eHealth, Inc.
Form 10-Q
August 07, 2018
UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549

FORM 10-Q

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

For the quarterly period ended June 30, 2018

OR

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

For the transition period from to

001-33071
(Commission File Number)

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

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulations S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required

to submit and post such files). YES NO

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

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

The number of shares of the registrant’s common stock, par value $0.001 per share, outstanding as of July 31, 2018 was 19,175,834 shares.

Table of Contents

EHEALTH, INC. FORM 10-Q
TABLE OF CONTENTS

Table of Contents

PART I

FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(in thousands, unaudited)

	December 31, 2017 (Note 1)	June 30, 2018
Assets		
Current assets:		
Cash and cash equivalents	$40,293	$30,774
Accounts receivable	1,475	846
Commissions receivable - current	109,666	88,246
Prepaid expenses and other current assets	4,305	5,441
Total current assets	155,739	125,307
Commissions receivable - non-current	169,751	179,150
Property and equipment, net	4,705	4,640
Other assets	7,287	9,035
Intangible assets, net	7,540	13,342
Goodwill	14,096	40,233
Total assets	$359,118	$371,707
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	$3,246	$2,154
Accrued compensation and benefits	15,498	12,032
Accrued marketing expenses	4,693	2,742
Earnout liability - current	—	15,766
Other current liabilities	2,008	3,523
Total current liabilities	25,445	36,217
Earnout liability - non-current	—	14,434
Deferred income taxes - non-current	45,089	38,607
Other non-current liabilities	1,920	2,197
Stockholders' equity:		
Common stock	30	30
Additional paid-in capital	281,706	292,159
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	204,725	187,866
Accumulated other comprehensive income	201	195
Total stockholders' equity	286,664	280,252
Total liabilities and stockholders' equity	$359,118	$371,707

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017 (Note 1)	2018	2017 (Note 1)	2018
Revenue				
Commission	$32,451	$30,646	$71,288	$71,353
Other	2,115	2,011	4,834	4,374
Total revenue	34,566	32,657	76,122	75,727
Operating costs and expenses:				
Cost of revenue	56	151	237	303
Marketing and advertising	14,240	14,606	29,295	29,608
Customer care and enrollment	12,012	13,219	24,121	26,458
Technology and content	7,932	7,287	16,004	15,628
General and administrative	10,534	11,240	20,526	21,931
Change in fair value of earnout liability	—	2,500	—	2,500
Restructuring charges	—	9	—	1,865
Acquisition costs	—	18	—	76
Amortization of intangible assets	260	547	520	998
Total operating costs and expenses	45,034	49,577	90,703	99,367
Loss from operations	(10,468)	(16,920)	(14,581)	(23,640)
Other income (expense), net	298	296	575	480
Loss before benefit from income taxes	(10,170)	(16,624)	(14,006)	(23,160)
Benefit from income taxes	(8,664)	(4,610)	(13,580)	(6,301)
Net loss	$(1,506)	$(12,014)	$(426)	$(16,859)
Net loss per share:				
Basic	$(0.08)	$(0.63)	$(0.02)	$(0.89)
Diluted	$(0.08)	$(0.63)	$(0.02)	$(0.89)
Weighted-average number of shares used in per share amounts:				
Basic	18,481	19,063	18,424	18,968
Diluted	18,481	19,063	18,424	18,968
Comprehensive loss				
Net loss	$(1,506)	$(12,014)	$(426)	$(16,859)
Foreign currency translation adjustment, net of taxes	10	(71)	18	(6)
Comprehensive loss	$(1,496)	$(12,085)	$(408)	$(16,865)

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

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

	Six Months Ended June 30,	
	2017 (Note 1)	2018
Operating activities		
Net loss	$(426)	$(16,859)
Adjustments to reconcile net loss to net cash provided by operating activities:		
Deferred income taxes	(12,131)	(6,482)
Depreciation and amortization	1,513	1,250
Amortization of internally developed software	651	1,011
Amortization of intangible assets	520	998
Stock-based compensation expense	4,702	5,932
Change in fair value of earnout liability	—	2,500
Other non-cash items	(52)	376
Changes in operating assets and liabilities:		
Accounts receivable	1,386	629
Commissions receivable	20,145	27,495
Prepaid expenses and other assets	(88)	(1,120)
Accounts payable	(2,798)	(1,202)
Accrued compensation and benefits	(799)	(3,598)
Accrued marketing expenses	(2,771)	(1,951)
Deferred revenue	(490)	376
Accrued expense and other liabilities	(1,902)	1,081
Net cash provided by operating activities	7,460	10,436
Investing activities		
Capitalized internal-use software and website development costs	(1,665)	(2,763)
Purchases of property and equipment and other assets	(1,105)	(1,122)
Acquisition of business, net of cash acquired	—	(14,929)
Net cash used in investing activities	(2,770)	(18,814)
Financing activities		
Proceeds from exercise of common stock options	49	668
Cash used to net-share settle equity awards	(396)	(1,742)
Principal payments in connection with capital leases	(62)	(52)
Net cash used in financing activities	(409)	(1,126)
Effect of exchange rate changes on cash and cash equivalents	18	(15)
Net increase (decrease) in cash and cash equivalents	4,299	(9,519)
Cash and cash equivalents at beginning of period	61,781	40,293
Cash and cash equivalents at end of period	$66,080	$30,774

