobbying expenses and for 2011 and 2012, tax shortfalls related to share-based payments.

Liquidity and Capital Resources

At December 31, 2013, our cash and cash equivalents totaled $107.1 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, 2012, our cash and cash equivalents totaled $140.8 million. The decrease in cash and cash equivalents reflects $59.0 million used to repurchase 2.9 million shares of common stock, partially offset by cash flows generated from operations.

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

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

Stock repurchase activity under our stock repurchase programs during 2013 is summarized as follows (in thousands, except share and per share amounts):

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	Total Number of Shares Purchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2012 (1)	6,397,803	$ 14.22	$ 90,991
Repurchases of common stock	2,911,466	$ 20.27	59,007
Cumulative balance at December 31, 2013 (1)	9,309,269	$ 16.11	$ 149,998

(1) Cumulative balances at December 31, 2012 and 2013 consist of shares repurchased in connection with our stock repurchase programs announced on September 10, 2012 and March 6, 2013, as well as a previous stock repurchase plan announced in 2011, 2010 and 2008.
(2) Average price paid per share includes commissions.

In addition to the shares repurchased under our repurchase programs as of December 31, 2013, 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, 2012 and 2013, we had a total of 6.6 million shares and 9.5 million shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the years ended December 31, 2011, 2012 and 2013 (in thousands):

	Year Ended December 31,		
	2011	2012	2013
Net cash provided by operating activities	$ 22,541	$ 24,891	$ 20,947
Net cash used in investing activities	$ (6,597)	$ (10,096)	$ (7,326)
Net cash (used in) provided by financing activities	$ (20,381)	$ 2,440	$ (47,403)

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 and the effect of changes in working capital and other activities.

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

Historically, we have experienced a reduction in operating cash flows during the first quarter of the year compared to the other quarters due to the payment of annual performance bonuses to employees in the first quarter of the year. In the first quarter of 2012, we collected a substantial amount of lead referral payments related to Medicare leads sold during the annual enrollment period in the fourth quarter of 2011. The seasonal impact of Medicare lead referral collections was minimal in 2013 as we have transitioned away from lead referral transactions. Additionally, a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform. Since our marketing and advertising costs are expensed as incurred and the revenue from approved applications is recognized as commissions are subsequently reported to us, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter. The impact of the open enrollment period that began during the fourth quarter of 2013 for the purchase of major medical health individual and family insurance plans resulted in increased marketing and advertising expenses during the fourth quarter of 2013. The impact of open enrollment periods on our future cash flows is

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unclear. The first open enrollment period began in October 2013 and is scheduled to run through March 2014. In addition to the initial open enrollment period scheduled to end in March 2014, the annual open enrollment period for individual and family health insurance is proposed to run from November 15, 2014 through February 15, 2015 for coverage effective in 2015. Thereafter, the scheduled dates of annual open enrollment period are unknown. We expect the total marketing expenses to increase, however, the expected trend and timing of the increase is unclear.

2013—Our operating activities generated cash of $20.9 million during the year ended December 31, 2013 and consisted of net income of $1.7 million, increased by non-cash items of $15.2 million and cash provided by working capital and other activities of $4.0 million. Adjustments for non-cash items primarily consisted of $1.4 million of deferred income taxes, $7.8 million of stock-based compensation expense, $3.3 million of depreciation and amortization, $3.1 million of amortization of book-of-business consideration, $0.9 million of deferred rent and $1.4 million of amortization of intangible assets. Cash provided by working capital and other activities primarily consisted of an increase of $4.3 million in accrued marketing expenses, an increase of $0.9 million in deferred revenue, a $1.0 million increase in other current liabilities and an increase of $2.0 million in accrued compensation and benefits, partially offset by a decrease of $1.7 million in accounts payable and an increase of $2.3 million in prepaid expenses and other assets. Accrued marketing expenses increased due to higher marketing and advertising expenses in the fourth quarter of 2013 related to the increased submission of health insurance applications on our website. Accrued compensation and benefits increased primarily due to increased salaries and performance and incentive bonuses related to an increased employee headcount.

2012—Our operating activities generated cash of $24.9 million during the year ended December 31, 2012 and consisted of net income of $7.1 million, increased by non-cash items of $13.6 million and cash provided by working capital and other activities of $4.2 million. Adjustments for non-cash items primarily consisted of $1.1 million of deferred income taxes, $5.6 million of stock-based compensation expense, $2.4 million of depreciation and amortization, $2.7 million of amortization of book-of-business consideration and $1.6 million of amortization of intangible assets. Amortization of book-of-business consideration includes a $0.4 million asset impairment charge to the carrying value of an acquired Medicare book-of-business. Cash provided by working capital and other activities primarily consisted of a decrease of $3.6 million in accounts receivable, an increase of $3.7 million in accounts payable, an increase of $1.0 million in deferred revenue and an increase of $0.3 million in accrued compensation and benefits, partially offset by a decrease of $2.3 million in accrued marketing expenses and an increase of $1.1 million in prepaid expenses and other assets. Accounts payable increased due primarily to the timing of payments to our vendors, accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2011 and accounts receivable decreased due to collections.

2011—Our operating activities generated cash of $22.5 million during the year ended December 31, 2011 and consisted of net income of $6.7 million, increased by non-cash items of $13.3 million and cash provided by working capital and other activities of $2.5 million. Adjustments for non-cash items primarily consisted of $0.9 million of deferred income taxes, $7.1 million of stock-based compensation expense, $2.4 million of depreciation and amortization, $0.8 million of amortization of book-of-business consideration and $2.0 million of amortization of intangible assets. Amortization of intangible assets includes a $0.3 million intangible asset impairment charge. Cash provided by working capital and other activities primarily consisted of a decrease of $3.4 million in accounts receivable, an increase of $2.6 million in

accrued marketing expenses and a decrease of $1.8 million in prepaid expenses and other assets, partially offset by a decrease of $2.5 million in deferred revenue, a decrease of $1.9 million in accounts payable and a decrease of $1.1 million in other current liabilities.

Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software to enhance our website and customer care operations and to support our growth, leasehold improvements related to facilities expansion and 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.

2013—Net cash used in investing activities of $7.3 million during the year ended December 31, 2013 was attributable entirely to capital expenditures. The increase in capital expenditures in 2013 as compared to 2012 primarily related to leasehold improvements as we expanded facilities during 2013.

2012—Net cash used in investing activities of $10.1 million during the year ended December 31, 2012 was attributable to consideration of $6.2 million paid to a partner related to the transfer of two books-of-business, 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 $3.9 million.

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2011—Net cash used in investing activities of $6.6 million during 2011 was attributable to net cash paid of $4.2 million to a partner for transferring certain of its existing Medicare plan members to us as the broker of record on the underlying policies, and capital expenditures of $2.4 million.

Financing Activities

2013—Net cash used in financing activities of $47.4 million during the year ended December 31, 2013 was due to $59.0 million used to repurchase 2.9 million shares of our common stock and $0.9 million used to net-share settle the tax obligation related to vesting equity awards, partially offset by $9.2 million of net proceeds from the exercise of common stock options and $3.4 million of excess tax benefits from stock-based compensation.

2012—Net cash provided by financing activities of $2.4 million during the year ended December 31, 2012 was due to $9.4 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 $8.4 million of net proceeds from the exercise of common stock options and $4.5 million of excess tax benefits from stock-based compensation.

2011— Net cash used in financing activities of $20.4 million during 2011 was due to $25.4 million used to repurchase 1.9 million shares of our common stock and $0.6 million used to net share settle equity awards, partially offset by $4.7 million of excess tax benefits from stock-based compensation and $0.9 million of proceeds received from the issuance of common stock pursuant to stock option exercises.

Future Needs

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

Contractual Obligations and Commitments

Operating Lease Obligations

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

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

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

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

Service and Licensing Obligations

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

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and contractual service and licensing obligations as of December 31, 2013 (in thousands):

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Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2014	$ 4,063	$ 1,055	$ 5,118
2015	2,725	245	2,970
2016	2,771	-	2,771
2017	2,762	-	2,762
2018	1,938	-	1,938
Thereafter	4,565	-	4,565
Total	$ 18,824	$ 1,300	$ 20,124

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.

Recent Accounting Pronouncements

See Note 1 of Notes to Consolidated Financial Statements for recently issued accounting standards that could have an effect on us.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

ecember

	December 31, 2012	December 31, 2013
Cash (1)	$ 27,484	$ 16,935
Money market funds (2)	113,365	90,120
Total cash and cash equivalents	$ 140,849	$ 107,055

(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, 2012 and 2013 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, 2012, four customers represented 25%, 22%, 14% and 11%, respectively, for a combined total of 72% of our $4.5 million outstanding accounts receivable balance. As of December 31, 2013, two customers represented 37% and 15%, respectively, for a combined total of 52% of our $4.6 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2012 and December 31, 2013. We believe the potential for collection issues with

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any of our customers is minimal as of December 31, 2013. Accordingly, our estimate for uncollectible amounts at December 31, 2013 was not material.

Significant Customers

Substantially all revenue for the years ended December 31, 2012 and 2013 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the years ended December 31, 2011, 2012 and 2013 are presented in the table below:

	Year Ended December 31,		
	2011	2012	2013
Humana	8 %	18 %	21 %
WellPoint (1)	11 %	13 %	12 %
UnitedHealthcare (2)	13 %	12 %	11 %
Aetna (3)	8 %	8 %	10 %

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

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

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Index to the Consolidated Financial Statements

The supplementary financial information required by this Item 8 is included in Note 9 to the Consolidated Financial Statements under the caption "Selected Quarterly Financial Data (Unaudited)."