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

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 1 - Summary of Business and Significant Accounting Policies

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

Basis of Presentation — The accompanying condensed consolidated balance sheets as of December 31, 2017 and June 30, 2018, the condensed consolidated statements of comprehensive loss for the three and six months ended June 30, 2017 and 2018 and the condensed consolidated statements of cash flows for the six months ended June 30, 2017 and 2018, respectively, are unaudited. Effective January 1, 2018, we adopted the requirements of Accounting Standards Update ("ASU") No. 2014-09, Revenue from Contracts with Customers (Topic 606), as discussed in detail below under Adoption of New Accounting Standards. All amounts and disclosures set forth in this Quarterly Report on Form 10-Q have been updated to comply with Topic 606. Except for the impact of the adoption of Topic 606, the condensed consolidated balance sheet data as of December 31, 2017 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2017, which was filed with the Securities and Exchange Commission on March 19, 2018. The accompanying statements should be read in conjunction with the audited consolidated financial statements and related notes contained in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP") for interim financial information. Certain information and disclosures normally included in financial statements prepared in accordance with U.S. GAAP have been condensed or omitted in accordance to such rules and regulations. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2017 and include all adjustments necessary for the fair presentation of our financial position as of December 31, 2017 and June 30, 2018, our results of operations for the three and six months ended June 30, 2017 and 2018 and our cash flows for the six months ended June 30, 2017 and 2018. The results for the three and six months ended June 30, 2018 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2018 and therefore should not be relied upon as an indicator of future results.

Principles of Consolidation — The condensed consolidated financial statements include the accounts of eHealth, Inc. and its wholly-owned subsidiaries. All intercompany accounts and transactions have been eliminated in consolidation.

Seasonality — A greater number of our Medicare-related health insurance plans are sold in our fourth quarter during the Medicare annual enrollment period when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, our Medicare plan-related commission revenue is highest in our fourth quarter.

The majority of our individual and family health insurance plans are sold in the fourth quarter during the annual open enrollment period as defined under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act. Individuals and families generally are not able to purchase individual and family health insurance outside of these open enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance or moving to another state.

Recent Accounting Pronouncements Not Yet Adopted

Leases (Topic 842) — In February 2016, the Financial Accounting Standards Board ("FASB") issued ASU No. 2016-02, Leases (Topic 842). ASU 2016-02 requires lessees to recognize a right-of-use asset and lease liability for all leases with terms of more than 12 months. Recognition, measurement, and presentation of expenses will depend on classification as a finance or operating lease. The guidance also eliminates existing real estate-specific provisions for all entities. The new

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

standard is effective for annual reporting periods beginning after December 15, 2018, including interim periods within that reporting period. Early adoption is permitted. We expect to adopt this new accounting standard in the first quarter of 2019. While we are currently evaluating the impact of adopting ASU 2016-02, based on the lease portfolio as of June 30, 2018, we anticipate recording lease assets and liabilities of approximately $31.7 million on its Condensed Balance Sheets, with no material impact to its condensed consolidated statements of comprehensive loss. However, the ultimate impact of adopting ASU 2016-02 will depend on our lease portfolio as of the adoption date.

Adoption of New Accounting Standards

Compensation — Stock Compensation (Topic 718) — In May 2017, the FASB issued ASU No. 2017-09, Compensation—Stock Compensation (Topic 718): Scope of Modification Accounting, which provides guidance about which changes to the terms or conditions of a share-based payment award require an entity to apply modification accounting. We adopted ASU 2017-09 in the first quarter of 2018. The adoption of this new standard did not have a material impact on our condensed consolidated financial statements.

Statement of Cash Flows (Topic 230) — In November 2016, the FASB issued ASU No. 2016-18, Statement of Cash Flows (Topic 230): Restricted Cash, which clarifies guidance on the classification and presentation of restricted cash in the statement of cash flows. Under ASU 2016-18, changes in restricted cash and restricted cash equivalents would be included along with those of cash and cash equivalents in the statement of cash flows. As a result, entities would no longer present transfers between cash/equivalents and restricted cash/equivalents in the statement of cash flows. In addition, a reconciliation between the balance sheet and the statement of cash flows would be disclosed when the balance sheet includes more than one line item for cash/equivalents and restricted cash/equivalents. We adopted ASU 2016-18 in the first quarter of 2018. The adoption of this new standard did not have a material impact on our condensed consolidated financial statements.