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of eHealth, Inc.

We have audited the accompanying consolidated balance sheets of eHealth, Inc. as of December 31, 2013 and 2012, and the related consolidated statements of comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2013. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of eHealth, Inc. at December 31, 2013 and 2012, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2013, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), eHealth, Inc.'s internal control over financial reporting as of December 31, 2013, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (1992 framework) and our report dated March 12, 2014 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Redwood City, California

March 12, 2014

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EHEALTH, INC.

CONSOLIDATED BALANCE SHEETS

(In thousands, except share and per share information)

	December 31, 2012	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$ 140,849	$ 107,055
Accounts receivable	4,468	4,586
Deferred income taxes	4,098	4,459
Prepaid expenses and other current assets	6,643	8,364
Total current assets	156,058	124,464
Property and equipment, net	6,185	10,283
Deferred income taxes	2,928	4,569
Other assets	8,123	5,518
Intangible assets, net	8,911	7,496
Goodwill	14,096	14,096
Total assets	$ 196,301	$ 166,426
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$ 6,123	$ 4,381
Accrued compensation and benefits	8,244	10,291
Accrued marketing expenses	3,941	8,227
Deferred revenue	926	1,784
Other current liabilities	1,575	2,561
Total current liabilities	20,809	27,244
Non-current liabilities	4,625	6,165
Commitments and contingencies (see Note 7)	-	-
Stockholders' equity:		
Preferred stock: $0.001 par value; Authorized shares: 10,000,000; Issued and outstanding shares: none	-	-
Common stock: $0.001 par value; Authorized shares: 100,000,000; Issued shares 27,006,144 and 28,300,048 at December 31, 2012 and 2013, respectively; Outstanding shares: 20,449,841 and 18,780,762 at December 31, 2012 and 2013, respectively	27	28
Additional paid-in capital	232,903	252,361
	(90,991)	(149,998)

Treasury stock, at cost: 6,556,303 and 9,519,286 shares at December 31, 2012 and 2013, respectively		
Retained earnings	28,743	30,466
Accumulated other comprehensive income	185	160
Total stockholders' equity	170,867	133,017
Total liabilities and stockholders' equity	$ 196,301	$ 166,426

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

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EHEALTH, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(In thousands, except per share amounts)

	Year Ended December 31,		
	2011	2012	2013
Revenue			
Commission	$ 120,321	$ 130,663	$ 153,383
Other	31,327	24,810	25,797
Total revenue	151,648	155,473	179,180
Operating costs and expenses:			
Cost of revenue	8,340	4,783	5,461
Marketing and advertising	56,877	57,789	71,660
Customer care and enrollment	22,898	30,282	35,099
Technology and content	21,657	21,406	32,579
General and administrative	26,593	26,169	29,235
Amortization of intangible assets	2,046	1,615	1,414
Total operating costs and expenses	138,411	142,044	175,448
Income from operations	13,237	13,429	3,732
Other income (expense), net	(53)	23	(92)
Income before provision for income taxes	13,184	13,452	3,640
Provision for income taxes	6,460	6,370	1,917
Net income	$ 6,724	$ 7,082	$ 1,723
Net income per share:			
Basic	$ 0.32	$ 0.36	$ 0.09
Diluted	$ 0.31	$ 0.34	$ 0.09
Weighted-average number of shares used in per share amounts:			
Basic	20,947	19,867	19,145
Diluted	21,703	20,753	19,846
Comprehensive income:			
Net income	$ 6,724	$ 7,082	$ 1,723
Foreign currency translation adjustment, net of taxes	(25)	5	(25)
Comprehensive income	$ 6,699	$ 7,087	$ 1,698

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

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EHEALTH, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(In thousands)

	Common Stock			Treasury Stock				
	Shares	Amount	Additional Paid-in Capital	Shares	Amount	Retained Earnings	Accumulated Other Comprehensive Income	Total Stockholders' Equity
Balance at December 31, 2010	25,531	$ 26	$ 203,231	(3,956)	$ (56,202)	$ 14,937	$ 205	$ 162,197
Issuance of common stock in connection with exercise of common stock options and release of vested restricted stock units, net of cash used to net settle equity awards	246	-	347	-	-	-	-	347
Stock-based compensation expense	-	-	7,096	-	-	-	-	7,096
Excess tax benefits from stock-based compensation	-	-	4,690	-	-	-	-	4,690
Change in unrealized gain on investments, net of taxes	-	-	-	-	-	-	-	-
Foreign currency translation adjustment, net of taxes	-	-	-	-	-	-	(25)	(25)
Repurchase of common stock	-	-	-	(1,938)	(25,355)	-	-	(25,355)
Net income	-	-	-	-	-	6,724	-	6,724
Balance at December 31, 2011	25,777	26	215,364	(5,894)	(81,557)	21,661	$ 180	155,674
Issuance of common stock in connection with	1,229	1	7,451	(62)	-	-	-	7,452

exercise of common stock options and release of vested restricted stock units, net of cash used to net settle equity awards								
Stock-based compensation expense	-	-	5,622	-	-	-	-	5,622
Excess tax benefits from stock-based compensation	-	-	4,466	-	-	-	-	4,466
Foreign currency translation adjustment, net of taxes	-	-	-	-	-	-	5	5
Repurchase of common stock	-	-	-	(600)	(9,434)	-	-	(9,434)
Net income	-	-	-	-	-	7,082	-	7,082
Balance at December 31, 2012	27,006	27	232,903	(6,556)	(90,991)	28,743	185	170,867
Issuance of common stock in connection with exercise of common stock options and release of vested restricted stock units, net of cash used to net settle equity awards	1,294	1	8,273	(52)	-	-	-	8,274
Stock-based compensation expense	-	-	7,802	-	-	-	-	7,802
Excess tax benefits from stock-based compensation	-	-	3,383	-	-	-	-	3,383
Foreign currency translation adjustment, net of taxes	-	-	-	-	-	-	(25)	(25)
Repurchase of common stock	-	-	-	(2,911)	(59,007)	-	-	(59,007)
Net income	-	-	-	-	-	1,723	-	1,723
Balance at December 31, 2013	28,300	$ 28	$ 252,361	(9,519)	$ (149,998)	$ 30,466	$ 160	$ 133,017

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

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EHEALTH, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)

	Year Ended December 31,		
	2011	2012	2013
Operating activities			
Net income	$ 6,724	$ 7,082	$ 1,723
Adjustments to reconcile net income to net cash provided by operating activities:			
Deferred income taxes	914	1,071	(1,368)
Depreciation and amortization	2,358	2,411	3,266
Amortization of book-of-business consideration	843	2,724	3,147
Amortization of intangible assets	2,046	1,615	1,414
Stock-based compensation expense	7,096	5,622	7,802
Deferred rent	35	176	927
Changes in operating assets and liabilities:			
Accounts receivable	3,383	3,587	(118)
Prepaid expenses and other current assets	1,769	(1,097)	(2,257)
Accounts payable	(1,948)	3,732	(1,742)
Accrued compensation and benefits	363	336	2,026
Accrued marketing expenses	2,551	(2,254)	4,285
Deferred revenue	(2,471)	979	885
Other current liabilities	(1,122)	(1,093)	957
Net cash provided by operating activities	22,541	24,891	20,947
Investing activities			
Purchases of property and equipment	(2,407)	(3,853)	(7,326)
Consideration paid in connection with book-of-business transfers	(4,190)	(6,243)	-
Net cash used in investing activities	(6,597)	(10,096)	(7,326)
Financing activities			
Net proceeds from exercise of common stock options	899	8,445	9,217
Cash used to net-share settle equity awards	(552)	(994)	(943)
Excess tax benefits from stock-based compensation	4,690	4,466	3,383
Repurchase of common stock	(25,355)	(9,434)	(59,007)
Principal payments in connection with capital leases	(63)	(43)	(53)
Net cash used in financing activities	(20,381)	2,440	(47,403)
Effect of exchange rate changes on cash and cash equivalents	(30)	7	(12)
Net increase (decrease) in cash and cash equivalents	(4,467)	17,242	(33,794)
Cash and cash equivalents at beginning of period	128,074	123,607	140,849

Cash and cash equivalents at end of period	$ 123,607	$ 140,849	$ 107,055
Supplemental disclosure of non-cash activities			
Book-of-business transfers	$ 902	$ 53	$ -
Capital lease obligations incurred	$ 71	$ 135	$ 30
Supplemental disclosure of cash flows			
Cash paid for interest	$ 16	$ 23	$ 21
Cash paid for income taxes, net of refunds	$ 1,718	$ 1,879	$ 53

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

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Note 1 – Summary of Business and Significant Accounting Policies

Description of Business—eHealth, Inc. (the "Company," "eHealth," "we" or "us") is the leading online source of health insurar for individuals, families and small businesses in the United States. Through our 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. We actively market the availability of Medicare-related insurance plans and offer Medicare plan comparison tools and educational materials for Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Our ecommerce technology also enables us to deliver consumers' health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process. We are licensed to market and sell health insurance in all 50 states and the District of Columbia.

Principles of Consolidation—The consolidated financial statements include the accounts of eHealth, Inc. and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation. The consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP").

Operating Segment—We operate in one business segment. See Note 8 – Operating Segments, Geographic Information and Significant Customers for additional information regarding our business segment.