In August 2016, the FASB issued ASU No. 2016-15, Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments. ASU 2016-15 provides guidance on how certain cash receipts and cash payments are presented on the statement of cash flows. We adopted ASU 2016-15 in the first quarter of 2018. The adoption of this new standard did not have a material impact on our condensed consolidated financial statements.

Goodwill Impairment (Topic 350) — In January 2017, the FASB issued ASU No. 2017-04, Simplifying the Test for Goodwill Impairment (Topic 350). Under the new standard, goodwill impairment would be measured as the amount by which a reporting unit’s carrying value exceeds its fair value, not to exceed the carrying value of goodwill. ASU 2017-04 eliminates existing guidance that requires an entity to determine goodwill impairment by calculating the implied fair value of goodwill by hypothetically assigning the fair value of a reporting unit to all of its assets and liabilities as if that reporting unit had been acquired in a business combination. ASU 2017-04 is effective for annual periods, and interim periods within those annual periods, beginning after December 15, 2019 with early adoption permitted for annual goodwill impairment tests performed after January 1, 2017. The standard must be applied prospectively. We early adopted ASU 2017-04 in the first quarter of 2018. The adoption of this new standard has not materially impacted our condensed consolidated financial statements.

Revenue Recognition (Topic 606) — In May 2014, the FASB issued ASU 2014-09, Revenue from Contracts with Customers (Topic 606), requiring an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. In April 2016, the FASB issued ASU No. 2016-10, Identifying Performance Obligations and Licensing. ASU 2016-10 provides guidance in identifying performance obligations and determining the appropriate

accounting for licensing arrangements.

The effective date and transition requirements for ASU 2016-10 are the same as the effective date and transition requirements in Topic 606 (and any other Topic amended by ASU 2014-09). ASU 2014-09 may be adopted retrospectively to each prior reporting period presented (full retrospective method), or retrospectively with the cumulative effect of initially applying the guidance recognized at the date of initial application (modified retrospective method). We adopted ASC 2014-09 effective January 1, 2018, using the full retrospective method to restate each prior reporting period presented. The adoption of this standard had a material impact on our condensed consolidated balance sheets and condensed consolidated statements of comprehensive loss, but had no impact on total net cash provided by (used in) operating, investing, or financing activities within the condensed consolidated statements of cash flows.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Change in Significant Accounting Policies

Except for the accounting policies for revenue recognition, commissions receivable and deferred revenue that were updated as a result of adopting Topic 606, there have been no changes to our significant accounting policies described in the Annual Report on Form 10-K for the year ended December 31, 2017, filed with the SEC on March 19, 2018, that have had a material impact on our condensed consolidated financial statements and related notes.

Revenue Recognition Policy

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

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

- Identification of the contract, or contracts, with a customer. A contract with a customer exists when (i) we enter into an enforceable contract with a customer that defines each party's rights regarding the goods or services to be transferred and identifies the payment terms related to these goods or services, (ii) the contract has commercial substance, and (iii) we determine that collection of substantially all consideration for goods or services that are transferred is probable based on the customer's intent and ability to pay the promised consideration.

- Identification of the performance obligations in the contract. Performance obligations promised in a contract are identified based on the goods or services that will be transferred to the customer that are both capable of being distinct, whereby the customer can benefit from the goods or service either on its own or together with other resources that are readily available from third parties or from us, and are distinct in the context of the contract, whereby the transfer of the goods or services is separately identifiable from other promises in the contract.

- Determination of the transaction price. The transaction price is determined based on the consideration to which we will be entitled in exchange for transferring goods or services to the customer.

- Allocation of the transaction price to the performance obligations in the contract. If the contract contains a single performance obligation, the entire transaction price is allocated to the single performance obligation. Contracts that contain multiple performance obligations require an allocation of the transaction price to each performance obligation based on a relative standalone selling price basis.

- Recognition of revenue when, or as, we satisfy a performance obligation. We satisfy performance obligations either over time or at a point in time, as discussed in further detail below. Revenue is recognized at the time the related performance obligation is satisfied by transferring the promised good or service to the customer.

Commission Revenue — Our commission revenue is primarily comprised of commissions paid to us by health insurance carriers related to insurance plans that have been purchased by a member through our health insurance exchange service. We define a member as an individual currently covered by an insurance plan, which include Medicare-related, individual and family, small business and ancillary plans. We are compensated by the health insurance carrier, which we define as our customer.