Use of Estimates—The preparation of consolidated financial statements and related disclosures in conformity with U.S. GAAP requires management to make estimates, judgments and assumptions that affect the amounts reported and disclosed in the consolidated financial statements and accompanying notes. On an ongoing basis, we evaluate our estimates, including those related to, but not limited to, the useful lives of intangible assets, fair value of investments, fair value of our Medicare books-of-business, recoverability of intangible assets, estimates for commission forfeitures, valuation allowance for deferred income taxes, provision for income taxes, our assessment whether internal use software and website development costs will result in additional functionality and the assumptions used in determining stock-based compensation. We base our estimates of the carrying value of certain assets and liabilities on historical experience and on various other assumptions that we believe to be reasonable. Actual results may differ from these estimates.

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

Property and Equipment—Property and equipment are stated at cost, less accumulated depreciation and amortization. Capital lease amortization expenses are included in depreciation expense in our consolidated statements of comprehensive income. Depreciation and amortization is computed using the straight-line method based on estimated useful lives as follows:

Computer equipment and software	3 to 5 years
Office equipment and furniture	5 years
Leasehold improvements	Lesser of useful life (typically 5 to 10 years) or related lease term

Maintenance and minor replacements are expensed as incurred.

See Note 2 – Balance Sheet Accounts for additional information regarding our property and equipment.

Goodwill and Intangible Assets—Goodwill represents the excess of the consideration paid over the estimated fair value of assets acquired and liabilities assumed in a business acquisition. We do not amortize goodwill but test for impairment on an annual basis on or about November 30 of each year and whenever events or changes in circumstances indicate a reduction in its fair value below its carrying amount.

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

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Factors that we consider in deciding when to perform an impairment review include significant negative industry or economic trends or significant changes or planned changes in our use of the intangible assets. We measure the recoverability of assets that will continue to be used in our operations by comparing the carrying value of the asset grouping to our estimate of the related total future undiscounted net cash flows. If an asset grouping's carrying value is not recoverable through the related undiscounted cash flows, the asset grouping is considered to be impaired. The impairment is measured by comparing the difference between the asset grouping's carrying value and its fair value. Fair value is the price that would be received from selling an asset in an orderly transaction between market participants at the measurement date.

Goodwill and intangible assets are considered non-financial assets, and are recorded at fair value, subsequent to initial recognition, only when an impairment charge is recognized.

We must make subjective judgments in determining the independent cash flows that can be related to specific asset groupings. In addition, we must make subjective judgments regarding the remaining useful lives of assets with finite useful lives. When we determine that the useful life of an asset is shorter than we had originally estimated, we accelerate the rate of amortization over the assets' new, remaining useful life. We evaluated the remaining useful lives of our intangible assets with finite lives in the fourth quarter of 2013 and determined no adjustments to the remaining lives were required.

Book-of-Business Transfers—We have entered into several agreements with a broker partner, whereby the partner has transferred certain of its existing Medicare plan members to us as the broker of record on the underlying policies. The first of these book-of-business transfers occurred in November 2010 and the most recent in June 2012. Total consideration for these books-of-business amounted to $13.9 million, of which $6.3 million is related to transfers during 2012. Consideration for these books-of-business is included in Prepaid Expenses and Other Current Assets and in Other Assets in the accompanying 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 consolidated statements of comprehensive income and is presented as Amortization of Book-of-Business Consideration in the consolidated statements of cash flows as we recognize commission revenue related to the transferred Medicare plan members, over a period of up to five years. The amount of consideration we amortize to cost of revenue each quarter is proportional to the amount of commission revenue we recognize on the underlying policies each quarter. Amortization expense recorded to cost of revenue for these books-of-business for the years ended December 31, 2011, 2012 and 2013 totaled $0.8 million, $2.7 million and $3.1 million, respectively. Cash consideration paid in connection with the book-of-business transfers is presented under Investing activities in the consolidated statements of cash flows. In 2011 and 2012, we offset a portion of the total consideration against outstanding accounts receivable from the partner.

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

exceeds its fair value.

Revenue Recognition

We recognize revenue for our services when each of the following four criteria is met: persuasive evidence of an arrangement exists; delivery has occurred or services have been rendered; the seller's price to the buyer is fixed or determinable; and collectability is reasonably assured. Our revenue is primarily comprised of compensation paid to us by health insurance carriers related to insurance policies that have been purchased by a member who used our service. We define a member as an individual currently covered by an insurance plan, including individual and family, Medicare-related, small business and ancillary plans, for which we are entitled to receive compensation from an insurance carrier.

Commission Revenue—For individual and family, Medicare Supplement, small business and ancillary plans, our compensation generally represents a flat amount per member per month or a percentage of the premium amount collected by the carrier during the period that a member maintains coverage under a policy (commissions) and, to a much lesser extent, override commissions that health insurance carriers pay us for achieving certain objectives. Premium-based commissions are reported to us after the premiums are collected by the carrier, generally on a monthly basis. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. We recognize commission revenue for individual and family, Medicare Supplement, small business and ancillary plans as the commissions are reported to us by the carrier, net of an estimate for future forfeiture amounts due to policy cancellations. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier, a carrier reports to us that it has approved an application submitted through our ecommerce platform and the applicant starts making payments on the policy. Our services are

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complete when a carrier has approved an application. The seller's price is fixed or determinable and collectability is reasonably assured when commission amounts have been reported to us by a carrier.

We recognize individual and family, small business and ancillary commission override revenue when reported to us by a carrier based on the actual attainment of predetermined target sales levels or other objectives as determined by the carrier. Commission override revenue, which we recognize on the same basis as individual and family, small business and ancillary commissions, is generally reported to us in a more irregular pattern than such commissions.

For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission payment from insurance carriers once the policy is approved by the carrier and either a fixed, monthly commission payment beginning with and subsequent to the second policy year for a Medicare Advantage policy or a fixed, annual commission payment beginning with and subsequent to the second policy year for a Medicare Part D prescription drug policy. 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 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 when our commission term with the carrier expires, typically six years from the effective date of the policy, or longer depending on the carrier arrangement. We determine that there is persuasive evidence of an arrangement when we have a commission agreement with a health insurance carrier. Our services are complete when a carrier has approved an application in the initial year and when a member has renewed in a renewal year. The seller's price is fixed or determinable and collectability is reasonably assured when a carrier has approved an application and the carrier reports to us the annual or first monthly renewal commission amount for each policy year.

Commissions for all health insurance plans we sell 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 following the end of the accounting period. If the second corroborating communication is not received shortly following 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 future forfeiture amounts due to policy cancellations. As a result, we recognize the net amount of compensation earned as the agent in the transaction.

Certain commission amounts are subject to forfeiture when the policy is subsequently cancelled and either the carrier takes back all or a portion of the commission they have paid to us or we will no longer receive monthly commission payments for the remainder of the policy year. We record an estimate for these forfeitures based on our historical cancellation experience using data provided on commission statements. Policy cancellations and the commission amounts, if any, to be taken back by the carrier are typically reported to us by health insurance carriers several months after the policy's cancellation date. Our estimate for forfeitures payable to a carrier, which is included in Other Current Liabilities in the accompanying balance sheets, includes an estimate of both the reporting time lag and the forfeiture amount, based on our historical experience by policy type. Similarly, our estimate for commission amounts not expected to be collected due to policy cancellations, which is recorded as a reduction of Accounts Receivable in the accompanying balance sheets, includes an estimate of the annual policy cancellation rate, based on our historical

experience by policy type.

Other Revenue

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

Technology Licensing Revenue—Our technology licensing business allows carriers the use of our ecommerce platform to offer their own health insurance policies on their websites and agents to utilize our technology to power their online quoting, content and application submission processes. Typically, we are paid a one-time implementation fee, which we recognize on a straight-line basis over the estimated term of the customer relationship (generally the initial term of the

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agreement), commencing once the technology is available for use by the third party, and a performance fee based on metrics such as submitted health insurance applications. The metrics used to calculate performance fees for both sponsorship and advertising and technology licensing are based on performance criteria that are either measured based on data tracked by us, or based on data tracked by the third party. In instances where the performance criteria data is tracked by us, we recognize revenue in the period of performance. In instances where the performance criteria data is 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.

Medicare Lead Referral Revenue—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 sell our leads to a limited number of purchasers, and 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. We recognize lead referral revenue when persuasive evidence of an arrangement exists, delivery of a lead has occurred, the fee is fixed or determinable and collectability is reasonably assured. Delivery is deemed to have occurred at the time a lead is delivered to the customer. During the second quarter of 2012 we transitioned away from selling Medicare leads and began servicing the majority of Medicare leads we generate as a health insurance agent.

Multiple-element Arrangements—We allocate revenue to all units of accounting within an arrangement with multiple deliverables at the inception of the arrangement using the relative selling price method. The relative selling price method allocates any discount in an arrangement proportionally to each deliverable on the basis of each deliverable's relative selling price. The relative selling price established for each deliverable is based on vendor-specific objective evidence of fair value ("VSOE") if available, third-party evidence of selling price if VSOE is not available, or best estimate of selling price if neither VSOE nor third-party evidence is available. When used, the best estimate of selling price reflects our best estimates of what the selling prices of certain deliverables would be if they were sold regularly on a stand-alone basis. Our process for determining best estimate of selling price for deliverables without VSOE or third-party evidence of selling price considers multiple factors that may vary depending upon the unique facts and circumstances related to each deliverable. Key factors considered by us in developing the relative selling prices for our technology licensing fees include prices charged by us for similar offerings and our historical pricing practices. We may also consider additional factors as appropriate, including competition.