We typically enter into contractual relationships with health insurance carriers that are non-exclusive and terminable on short notice by either party for any reason. In addition, health insurance carriers often have the ability to terminate or amend our agreements unilaterally on short notice, including provisions in our agreements relating to the commission rates paid to us by the health insurance carriers. The amendment or termination of an agreement we have with a health insurance carrier may

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

adversely impact the commissions we are paid on health insurance plans purchased from the carrier by means of our health insurance exchange services.

For both Medicare Advantage and Medicare Part D prescription drug plans, we receive a fixed, annual commission payment from insurance carriers once the plan is approved by the carrier and either a fixed, monthly or annual commission payment beginning with and subsequent to the second plan year. In the first plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application but during the effective year of the plan, we are paid a fixed commission that is prorated for the number of months remaining in the calendar year. Additionally, if the plan is the first Medicare Advantage or Medicare Part D plan issued to the member, we may receive a higher commission rate that covers a full twelve-month period, regardless of the month the plan was effective. We earn commission revenue for Medicare Advantage and Medicare Part D prescription drug plans for which we are the broker of record, typically until either the policy is cancelled or we otherwise do not remain the agent on the policy.

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

We utilize a practical expedient to estimate commission revenue for each insurance product by applying the use of a portfolio approach to group approved members by the effective month of the relevant policy (referred to as a “cohort”). This allows us to estimate the commissions we expect to collect for each approved member cohort by evaluating various factors, including but not limited to, contracted commission rates, carrier mix and expected member churn.

For Medicare-related, individual and family and ancillary health insurance plans, our services are complete once a submitted application is approved by the relevant health insurance carrier. Accordingly, we recognize commission revenue based upon the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application, net of a constraint. We refer to these estimated and constrained lifetime values as the "constrained lifetime value" for the plan. We provide annual services in selling and renewing small business health insurance plans; therefore, we recognize small business health insurance plan commission revenue at the time the plan is approved by the carrier, and when it renews each year thereafter, equal to the estimated commissions we expect to collect from the plan over the following 12-months. Our estimate of commission revenue for each product line is based on a number of assumptions, which include, but are not limited to, estimating conversion of an approved member to a paying member, forecasting member churn and forecasting the commission amounts likely to be received per member. These assumptions are based on historical trends and incorporate management’s judgment in interpreting those trends and in applying constraints discussed below. To the extent we make changes to the assumptions, we will recognize any material impact of the changes to commission revenue in the reporting period in which the change is made, including revisions of estimated lifetime commissions either below or in excess of previously estimated constrained lifetime value recognized as revenue.

For Medicare-related, individual and family and ancillary health insurance plans, we apply constraints to determine the amount of commission revenue to recognize per approved member. The constraints are applied to help ensure that the total estimated lifetime commissions expected to be collected for an approved member’s plan are recognized as revenue only to the extent that it is probable that a significant reversal in the amount of cumulative revenue recognized

will not occur when the uncertainty associated with future commissions receivable from the plan is subsequently resolved. We evaluate the appropriateness of these constraints on at least an annual basis, including assessing factors affecting our estimate of the estimated lifetime value of commissions per approved member based on current trends impacting our business and assessing whether any adjustment to those constraints should be made. We update the assumptions when we observe a sufficient level of evidence that would suggest that the long term expectation of the assumption has changed.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

For the three months ended June 30, 2017 and 2018, the constraints applied to the total estimated lifetime commissions we expect to receive for selling the plan after the carrier approves an application in order to derive the constrained lifetime value of commissions per approved member are as follows:

	Three Months Ended June 30,	
	2017	2018
Medicare		
Medicare Advantage	7 %	7 %
Medicare Supplement	5 %	5 %
Medicare Part D	5 %	5 %
Individual and Family		
Non-Qualified Health Plans	15%	15%
Qualified Health Plans	20%	20%
Ancillary	10%	10%
Small Business	—	—

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

Our commercial technology licensing business allows carriers the use of our ecommerce platform to offer their own health insurance policies on their websites and allows 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 upon transfer of control at a point in time, commencing once the technology is available for use by the third party. Variable consideration in the form of performance fees based on metrics such as submitted health insurance applications are recognized upon achieving the metrics. 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 data tracked by the third party.

Deferred revenue includes deferred technology licensing implementation fees and 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.

Some of our contracts with customers contain multiple performance obligations. We allocate revenue to all performance obligations within an arrangement with multiple deliverables at the inception of the arrangement using

the relative standalone selling price method.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Disaggregation of Revenue

The table below depicts the disaggregation of revenue by product for the three and six months ended June 30, 2017 and 2018 and is consistent with how we evaluate our financial performance:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Commission Revenue:				
Medicare				
Medicare Advantage	$18,677	$17,738	$37,882	$39,673
Medicare Supplement	2,886	5,355	6,800	10,947
Medicare Part D	1,203	715	2,581	1,874
Total Medicare	22,766	23,808	47,263	52,494
Individual and Family [1]				
Non-Qualified Health Plans	1,988	1,069	5,761	2,510
Qualified Health Plans	2,634	1,675	5,766	3,837
Total Individual and Family	4,622	2,744	11,527	6,347
Ancillary				
Short-term	1,029	1,293	2,875	2,543
Dental	1,003	147	2,850	1,366
Vision	282	391	852	731
Other	762	(118)	1,527	2,653
Total Ancillary	3,076	1,713	8,104	7,293
Small Business	1,532	1,772	3,456	4,131
Commission Bonus	455	609	938	1,088
Total Commission Revenue	32,451	30,646	71,288	71,353
Other Revenue	2,115	2,011	4,834	4,374
Total Revenue	$34,566	$32,657	$76,122	$75,727

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

Book-of-Business Transfers

We entered into several agreements with a broker partner, whereby the partner transferred certain of its existing Medicare plan members to us as the broker of record on the underlying policies. The first of these book-of-business transfers occurred in November 2010 and the most recent in June 2012. Total consideration paid by us for these books-of-business amounted to $13.9 million. Consideration paid for these books-of-business is included within commissions receivable in the accompanying condensed consolidated balance sheets. The consideration we paid to the broker partner was based on the discounted commissions expected to be received over the remaining life of each

transferred Medicare plan member. As we receive commission payments from health insurance carriers for these plan members, we reduce commissions receivable for the discounted commissions expected to be received, with the remaining margin earned recorded to other income (expense), net in the condensed consolidated statements of comprehensive income (loss). The margin earned and recorded to other income

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

(expense), net for these books-of-business for the three and six months ended June 30, 2017 and 2018 totaled $0.5 million and $0.4 million, respectively.

Incremental Costs to Obtain a Contract

We reviewed our sales compensation plans, which are directed at converting leads into approved members, and concluded that they are fulfillment costs and not costs to obtain a contract with a health insurance carrier, which we define as our customer. Additionally, we reviewed compensation plans related to personnel responsible for identifying new health insurance carriers and entering into contracts with new health insurance carriers and concluded that no incremental costs are incurred to obtain such contracts.

Income Taxes

As described in more detail in Note 6 - Income Taxes, as a result of the adoption of Topic 606, we recorded a significant deferred tax liability on our recasted opening balance sheet related to the resulting accelerated revenue recognition under Topic 606. Additionally, as a result of the deferred tax liability, we re-evaluated the need for the valuation allowance recorded against our U.S. deferred tax assets. As a result of this evaluation, we determined that the deferred tax liability is a source of income that can be used to support realization of deferred tax assets on a more-likely-than-not level and accordingly reversed our previously recorded valuation allowance as of January 1, 2015, the earliest period to which the retrospective the adoption of Topic 606 was applied.

Impact to Previously Reported Results

The adoption of ASU 2014-09 impacted our reported results as follows (in thousands, except per share amounts):

	December 31, 2017		
Balance Sheets	As Reported	ASC 606 Adoption Adjustment	As Adjusted
Accounts receivable	$9,894	$(8,419)	$1,475
Commissions receivable - current	$—	$109,666	$109,666
Prepaid expenses and other current assets	$4,845	$(540)	$4,305
Commissions receivable - non-current	$—	$169,751	$169,751
Other assets	$7,317	$(30)	$7,287
Accrued marketing expenses	$4,088	$605	$4,693
Other current liabilities	$3,815	$(1,807)	$2,008
Deferred income taxes - non-current	$—	$45,089	$45,089
Non-current liabilities	$900	$1,020	$1,920
Retained earnings (accumulated deficit)	$(20,796)	$225,521	$204,725

	Three Months Ended June 30, 2017			Six Months Ended June 30, 2017		
Statements of Operations	As Reported	ASC 606 Adoption Adjustment	As Adjusted	As Reported	ASC 606 Adoption Adjustment	As Adjusted
Revenue	$27,957	$ 6,609	$34,566	$106,896	$(30,774)	$76,122
Cost of revenue	$204	$ (148)	$56	$1,833	$(1,596)	$237
Other income, net	$90	$ 208	$298	$116	$ 459	$575
Provision (benefit) from income taxes	$125	$ (8,789)	$(8,664)	$(1,448)	$(12,132)	$(13,580)
Net income (loss)	$(17,260)	$ 15,754	$(1,506)	$16,161	$(16,587)	$(426)
Net income (loss) per diluted share	$(0.93)	$ 0.85	$(0.08)	$0.86	$(0.90)	$(0.02)