A deliverable constitutes a separate unit of accounting when it has stand-alone value and there are no customer-negotiated right of refunds for the delivered elements. If the arrangement includes a customer-negotiated right of refund relative to the delivered item, and the delivery and performance of the undelivered item is considered probable and substantially in our control, the delivered element constitutes a separate unit of accounting. In circumstances when the aforementioned criteria are not met, the deliverable is combined with the undelivered elements, and the allocation of the arrangement consideration and revenue recognition is determined for the combined unit as a single unit. Allocation of the consideration is determined at the inception of the arrangement on the basis of each unit's relative selling price. After the arrangement consideration has been allocated to each unit of accounting based on their relative selling prices, we apply revenue recognition criteria separately to each respective unit of accounting in the arrangement in accordance with applicable accounting guidance.

Deferred Revenue—Deferred revenue includes deferred technology licensing implementation fees and amounts billed for deliverables, including professional services, in multiple element arrangements that do not have stand-alone value from other, undelivered elements as well as amounts billed or collected from sponsorship or technology licensing customers in advance of our performing our service for such customers. It also includes the amount by which both unbilled and billed services provided under our technology licensing arrangements exceed the straight-line revenue recognized to date. We defer commission amounts that have been paid to us related to transactions where our services are complete, but where we cannot currently estimate future forfeitures related to those amounts.

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.

In 2011, cost of revenue also included a significant amount of direct labor and other direct costs incurred in connection with a contract with the federal government, the term of which expired in January 2012.

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Additionally, cost of revenue includes the amortization of consideration we paid to a broker partner in connection with the transfer of their Medicare-related health insurance members to us as the new broker of record on the underlying policies.

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

Marketing and Advertising Expenses—Marketing and advertising expenses consist primarily of member acquisition expenses associated with our direct, marketing partner and online advertising member acquisition channels, in addition to compensation and other expenses related to marketing, business development, partner management, public relations and carrier relations personnel who support our offerings. Advertising costs incurred in the years ended December 31, 2011, 2012 and 2013 totaled $49.2 million, $50.3 million and $63.4 million, respectively.

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

Research and Development Expenses—Research and development expenses consist primarily of compensation and related expenses incurred for enhancements to the functionality of our website. Research and development costs, which totaled $7.3 million, $8.4 million and $10.1 million for the years ended December 31, 2011, 2012 and 2013, respectively, are included in technology and content expense in the accompanying consolidated statements of comprehensive income.

Internal-Use Software and Website Development Costs—We capitalize costs of materials, consultants and compensation and benefits costs of employees who devote time to the development of internal-use software; however, we usually expense as incurred website development costs for new features and functionalities because it is not probable that they will result in additional functionality until they are both developed and tested with confirmation that they are more effective than the current set of features and functionalities on our website. Our judgment is required in determining the point at which various projects enter the phases at which costs may be capitalized, in assessing the ongoing value of the capitalized costs and in determining the estimated useful lives over which the costs are amortized, which is generally three years. To the extent that we change the manner in which we develop and test new features and functionalities related to our website, assess the ongoing value of capitalized assets or determine the estimated useful lives over which the costs are amortized, the amount of website development costs we capitalize and amortize in future periods would be impacted. During the year ended December 31, 2013, we capitalized $0.2 million in website

development costs.

Stock-Based Compensation—We recognize stock-based compensation expense in the accompanying consolidated statements of comprehensive income based on the fair value of our stock-based awards over their respective vesting periods, which is generally four years. The estimated grant date fair value of our stock options is determined using the Black-Scholes-Merton pricing model and a single option award approach. The weighted-average expected term for stock options granted is calculated using historical option exercise behavior. The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through December 31, 2013, we had not declared or paid any cash dividends, and we do not expect to pay any in the foreseeable future. We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options. The estimated attainment of performance-based awards and related expense is based on the expectations of revenue target achievement. The assumptions used in calculating the fair value of stock-based payment awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions could significantly impact the valuation of such instruments.

401(k) Plan—In September 1998, our board of directors adopted a defined contribution retirement plan (401(k) Plan), which qualifies under Section 401(k) of the Internal Revenue Code of 1986. Participation in the 401(k) Plan is available to substantially all employees in the United States. Employees can contribute up to 25% of their salary, up to the federal maximum allowable limit, on a before-tax basis to the 401(k) Plan. Employee contributions are fully vested when contributed. Company contributions to the 401(k) Plan are discretionary and are expensed when incurred. In April 2006, we

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began matching employee contributions to our 401(k) Plan at 25% of an employee's contribution each pay period, up to a maximum of 1% of the employee's salary during such pay period. Our matching contributions are expensed as incurred and vest one-third for each of the first three years of the recipient's service. The recipient is fully vested in all 401(k) Plan matching contributions after three years of service.

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

We consider stock option deduction benefits in excess of book compensation charges realized when we obtain an incremental benefit determined by the "With and Without" calculation method. Under the "With and Without" approach, excess tax benefits related to share-based payments are not deemed to be realized until after the utilization of all other tax benefits available to us. For example, net operating loss and tax credit carry forwards from prior years are used to reduce taxes currently payable prior to deductions from stock option exercises for purposes of financial reporting, while for tax return purposes, current year stock compensation deductions are generally used before net operating loss carry forwards. Indirect effects of excess tax benefits, such as the effect on research and development tax credits, are not considered.

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

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

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

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

Additionally, in preparation for the Medicare annual enrollment period, and to a lesser extent the initial open enrollment period for individual and family plans, we begin ramping up our customer care center staff during our second and third quarters to handle increased volume of health insurance transactions during the fourth quarter. Accordingly, our customer care center staffing costs are significantly higher in our third and fourth quarters compared to our first and second quarters.

Based on these seasonal trends, historically our revenue is highest in the fourth quarter of the year and our profitability is relatively higher in the first and fourth quarters and substantially lower in the third quarter of the year. The future impact of annual open enrollment periods for individual and family health insurance on our submitted applications and marketing and advertising expenses is unclear.

Recent Accounting Pronouncements—Effective January 1, 2013, we adopted an accounting standards update with new guidance on the presentation of reclassifications from accumulated other comprehensive income to net income. This

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standard requires an entity to present reclassifications from accumulated other comprehensive income to net income either on the face of the consolidated financial statements or in the notes to the consolidated financial statements. In the year ended December 31, 2013 we did not have any reclassifications from accumulated other comprehensive income to net income.

In March 2013, the Financial Accounting Standards Board ("FASB") issued an accounting standards update providing guidance with respect to the release of cumulative translation adjustments into net income when a parent sells either a part or all of its investment in a foreign entity. The update also requires the release of cumulative translation adjustments when a company no longer holds a controlling financial interest in a subsidiary or group of assets that is a business within a foreign entity, and provides guidance for the acquisition in stages of a controlling interest in a foreign entity. The standards update is effective for fiscal years beginning after December 15, 2013, with early adoption permitted. We do not believe the adoption of this standards update will have a material impact on our consolidated financial statements.

Note 2 – Balance Sheet Accounts

Cash and Cash Equivalents—As of December 31, 2012 and 2013, 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, 2012 and 2013, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the years ended December 31, 2011, 2012 and 2013.

As of December 31, 2012 and 2013, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2012	December 31, 2013
Cash	$ 27,484	$ 16,935
Money market funds	113,365	90,120
Total cash and cash equivalents	$ 140,849	$ 107,055

We used observable prices in active markets in determining the classification of our money market funds as Level 1 as of December 31, 2012 and 2013.

Concentration of Credit Risk—Our financial instruments that are exposed to concentrations of credit risk principally consist of cash, cash equivalents and accounts receivable. We invest our cash and cash equivalents with major banks and financial institutions and, at times, such investments are in excess of federally insured limits. We also have deposits with major banks in China that are denominated in both U.S. dollars and Chinese Renminbi and are not insured by the U.S. federal government.

Accounts Receivable—We do not require collateral or other security for our accounts receivable. As of December 31, 2012, four customers represented 25%, 22%, 14% and 11%, respectively, for a combined total of 72% of our $4.5 million outstanding accounts receivable balance. As of December 31, 2013, two customers represented 37% and 15%, respectively, for a combined total of 52% of our $4.6 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2012 and December 31, 2013. We believe the potential for collection issues with any of our customers was minimal as of December 31, 2013. Accordingly, our estimate for uncollectible amounts at December 31, 2013 was not material.

As of December 31, 2012 and 2013, our accounts receivable consisted of the following (in thousands):

	December 31, 2012	December 31, 2013
Accounts receivable – for other revenues	$ 3,319	$ 2,322
Commissions receivable	1,149	2,264
Total accounts receivable	$ 4,468	$ 4,586

Prepaid Expenses and Other Current Assets—Prepaid expenses and other current assets consisted of the following (in thousands):

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	As of December 31,	
	2012	2013
Book-of-business transfers, net (current)	$ 3,219	$ 2,937
Income tax receivable	1,133	1,405
Prepaid maintenance contracts (current)	1,027	1,794
Prepaid insurance	404	534
Prepaid rent	269	364
Other assets (current)	591	1,330
Prepaid expenses and other current assets	$ 6,643	$ 8,364

Property and Equipment—Property and equipment consisted of the following (in thousands):

	As of December 31,	
	2012	2013
Computer equipment and software	$ 13,393	$ 14,929
Office equipment and furniture	2,272	3,087
Leasehold improvements	1,084	3,279
Property and equipment, gross	16,749	21,295
Less accumulated depreciation and amortization	(10,564)	(11,012)
Property and equipment, net	$ 6,185	$ 10,283

Depreciation and amortization expense related to property and equipment totaled $2.4 million, $2.4 million and $3.3 million in the years ended December 31, 2011, 2012 and 2013, respectively.