13

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Segment Information	Three Months Ended June 30, 2017			Six Months Ended June 30, 2017		
	As Reported	ASC 606 Adoption Adjustment	As Adjusted	As Reported	ASC 606 Adoption Adjustment	As Adjusted
Revenue						
Medicare	$11,014	$ 13,148	$24,162	$68,988	$ (19,416)	$49,572
Individual, Family and Small Business	16,943	(6,539)	10,404	37,908	(11,358)	26,550
Total revenue	$27,957	$ 6,609	$34,566	$106,896	$ (30,774)	$76,122
Segment profit (loss)						
Medicare segment profit (loss)	$(15,107)	$ 13,094	$(2,013)	$15,588	$ (18,530)	$(2,942)
Individual, Family and Small Business segment profit	8,404	(6,339)	2,065	19,483	(10,648)	8,835
Total segment profit (loss)	$(6,703)	$ 6,755	$52	$35,071	$ (29,178)	$5,893

Note 2 - Acquisition

On January 22, 2018, we completed our acquisition of all outstanding membership interests of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. This acquisition is expected to enhance our growing presence in the Medicare Supplement market and put us in a stronger position with carriers and strategic partners. The acquisition consideration consisted of cash of $15.0 million, less $0.1 million of cash acquired, and 294,637 shares of our common stock. In addition, the members of GoMedigap are entitled to receive earnout payments ("Earnout Consideration") consisting of up to $20 million in cash and 589,275 shares of our common stock. The Earnout Consideration will become payable, subject to the terms and conditions of the purchase agreement relating to the acquisition, upon the final determination of the achievement of certain milestones in 2018 and 2019.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

Acquisition Consideration	
Cash paid	$15,000
Fair value of equity awards issued to GoMedigap members [1]	5,595
Estimated fair value of earnout liability	27,700
	$48,295
Allocation	
Cash and cash equivalents	$71
Commission receivable - current	4,371
Prepaid expenses and other current assets	11
Commission receivable - non-current	11,103
Property and equipment, net	174
Accounts payable	(110)
Accrued compensation and benefits	(132)
Other current liabilities	(131)
Net tangible assets acquired	15,357
Intangible assets	6,800
Goodwill	26,138
Total intangible assets acquired	32,938
Total net assets acquired	$48,295

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

The acquisition consideration allocation as of the date of the acquisition was based on a preliminary valuation and is subject to revision as more detailed analyses are completed and additional information about the fair value of assets acquired and liabilities assumed becomes available. Additional information that result in adjustments to the provisional current and non-current commissions receivable amounts recognized as of the acquisition date may result in a corresponding adjustment to goodwill in the period in which new information becomes available.

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

Earnout liability — The earnout liability represents the fair value of the Earnout Consideration payable and will be adjusted to fair value at each reporting date until settled. Changes in fair value will be recognized in income (loss) from operations. The earnout liability will be adjusted to the extent the specified enrollment targets are not achieved.

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

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

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

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

The fair values of the acquired intangible assets were determined using the profit allocation method, which is based on determining the estimated royalties we are relieved from paying because we own the assets.

The fair value of the earnout liability was measured using probability-weighted analysis and is discounted using a rate that appropriately captures the risk associated with the obligation. Key assumptions included new enrollments and volatility for the years ending December 31, 2018 and 2019 and eHealth’s simulated stock price at the time of payment. The earnout liability was part of the acquisition consideration and will be adjusted to fair value at each reporting date until settled. The fair value adjustments to the earnout liability during both the three and six months ended June 30, 2018 totaled $2.5 million. We will continue to update the key assumptions each period and record any fair value adjustments, as necessary.

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

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

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

We incurred $0.1 million of acquisition-related costs during the six months ended June 30, 2018, which were expensed as incurred.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 3 - Balance Sheet Accounts

Cash and Cash Equivalents — As of December 31, 2017 and June 30, 2018, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. As of December 31, 2017 and June 30, 2018, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three or six months ended June 30, 2017 and 2018.

As of December 31, 2017 and June 30, 2018, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2017	June 30, 2018
Cash	$ 5,098	$7,396
Money market funds	35,195	23,378
Total cash and cash equivalents	$ 40,293	$30,774

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

	December 31, 2017	June 30, 2018
Prepaid maintenance contracts	$ 1,945	$ 1,849
Prepaid insurance	490	1,169
Prepaid rent	311	508
Other current assets	1,559	1,915
Total prepaid expenses and other current assets	$ 4,305	$ 5,441