Other Assets—Other assets consisted of the following (in thousands):

Non-

	As of December 31,	
	2012	2013
Book-of-business transfers, net (non-current)	$ 7,313	$ 4,447
Security deposits	506	466
Capitalized project costs	153	280
Prepaid maintenance contracts (non-current)	151	325
Other assets	$ 8,123	$ 5,518

Intangible Assets—As a result of the streamlining of a legacy software product, we assessed intangible assets for impairment in the fourth quarter of 2011 and recorded an impairment charge of $0.3 million related to certain acquired intangible assets. The impairment charge is included in Amortization of Intangible Assets on the consolidated

statements of comprehensive income and reduced the intangible assets, net carrying balance on the consolidated balance sheets.

The carrying amounts, accumulated amortization, net carrying value and weighted average remaining life of our definite-lived amortizable intangible assets, as well as our indefinite-lived non-amortizable intangible trademarks, are presented in the tables below for (dollars in thousands, weighted-average useful life is as of December 31, 2013):

	December 31, 2012			December 31, 2013			Weighted Average Useful Life
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	December 31, 2013
Technology	$ 1,752	$ (933)	$ 819	$ 1,752	$ (1,277)	$ 475	1.4 years
Pharmacy and customer relationships	10,410	(3,287)	7,123	10,410	(4,267)	6,143	6.3 years
Trade names, trademarks and website addresses	907	(245)	662	907	(336)	571	6.3 years
Total intangible assets subject to amortization	$ 13,069	$ (4,465)	8,604	$ 13,069	$ (5,880)	7,189	
Indefinite-lived trademarks			307			307	Indefinite
Intangible assets			$ 8,911			$ 7,496	

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During the years ended December 31, 2011, 2012 and 2013, amortization expense related to intangible assets totaled $2.0 million, $1.6 million and $1.4 million, respectively. Amortization expense for the year ended December 31, 2011 includes an impairment charge of $0.3 million related to certain acquired intangible assets.

As of December 31, 2013, expected amortization expense in future periods is as follows (in thousands):

Years Ending December 31,	Technology	Pharmacy and Customer Relationships	Trade Names, Trademarks and Website Addresses	Total
2014	345	979	91	1,415
2015	118	979	91	1,188
2016	5	979	91	1,075
2017	5	979	91	1,075
2018	2	959	91	1,052
Thereafter	-	1,268	116	1,384
Total	$ 475	$ 6,143	$ 571	$ 7,189

Other Current Liabilities—Other current liabilities consisted of the following (in thousands):

	As of December 31,	
	2012	2013
Payable to carriers – estimate for forfeitures	$ 1,245	$ 1,860
Professional fees	154	380
Other accrued expenses	176	321
Total other current liabilities	$ 1,575	$ 2,561

Non-current Liabilities—Non-current liabilities consisted of the following (in thousands):

	As of December 31,	
	2012	2013
Deferred rent – non-current	$ 301	$ 1,210
Income tax payable – non-current	3,860	4,493
Other non-current liabilities	464	462
Total non-current liabilities	$ 4,625	$ 6,165

Note 3 – Fair Value Measurements

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

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

As of December 31, 2012 and 2013, our cash equivalents were invested in money market funds and were classified as Level 1. We endeavor to utilize the best available information in measuring fair value. We used observable prices in active markets in determining the classification of our money market funds as Level 1.

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The determination of fair value of the acquired book-of-business for which a $0.4 million impairment charge was recorded during 2012 was classified as a Level 3 fair value assessment because of the use of unobservable inputs in the calculation. We utilized an income approach, under which the fair value of the book of business was determined based on the present value of the estimated future cash flows using the expected present value technique. Under the expected present value technique possible cash flows are probability-weighted to determine an expected cash flow. The discount rate used was adjusted from a risk-free rate to reflect a market risk premium. The unobservable inputs used to calculate the fair value of the book-of-business included the projected cash flows and the market risk premium added to the discount rate. We determined that the fair value of the impaired Medicare book-of-business asset was $1.3 million as of December 31, 2012.

Note 4 – Stockholders' Equity

Preferred Stock—Our board of directors has the authority, without any further action by our stockholders, to issue up to 110,000,000 shares, par value $0.001 per share, of which 10,000,000 shares are designated as preferred stock. As of December 31, 2012 and 2013, there were no shares of preferred stock outstanding.

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

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

	As of December 31,	
	2012	2013
Common stock:		
Stock options issued and outstanding	2,956	1,979
Restricted stock units issued and outstanding	381	779
Shares available for grant	3,982	4,085

Total shares reserved	7,319	6,843

Stock Plans—Our 2006 Equity Incentive Plan (the "2006 Plan") became effective in October 2006. In general, if options or shares awarded under the 2006 Plan are forfeited or repurchased, those options or shares will again become available for grant under the 2006 Plan. In addition, on January 1 of each year, the number of shares available for future grant under the 2006 Plan will automatically increase by the lowest of (a) 1,500,000 shares, (b) 4% of the total number of shares of our common stock then outstanding or (c) a lower number determined by our board of directors or its compensation committee. Employees, non-employee members of our board of directors and consultants of our company are eligible to participate in our 2006 Plan. The 2006 Plan requires that the exercise price of stock options and stock appreciation rights awarded shall in no event be less than 100% of the fair market value of a share of common stock on the date of grant.

We also maintain the 1998 Stock Plan and the 2005 Stock Plan, under which we previously granted options to purchase shares of our common stock and restricted common stock. The 1998 and 2005 Stock Plans were terminated with respect to the grant of additional awards upon the effective date of the registration statement related to our initial public offering in October 2006, although we will continue to issue new shares of common stock upon the exercise of stock options previously granted under the 1998 and 2005 Stock Plans.

Our stock options and restricted stock awards granted under the 2006 Plan and the 1998 and 2005 Stock Plans (collectively, the "Stock Plans") generally vest over four years at a rate of 25% after one year and 1/48th per month thereafter. Our stock options granted prior to December 31, 2007 generally expire after ten years from the date of grant. Stock options granted subsequent to December 31, 2007 generally expire after seven years from the date of grant. As of

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December 31, 2013, no shares were subject to repurchase. Our restricted stock unit awards granted under the 2006 Plan generally vest over four years at a rate of 25% after one year and 25% annually thereafter.

In 2011, 2012 and 2013, we issued restricted stock units with both service and performance-based vesting criteria to our executive officers. The performance-based contingency period for our restricted stock units with both service and performance-based vesting criteria granted in the fiscal years 2011 and 2012 were the fiscal years ending December 31, 2011 and 2012, respectively, and the measurement of achievement was based on our revenue, non-GAAP operating earnings and EBITDA results for the fiscal years ending December 31, 2011 and 2012, respectively. The performance-based contingency period for our restricted stock units with both service and performance-based vesting criteria granted in the fiscal year 2013 is the fiscal years ending December 31, 2013 and 2014, and the measurement of achievement is based on our revenue results for the fiscal years ending December 31, 2013 and 2014. The amount of expense recorded for the performance-based restricted stock units is based on expected attainment of performance criteria and is expensed over the respective service period of the awards. Our performance-based restricted stock units are granted pursuant to the terms of our 2006 Plan. Shares earned and eligible to vest will vest one-third annually following the performance-based contingency period for performance-based restricted stock units granted in 2011 and 2012. Shares earned and eligible to vest will vest annually during a four year service period following the performance-based contingency period for performance-based restricted stock units granted in 2013.

The following table summarizes activity under our Stock Plans (in thousands):

	Shares Available for Grant (1)
Shares available for grant December 31, 2010	3,283
Reduction in number of authorized shares (2)	(5)
Additional shares authorized (3)	863
Restricted stock units granted (4)	(323)
Options granted	(278)
Restricted stock units cancelled (5)	79
Options cancelled	251
Shares available for grant December 31, 2011	3,870
Reduction in number of authorized shares (2)	(2)
Additional shares authorized (3)	795
Restricted stock units granted (4)	(265)
Options granted	(846)
Restricted stock units cancelled (5)	121
Options cancelled	309
Shares available for grant December 31, 2012	3,982
Additional shares authorized (3)	818
Restricted stock units granted (4)	(595)
Options granted	(227)
Restricted stock units cancelled (5)	24

Options cancelled	83
Shares available for grant December 31, 2013	4,085

(1) Shares available for grant do not include treasury stock shares that could be granted if we determined to do so.
(2) The 1998 and 2005 Stock Plans were terminated with respect to the grant of additional shares upon the effective date of the registration statement related to our initial public offering in October 2006, resulting in reductions in the total number of shares authorized for issuance.
(3) On January 1, 2011, 2012 and 2013, 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.
(4) 2011, 2012 and 2013 include grants of restricted stock units with both service and performance-based vesting criteria to our executive officers.
(5) 2011, 2012 and 2013 include cancelled restricted stock units with both service and performance-based vesting criteria.