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

	December 31, 2017			June 30, 2018			
	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Gross Carrying Amount	Accumulated Amortization	Net Carrying Amount	Weighted-Average Remaining Life
Technology	$1,700	$ (1,700)	$ —	$3,700	$ (1,978)	$ 1,722	2.6 years
Pharmacy and customer relationships	10,100	(7,884)	2,216	10,100	(8,358)	1,742	1.8 years
Trade names, trademarks and website addresses	907	(697)	210	5,707	(943)	4,764	9.3 years
Total intangible assets subject to amortization	$12,707	$ (10,281)	2,426	$19,507	$ (11,279)	8,228	
Indefinite-lived trademarks and domain			5,114			5,114	Indefinite

names		
Total intangible assets	$ 7,540	$ 13,342

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

As of June 30, 2018, 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
2018	$ 333	$ 475	$ 284	$1,092
2019	667	950	570	2,187
2020	667	317	510	1,494
2021	55	—	480	535
2022	—	—	480	480
Thereafter	—	—	2,440	2,440
Total	$ 1,722	$ 1,742	$ 4,764	$8,228

Note 4 - Fair Value Measurements

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

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

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

	December 31, 2017			June 30, 2018			
	Carrying Value	Level 1	Total	Carrying Value	Level 1	Level 3	Total
Assets							
Money market funds	$35,195	$35,195	$35,195	$23,378	$23,378	$—	$23,378
Total assets measured and recorded at fair value	$35,195	$35,195	$35,195	$23,378	$23,378	$—	$23,378
Liability							
Earnout liability - current	$—	$—	$—	$15,766	$—	$15,766	$15,766
Earnout liability - non-current	—	—	—	14,434	—	14,434	14,434
Total liabilities measured and recorded at fair value	$—	$—	$—	$30,200	$—	$30,200	$30,200

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.

The earnout liability represents the fair value of the Earnout Consideration payable to acquire GoMedigap and will be adjusted to fair value at each reporting date until settled. See Note 2 - Acquisition for additional information on the earnout consideration.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

Note 5 - Stockholder's Equity

2014 Equity Incentive Plan — The following table summarizes activity under our 2014 Equity Incentive Plan (the "2014 Plan") for the six months ended June 30, 2018 (in thousands):

	Shares Available for Grant
Shares available for grant December 31, 2017	1,409
Restricted stock units granted [1]	(499)
Options granted[2]	(111)
Restricted stock units cancelled [3]	112
Options cancelled	17
Shares available for grant June 30, 2018	928

(1) Includes grants of restricted stock units with service, performance-based or market-based vesting criteria.

(2) Includes grants of stock options with service, performance-based or market-based vesting criteria.

(3) Includes cancelled restricted stock units with service, performance-based or market-based vesting criteria.

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

	Number of Stock Options [1]	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value [2]
Balance outstanding at December 31, 2017	983	$ 17.38	4.6	$ 2,522
Granted	111	$ 15.69		
Exercised	(46)	$ 13.47		
Cancelled	(95)	$ 25.19		
Balance outstanding at June 30, 2018	953	$ 16.45	4.7	$ 6,344
Vested and expected to vest at June 30, 2018	909	$ 16.45	4.7	$ 6,083
Exercisable at June 30, 2018	437	$ 17.38	3.6	$ 2,945

(1) Includes certain stock options with service, performance-based or market-based vesting criteria.

(2) The aggregate intrinsic value is calculated as the difference between the closing price of our common stock as of December 31, 2017 and June 30, 2018 and the exercise price multiply by number of in-the-money options.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

	Number of Restricted Stock Units [1]	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Service Period	Aggregate Intrinsic Value [2]
Unvested as of December 31, 2017	1,745	$ 14.24	2.3	$ 30,313
Granted	499	$ 14.03		
Vested	(264)	$ 14.04		
Cancelled	(112)	$ 16.05		
Unvested as of June 30, 2018	1,868	$ 14.92	5.8	$ 41,286

(1) Includes certain restricted stock units with service, performance-based or market-based vesting criteria.

(2) The aggregate intrinsic value is calculated as the product of our closing stock price as of December 31, 2017 and June 30, 2018 and the number of restricted stock units outstanding as of December 31, 2017 and June 30, 2018, respectively.

Stock Repurchase Programs — We had no stock repurchase activity during the six months ended June 30, 2018. In addition to 10,663,888 shares repurchased under our past repurchase programs as of June 30, 2018, we have in treasury 660,493 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, 2017 and June 30, 2018, we had a total of 11,237,995 shares and 11,324,381 shares, respectively, held in treasury.