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

	Number of Stock Options	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding at December 31, 2010	3,491	$ 11.62	4.69	$ 16,349
Granted	278	$ 12.93		
Exercised	(106)	$ 8.50		$ 638
Cancelled	(251)	$ 17.93		
Balance outstanding at December 31, 2011	3,412	$ 11.36	3.80	$ 17,078
Granted	846	$ 17.76		
Exercised	(993)	$ 8.51		$ 10,512
Cancelled	(309)	$ 18.39		
Balance outstanding at December 31, 2012	2,956	$ 13.41	3.91	$ 41,642
Granted	227	$ 28.82		
Exercised	(1,121)	$ 8.22		$ 22,486
Cancelled	(83)	$ 18.40		
Balance outstanding at December 31, 2013	1,979	$ 17.91	4.20	$ 56,569
Vested and expected to vest after December 31, 2013	1,919	$ 17.80	4.15	$ 55,046
Exercisable at December 31, 2013	1,202	$ 16.27	3.32	$ 36,322

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

The total fair value of stock options vested during the years ended December 31, 2011, 2012 and 2013 was $4.6 million, $2.4 million and $3.3 million, respectively. As of December 31, 2013, there was $5.5 million of unrecognized stock-based compensation expense related to unvested stock options, which is expected to be recognized over the next 2.9 years.

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

	Number of Restricted Stock Units (1)	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (2)
Balance outstanding at December 31, 2010	370	$ 17.80	2.22	$ 4,816
Granted	323	$ 12.55		
Vested	(140)	$ 17.59		
Cancelled	(79)	$ 16.06		
Balance outstanding at December 31, 2011	474	$ 14.72	1.92	$ 6,958
Granted	265	$ 17.61		
Vested	(237)	$ 15.49		
Cancelled	(121)	$ 14.04		
Balance outstanding at December 31, 2012	381	$ 16.21	2.22	$ 10,464
Granted	595	$ 20.73		
Vested	(173)	$ 15.78		
Cancelled	(24)	$ 17.33		
Balance outstanding at December 31, 2013	779	$ 19.57	2.30	$ 36,220

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(1) Includes restricted stock units with both service and performance-based vesting criteria granted to our executive officers.
(2) The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31 multiplied by the number of restricted stock units outstanding.

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 years ended December 31, 2011, 2012 and 2013 was $1.8 million, $3.8 million and $3.5 million, respectively. As of December 31, 2013, there was $10.7 million of unrecognized stock-based compensation expense related to restricted stock units, which is expected to be recognized over the next 2.3 years.

Stock Repurchase Programs—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. Repurchases under this program began in the third quarter of 2011. Purchases under the repurchase program were made in the open market and complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. In February 2012, we completed this stock repurchase program, having repurchased in aggregate 2.2 million shares for approximately $30 million at an average price of $13.78 per share including commissions. The cost of the repurchased shares was funded from available working capital.

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

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

Stock repurchase activity under our stock repurchase programs during the year ended December 31, 2011, 2012 and 2013 is summarized as follows (dollars in thousands, except share and per share amounts):

	Total Number of Shares Purchased	Average Price Paid per Share (1)	Amount of Repurchase
Cumulative balance at December 31, 2010	3,904,652	$ 14.39	$ 56,203
Repurchases of common stock during 2011	1,893,154	$ 13.39	25,354
Cumulative balance at December 31, 2011	5,797,806	$ 14.07	81,557
Repurchases of common stock during 2012	599,997	$ 15.72	9,434
Cumulative balance at December 31, 2012	6,397,803	$ 14.22	90,991
Repurchases of common stock during 2013	2,911,466	$ 20.27	59,007
Cumulative balance at December 31, 2013	9,309,269	$ 16.11	$ 149,998

(1) Average price paid per share includes commissions.

In addition to the shares repurchased under our repurchase programs as of December 31, 2013, we have in treasury an additional 210,017 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2012 and 2013, we had a total of 6,556,303 shares and 9,519,286 shares, respectively, held in treasury.

Stock-Based Compensation—The fair value of stock options granted to employees for the years ended December 31, 2011, 2012 and 2013 was estimated using the following weighted average assumptions:

	Year Ended December 31,		
	2011	2012	2013
Expected term	4.6 years	4.6 years	4.3 years

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Expected volatility	49.3%	43.9%	39.3%
Expected dividend yield	0%	0%	0%
Risk-free interest rate	1.74%	0.85%	0.96%
Weighted-average grant date fair value	$ 5.51	$ 6.65	$ 9.52

The following table summarizes stock-based compensation expense recorded during the years ended December 31, 2011, 2012 and 2013 (in thousands):

	Year Ended December 31,		
	2011	2012	2013
Common stock options	$ 3,712	$ 2,787	$ 2,817
Restricted stock units	3,384	2,835	4,985
Total stock-based compensation expense	$ 7,096	$ 5,622	$ 7,802

The following table summarizes stock-based compensation expense by operating function for the years ended December 31, 2011, 2012 and 2013 (in thousands):

	Year Ended December 31,		
	2011	2012	2013
Marketing and advertising	$ 962	$ 1,215	$ 2,112
Customer care and enrollment	344	321	342
Technology and content	1,669	1,021	1,641
General and administrative	4,121	3,065	3,707
Total stock-based compensation expense	$ 7,096	$ 5,622	$ 7,802

Note 5 – Income Taxes

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

	Year Ended December 31,		
	2011	2012	2013
United States	$ 13,327	$ 13,475	$ 3,412
Foreign	(143)	(23)	228
Income before provision for income taxes	$ 13,184	$ 13,452	$ 3,640

The provision (benefit) for income taxes consisted of the following (in thousands):

	Year Ended December 31,		
	2011	2012	2013
Current:			
Federal	$ 5,179	$ 5,009	$ 3,650
State	828	373	269
Total current	6,007	5,382	3,919
Deferred:			
Federal	620	819	(1,914)
State	(167)	169	(88)
Total deferred	453	988	(2,002)
Provision for income taxes	$ 6,460	$ 6,370	$ 1,917

The following table provides a reconciliation of the federal statutory income tax rate to our effective tax rate:

Year Ended December 31,		
2011	2012	2013

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Federal statutory rate	35.0%	35.0%	35.0%
State income taxes	3.0	3.5	3.9
Non-qualified stock option shortfalls, net	3.7	6.5	—
Lobbying	7.0	4.7	17.4
Research and development tax credits	(0.5)	—	(8.8)
Stock-based compensation	0.7	0.4	1.2
Section 162(m) limitation	—	0.2	2.3
Other	0.1	(2.9)	1.7
Effective tax rate	49.0%	47.4%	52.7%

Our effective tax rates in 2011, 2012 and 2013 were higher than statutory federal and state tax rates primarily due to non-deductible lobbying expenses and for 2011 and 2012, tax shortfalls related to share-based payments.

Deferred income taxes reflect the net tax effects of temporary differences between the carrying amounts of assets and liabilities for financial reporting purposes and the amounts used for income tax purposes, together with net operating loss and tax credit carry forwards. Significant components of our deferred tax assets were as follows (in thousands):

	As of December 31,	
	2012	2013
Deferred tax assets:		
Federal, state and foreign net operating loss carry forwards	$ 2,995	$ 1,953
Federal and state tax credit carry forwards	507	599
Stock-based compensation	3,963	4,584
Accruals and reserves	2,293	2,953
Intangible assets	1,175	1,969
Other	831	905
Gross deferred tax assets	11,764	12,963
Valuation allowance	(612)	(595)
Total deferred tax assets	11,152	12,368
Deferred tax liabilities – intangible assets	(3,125)	(2,617)
Deferred tax liabilities – fixed assets	(1,001)	(723)
Total net deferred tax assets	$ 7,026	$ 9,028
Net deferred tax assets – current	$ 4,098	$ 4,459
Net deferred tax assets – non-current	2,928	4,569
Total net deferred tax assets	$ 7,026	$ 9,028

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

taxable income change.

The changes in our net valuation allowance for the years ended December 31, 2012 and 2013 were not material.

For tax return purposes, we had net operating loss carry forwards at December 31, 2013 of approximately $9.1 million and $70.9 million for federal income tax and state income tax purposes, respectively. Included in the state net operating loss carry forward are unrealized state net operating loss deductions resulting from stock option exercises of approximately $59.4 million. The benefit of these unrealized stock option-related deductions has not been included in the deferred tax assets table above and will be recognized as a credit to additional paid-in capital when realized. Federal and state net operating loss carry forwards begin expiring in 2023 and 2016, respectively. The federal net operating loss carry forward is subject to an annual limitation of approximately $2.5 million due to section 382 of the Internal Revenue Code. Approximately $2.5 million of the state net operating loss carry forward is subject to an annual limitation of approximately $0.1 million due to section 382 of the Internal Revenue Code.

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In September 2008, the state of California approved its budget for fiscal year ending June 30, 2009, which contained changes to the California tax law which substantially limited our ability to utilize available state net operating loss and tax credit carry forwards to reduce our state income taxes payable. In October 2010, the state of California approved its budget for fiscal year ending June 30, 2011, which again contained changes to the California tax law which substantially limited our ability to utilize available state net operating loss carry forwards to reduce our state income taxes payable. The changes in the California tax law did not impact our effective tax rates for 2011, 2012 and 2013, nor will they affect the amount of net operating loss or tax credit carry forwards that we expect to ultimately use to offset future California taxes, but the changes did limit the amount of net operating loss carry forwards we were able to utilize to reduce our taxes payable during 2011. As a result, we experienced an increase in cash taxes payable to the state of California during the year ended December 31, 2011.

During the years ended December 31, 2011, 2012 and 2013 we utilized excess tax benefits related to share-based payments, which resulted in a decrease in cash generated from operating activities and a corresponding increase in cash generated from financing activities of $4.7 million, $4.5 million and $3.4 million for the years ended December 31, 2011, 2012 and 2013, respectively.

At December 31, 2013, we had tax credit carry forwards of approximately $1.6 million and $1.2 million for federal income tax and state income tax purposes, respectively. Federal tax credit carry forwards begin expiring in 2020 and state tax credits carry forward indefinitely.

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

	Unrecognized Tax Benefits
Balance at December 31, 2010	$ 3,287
Increases based on tax positions related to the prior year	23
Additions based on tax positions related to the current year	989
Settlements	—
Balance at December 31, 2011	4,299
Decreases based on tax positions related to the prior year	(45)
Additions based on tax positions related to the current year	296
Settlements	—
Balance at December 31, 2012	4,550
Increases based on tax positions related to the prior year	223
Lapse of statute of limitations	(66)
Additions based on tax positions related to the current year	890
Settlements	—
Balance at December 31, 2013	$ 5,597

As of December 31, 2012 and 2013, there were $3.7 million and $4.6 million, respectively, of unrecognized tax benefits, that, if recognized, would impact the effective tax rate.

All tax years after 1998 are open to examination and adjustment due to our net operating losses.

The Company’s 2009 and 2010 California income tax returns have been selected for audit by the Franchise Tax Board.

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Note 6 – 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):

	Year Ended December 31,		
	2011	2012	2013
Basic:			
Numerator:			
Net income allocated to common stock	$ 6,724	$ 7,082	$ 1,723
Denominator:			
Net weighted average number of common stock shares outstanding	20,947	19,867	19,145
Net income per share—basic:	$ 0.32	$ 0.36	$ 0.09
Diluted:			
Numerator:			
Net income allocated to common stock	$ 6,724	$ 7,082	$ 1,723
Denominator:			
Net weighted average number of common stock shares outstanding	20,947	19,867	19,145
Weighted average number of options	693	774	548
Weighted average number of restricted stock units	63	112	153
Total common stock shares used in per share calculation	21,703	20,753	19,846
Net income per share—diluted:	$ 0.31	$ 0.34	$ 0.09

For each of the years ended December 31, 2011, 2012 and 2013, 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):

	Year Ended December 31,		
	2011	2012	2013
Common stock options	1,833	1,276	92
Restricted stock units	85	4	6
Total	1,918	1,280	98

Note 7 – Commitments and Contingencies

Operating Lease Obligations

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

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

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

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

Total rent expense under all operating leases was approximately $4.0 million, $4.3 million and $4.8 million for the years ended December 31, 2011, 2012 and 2013, respectively.

Service and Licensing Obligations

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

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and contractual service and licensing obligations as of December 31, 2013 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2014	$ 4,063	$ 1,055	$ 5,118
2015	2,725	245	2,970
2016	2,771	-	2,771
2017	2,762	-	2,762
2018	1,938	-	1,938
Thereafter	4,565	-	4,565
Total	$ 18,824	$ 1,300	$ 20,124

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 have become, and may in the future become, involved in litigation in the ordinary course of our business. If we are found to have violated laws or regulations in any of the states, we could be subject to various fines and penalties, including revocation of our license to sell insurance in those states, and our business and financial results would be harmed. We would also be harmed to the extent that related publicity damages our reputation as a trusted source of objective information relating to health insurance and its affordability. It could also be costly to defend ourselves regardless of the outcome. At December 31, 2012 and 2013, we were not involved in any claims against us that were material and, accordingly, did not record any related liabilities as of December 31, 2012 and 2013.

Guarantees and Indemnifications—We have agreed to indemnify members of our board of directors and our executive officers for fees, expenses, judgments, fines and settlement amounts incurred in any action or proceeding, including actions or proceedings by or in the right of the Company, to which any of them is, or is threatened to be, made a party by reason of

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their service as a director or officer of the Company or service provided to another company or enterprise at our request. The term of the director and officer indemnification is perpetual as to events or occurrences that take place while the director or officer is, or was, serving at our request. As such, the maximum potential amount of future payment we could be required to make under these indemnification arrangements is unlimited. We, however, maintain directors and officers insurance coverage that limits our exposure under certain circumstances and that may allow us to recover a portion of future amounts paid. Accordingly, we have not recorded any liabilities for these agreements as of December 31, 2012 or 2013.

While we have made various guarantees included in contracts in the normal course of business, primarily in the form of indemnity obligations under certain circumstances, these guarantees do not represent significant commitments or contingent liabilities of the indebtedness of others. Accordingly, we have not recorded a liability related to these indemnification provisions.

Note 8 – Operating Segments, Geographic Information and Significant Customers

Operating Segments— Operating segments are defined as components of an enterprise about which separate financial information is available that is evaluated regularly by the chief operating decision maker, or decision making group, in deciding how to allocate resources and in assessing performance of the Company. We operate in one segment and accordingly we have provided only enterprise-wide disclosures. Our chief executive officer, who is our chief operating decision maker, reviews our financial information in a similar manner.

Geographic Information—As of December 31, 2012 and 2013, 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):

	December 31, 2012	December 31, 2013
United States	$ 37,037	$ 37,046
China	278	347
Total	$ 37,315	$ 37,393

Significant Customers—Substantially all revenue for the years ended December 31, 2011, 2012 and 2013 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue for the years ended December 31, 2011, 2012 and 2013 are presented in the table below:

	Year Ended December 31,		
	2011	2012	2013
Humana	8 %	18 %	21 %
WellPoint (1)	11 %	13 %	12 %
UnitedHealthcare (2)	13 %	12 %	11 %
Aetna (3)	8 %	8 %	10 %

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

Commission revenue attributable to major medical individual and family health insurance plans was approximately 86%, 75% and 69% of our total commission revenue in the years ended December 31, 2011, 2012 and 2013, 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, small business or other ancillary products such as short-term, stand-alone dental, life, accident, vision, travel and student insurance plan offerings.

Note 9 – Selected Quarterly Financial Data (Unaudited)

Selected summarized quarterly financial information for 2013 and 2012 is as follows (in thousands, except per share amounts):

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2013	1st Quarter	2ND Quarter	3RD Quarter	4TH Quarter	Year
Revenue	$ 43,207	$ 39,800	$ 42,008	$ 54,165	$ 179,180
Income (loss) from operations	3,941	2,031	403	(2,644)	3,732
Net income (loss)	2,361	1,146	174	(1,960)	1,723
Net income (loss) per share:					
Basic	$ 0.11	$ 0.06	$ 0.01	$ (0.11)	$ 0.09
Diluted	$ 0.11	$ 0.06	$ 0.01	$ (0.11)	$ 0.09

2012	1st Quarter	2ND Quarter	3RD Quarter	4TH Quarter	Year
Revenue	$ 37,075	$ 35,507	$ 37,586	$ 45,305	$ 155,473
Income from operations	3,909	4,135	1,075	4,310	13,429
Net income	2,125	2,305	205	2,447	7,082
Net income per share:					
Basic	$ 0.11	$ 0.12	$ 0.01	$ 0.12	$ 0.36
Diluted	$ 0.10	$ 0.11	$ 0.01	$ 0.11	$ 0.34

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

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures 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 Annual Report on Form 10-K.

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

Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Securities Exchange Act of 1934, as amended. Under

the supervision and with the participation of our management, including our chief executive officer and chief financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting as of December 31, 2013 based on the guidelines established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (1992 framework). Our internal control over financial reporting includes policies and procedures that provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with U.S. generally accepted accounting principles.

Based on the results of our evaluation, our management concluded that our internal control over financial reporting was effective as of December 31, 2013. We reviewed the results of management's assessment with our Audit Committee.

Ernst & Young LLP, our independent registered public accounting firm, has issued a report on the Company's internal control over financial reporting as of December 31, 2013, which is presented below.

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the three months ended December 31, 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our chief executive officer and chief financial officer, believes that our disclosure controls and our internal control over financial reporting are designed to provide reasonable assurance of achieving their objectives and are effective at the reasonable assurance level. However, our management does not expect that our disclosure controls or our internal control over financial reporting will prevent all errors and all fraud. A control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that all control issues and instances of fraud, if any, have been detected. These

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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.

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Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders of eHealth, Inc.

We have audited eHealth, Inc.'s internal control over financial reporting as of December 31, 2013, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (1992 framework) (the COSO criteria). eHealth, Inc.'s management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

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

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

In our opinion, eHealth, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of eHealth, Inc. as of December 31, 2013 and 2012, and the related consolidated statements of comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2013 of eHealth, Inc. and our report dated March 12, 2014 expressed an unqualified opinion thereon.

/s/ Ernst & Young LLP

Redwood City, California

March 12, 2014

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ITEM 9B. OTHER INFORMATION

None.

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PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information concerning our directors, executive officers, compliance with Section 16(a) of the Securities Exchange Act of 1934, as amended, and corporate governance required by this Item 10 of Form 10-K is incorporated by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2013.

We have adopted a code of ethics that applies to all employees, including our principal executive officer, Gary Lauer, principal financial and accounting officer, Stuart Huizinga, and all other executive officers. The code of ethics is available on the about us/investor relations/corporate governance page of our website at www.eHealth.com. A copy may also be obtained without charge by contacting investor relations, attention Director of Investor Relations, 440 East Middlefield Road, Mountain View, CA 94043 or by calling (650) 210-3111.

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

ITEM 11. EXECUTIVE COMPENSATION

The information required by Item 11 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2013.

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

As of December 31, 2013, one of our directors is party to individual Rule 10b5-1 trading plans pursuant to which shares of our common stock will be sold for their account from time to time in accordance with the provisions of the plans without any further action or involvement by the director.

Additional information required by Item 12 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2013.

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

The information required by Item 13 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2013.

ITEM 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by Item 14 of Form 10-K is incorporated herein by reference from the information contained in the Definitive Proxy Statement for the Annual Meeting of Stockholders, which is expected to be filed within 120 days after the Company's fiscal year ended December 31, 2013.

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PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

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

1. Consolidated Financial Statements

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

2. Financial Statement Schedules

None.

3. Exhibits

See Item 15(b) below.

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

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

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SIGNATURES

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

March 12, 2014

eHealth, Inc.

/ s / GARY L. LAUER	/ s / STUART M. HUIZINGA
Gary L. Lauer	Stuart M. Huizinga
Chief Executive Officer	Chief Financial Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities indicated on the 12th day of March, 2014.

Signature	Title
/s/ GARY L. LAUER Gary L. Lauer	Chief Executive Officer (Principal Executive Officer) and Chairman of the Board of Directors
/s/ STUART M. HUIZINGA Stuart M. Huizinga	Chief Financial Officer (Principal Financial and Accounting Officer)
/s/ SCOTT N. FLANDERS Scott N. Flanders	Director
/s/ MICHAEL D. GOLDBERG	Director

Michael D. Goldberg	
/s/ LAWRENCE M. HIGBY Lawrence M. Higby	Director
/s/ RANDALL S. LIVINGSTON Randall S. Livingston	Director
/s/ JACK L. OLIVER III Jack L. Oliver III	Director
/s/ ELLEN O. TAUSCHER Ellen O. Tauscher	Director
/s/ WILLIAM T. SHAUGHNESSY William T. Shaughnessy	Director

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EXHIBIT INDEX

Exhibit		Incorporation by Reference Herein Form	Date
Number	Description of Exhibit		
3.1	Amended and Restated Certificate of Incorporation of the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
3.2	Amended and Restated Bylaws of the Registrant	Current Report on Form 8 K (File No. 001-33071)	November 17, 2008
4.1	Form of the Registrant's Common Stock Certificate	Registration Statement on Form S-l, as amended (File No. 333-133526)	June 28, 2006
10.1	Form of Indemnification Agreement entered into between the Registrant and its directors and officers	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.2*	1998 Stock Plan of the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.3	2004 Stock Plan for eHealth China	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.4*	2005 Stock Plan of the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.5*	2006 Equity Incentive Plan of the Registrant, as amended and restated June 15, 2010	Current Report on Form 8 K (File No. 001-33071)	June 21, 2010
10.5.1*	Form of Notice of Stock Option Grant and Stock Option Agreement under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.5.2*	Form of Notice of Stock Option Grant and Stock Option Agreement (Initial Director Grant) under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.5.3*	Form of Notice of Stock Option Grant and Stock Option Agreement (Annual Director Grant) under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.5.4*	Form of Notice of Stock Unit Grant and Stock Unit Agreement under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 21, 2007
10.5.5*	Form of Notice of Initial Outside Director Stock Unit Grant Under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009
10.5.6*	Form of Notice of Annual Outside Director Stock Unit Grant Under the 2006 Equity Incentive Plan of the Registrant	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009
10.5.7*	Form of Outside Director Stock Unit Agreement	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009

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10.5.8*	Form of Notice of Stock Unit Grant and Stock Unit Agreement (Performance-Based Vesting) under the 2006 Equity Incentive Plan of the Registrant	Quarterly Report on Form 10-Q (File No. 001-33071)	May 6, 2011
10.5.9*	Form of Notice of Stock Unit Grant and Stock Unit Agreement under the 2006 Equity Incentive Plan of the Registrant	Quarterly Report on Form 10-Q (File No. 001-33071)	May 7, 2013
10.6*	Employment Agreement, dated November 30, 1999, between Gary Lauer and eHealthInsurance Services, Inc.	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.6.1*	Letter Amendment, dated November 2007, amending Offer Letter dated November 30, 1999, between Gary Lauer and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	November 14, 2007
10.6.2*	Second Amendment to Offer Letter, dated December 27, 2008, amending Offer Letter dated November 30, 1999, as amended, between Gary Lauer and eHealthInsurance Services, Inc.	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2009
10.6.3*	Management Retention Agreement, effective as of March 4, 2010, between eHealth, Inc. and Gary L. Lauer	Quarterly Report on Form 10-Q (File No. 001-33071)	May 10, 2010
10.7*	Employment Agreement, dated May 4, 2000, between Stuart Huizinga and eHealthInsurance Services, Inc., as amended on August 22, 2000	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.8*	Letter Agreement, dated November 17, 2005, between Jack L. Oliver III and the Registrant	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.9	Lease Agreement, dated May 2004, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust, as amended	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.9.1	First Amendment to Lease Agreement, effective as of May 15, 2009, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Current Report on Form 8 K (File No. 001-33071)	May 21, 2009

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10.9.2	Second Amendment to Lease Agreement, effective as of August 5, 2010 between eHealth Insurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Investments Trust	Current Report on Form 8 K (File No. 001-33071)	August 18, 2010
10.9.3	Third Amendment to Lease Agreement, effective as of July 8, 2011, between eHealthInsurance Services, Inc. and Brian Avery, Trustee of the 1983 Avery Generations Trust	Current Report on Form 8-K (File No. 001-33071)	July 12, 2011
10.10	Standard Lease Agreement, dated June 10, 2004, between eHealthInsurance Services, Inc. and Gold Pointe E LLC, as amended	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.10.1	Fourth Amendment to Standard Lease Agreement (Office), effective as of November 6, 2007, between eHealthInsurance Services, Inc. and Carlsen Investments, LLC	Current Report on Form 8-K (File No. 001-33071)	November 7, 2007
10.10.2	Sixth Amendment to Lease and Acknowledgment to Standard Lease Agreement, dated August 29, 2012, between Carlsen Investments, LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	August 31, 2012
10.11	Office Lease Contract, dated March 31, 2006, among Xiamen Torch Hi-tech Industrial Development Zone Finance Services Center, Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.; Appendix 1 to Office Lease Contract; and Property Management Service Contract, dated April 4, 2006, between Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Registration Statement on Form S-l, as amended (File No. 333-133526)	April 25, 2006
10.11.1	Appendix 3 to Office Lease Contract, dated November 25, 2007, among Xiamen Torch Hi-tech Industrial Development Zone Finance Services Center, Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Annual Report on Form 10-K (File No. 001-33071)	March 17, 2008

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10.11.2	Amendment Two to Property Management Service Contract, effective January 16, 2008, between Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Annual Report on Form 10-K (File No. 001-33071)	March 17, 2008
10.11.3	Appendix 4 to Office Lease Contract, dated March 27, 2008, among Xiamen Torch Hi-tech Industrial Development Zone Finance Services Center, Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Quarterly Report on Form 10-Q (File No. 001-33071)	May 12, 2008
10.11.4	Appendix 5 to Office Lease Contract, dated May 19, 2009, among Xiamen Torch Hi-tech Industrial Development Zone Finance Services Center, Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Current Report on Form 8 K (File No. 001-33071)	May 21, 2009
10.11.5	Office Lease Contract, dated September 23, 2009, among Xiamen Torch Hi-tech Industrial Development Zone Finance Services Center, Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Quarterly Report on Form 10-Q (File No. 001-33071)	November 9, 2009
10.11.6	Property Management Service Contract, effective September 24, 2009, between Xiamen Software Industry Investment & Development Co., Ltd. and eHealth China (Xiamen) Technology Co., Ltd.	Quarterly Report on Form 10-Q (File No. 001-33071)	November 9, 2009
10.12*	Executive Bonus Plan 2012	Quarterly Report on Form 10-Q (File No. 001-33071)	May 8, 2012
10.12.1*	Executive Bonus Plan 2013	Quarterly Report on Form 10-Q (File No. 001-33071)	May 7, 2013
10.13*	eHealth, Inc. Performance Bonus Plan	Definitive Proxy Statement on Schedule 14A (File No. 001-33071)	April 21, 2009
10.14	Lease Agreement, dated March 23, 2012, between 340 Middlefield, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	March 27, 2012

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10.14.1	First Amendment to Lease Agreement, effective as of May 28, 2013, between 340 Middlefield, LLC and eHealth, Inc.	Current Report on Form 8-K (File No. 001-33071)	May 7, 2013
10.15*	Employment Agreement, dated March 9, 2012, between eHealth, Inc. and William Shaughnessy.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 9, 2012
10.16	Office Lease, dated May 7, 2012, between Lake Pointe Three, LC, and eHealthInsurance Services, Inc.	Quarterly Report on Form 10-Q (File No. 001-33071)	August 9, 2012
10.17	Supplemental Agreement, effective as of April 1, 2013, between eHealth China (Xiamen) Technology Co., Ltd. And Xiamen Software Industry Investment & Development Co., Ltd.	Current Report on Form 8-K (File No. 001-33071)	May 15, 2013
21.1	‡List of Subsidiaries	Annual Report on Form 10-K (File No. 001-33071)	March 13, 2013
23.1	†Consent of Independent Registered Public Accounting Firm		
31.1	†Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a 14(a) and 15d 14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002		
31.2	†Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a 14(a) and 15d 14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002		
32.1	‡Certification of 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.

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