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

Stock-Based Compensation Expense — The following table summarizes stock-based compensation expense recorded during the three and six months ended June 30, 2017 and 2018 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Common stock options	$714	$436	$901	$934
Restricted stock units	1,855	2,695	3,801	4,998
Total stock-based compensation expense	$2,569	$3,131	$4,702	$5,932

The following table summarizes stock-based compensation expense by operating function for the three and six months ended June 30, 2017 and 2018 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Marketing and advertising	$220	$553	$435	$923
Customer care and enrollment	124	206	136	371
Technology and content	274	383	668	726
General and administrative	1,951	1,989	3,463	3,661
Restructuring	—	—	—	251
Total stock-based compensation expense	$2,569	$3,131	$4,702	$5,932

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

During the six months ended June 30, 2018, as part of our workforce reduction as discussed in Note 10 - Restructuring Charges, we accelerated the vesting dates of certain stock options and restricted stock units granted to a former employee. We recorded $0.3 million of incremental stock-based compensation expense in connection with this modification.

Note 6 - Income Taxes

The following table summarizes our benefit from income taxes and our effective tax rates for the three and six months ended June 30, 2017 and 2018 (in thousands, except effective tax rate):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Loss before benefit from income taxes	$(10,170)	$(16,624)	$(14,006)	$(23,160)
Benefit from income taxes	$(8,664)	$(4,610)	$(13,580)	$(6,301)
Effective tax rate	85.2%	27.7%	97.0%	27.2%

For the three months ended June 30, 2018, we recognized a benefit from income taxes of $4.6 million, representing an effective tax rate of 28%, which was higher than the statutory federal tax rate due primarily to stock-based compensation adjustments, non-deductible lobbying expenses, and foreign income inclusions, partially offset by research and development credits. For the three months ended June 30, 2017, we recognized a benefit from income taxes of $8.7 million, representing an effective tax rate of 85%, which was higher than the statutory federal tax rate due primarily to the release of a liability for unrecognized tax benefits, research and development credits and stock-based compensation adjustments, partially offset by non-deductible lobbying expenses.

For the six months ended June 30, 2018, we recognized a benefit from income taxes of $6.3 million, representing an effective tax rate of 27%, which was higher than the statutory federal tax rate due primarily to stock-based compensation adjustments, non-deductible lobbying expenses, and foreign income inclusions, partially offset by research and development credits. For the six months ended June 30, 2017, we recognized a benefit from income taxes of $13.6 million, representing an effective tax rate of 97%, which was higher than the statutory federal tax rate due primarily to the release of a liability for unrecognized tax benefits, research and development credits and stock-based compensation adjustments, partially offset by non-deductible lobbying expenses.

As a result of our adoption of Topic 606 using the full retrospective method, we recognized a significant deferred tax liability in our recasted opening balance sheet due to the resulting acceleration of revenue recognition while revenue for tax purposes will continue to be recognized as we collect cash. This deferred tax liability is a source of income that can be used to support the realizability of our deferred tax assets. As a result of the significantly increased deferred tax liability, we reversed the valuation allowance recorded against our U.S. deferred tax assets as of January 1, 2015, the earliest period to which the retrospective adoption of Topic 606 was applied. We continue to recognize all our deferred tax assets as of June 30, 2018 as we believe it is more likely than not that the net deferred tax assets will be fully realized.

The Tax Cuts and Jobs Act ("Jobs Act") legislation was passed in December 2017, which has various implications on our income tax provision accrual. The main impact of the Jobs Act on our provision (benefit) for income taxes is the decrease in our statutory federal income tax rate from 35% to 21% and the change in the deferred income tax rate used

in determining deferred tax balances. Our estimated annual effective tax rate has been adjusted for the impact of the Jobs Act including, among other things, certain limitations on deductions and taxes on Global Intangible Low-Taxed Income ("GILTI") earned by our China subsidiary. Given the complexity of the GILTI provisions, we are still evaluating their effects and as of June 30, 2018, we have included GILTI related to current-year operations only in our estimated annual effective tax rate and have not provided for additional GILTI on deferred items. The effects of other provisions of the tax reform legislation are not expected to have a material impact on our condensed consolidated financial statements. However, the final impact of the Jobs Act may differ from our estimates, due to, among other things, changes in our interpretations and assumptions, additional guidance that may be issued, and resulting actions we may take.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Note 7 - Net Loss Per Share

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Basic:				
Numerator:				
Net loss	$(1,506)	$(12,014)	$(426)	$(16,859)
Denominator:				
Weighted-average number of common stock shares outstanding	18,481	19,063	18,424	18,968
Net loss per share—basic:	$(0.08)	$(0.63)	$(0.02)	$(0.89)
Diluted:				
Numerator:				
Net loss	$(1,506)	$(12,014)	$(426)	$(16,859)
Denominator:				
Net weighted average number of common stock shares outstanding	18,481	19,063	18,424	18,968
Dilutive effect of potential common stock	—	—	—	—
Total common stock shares used in per share calculation	18,481	19,063	18,424	18,968
Net loss per share—diluted:	$(0.08)	$(0.63)	$(0.02)	$(0.89)

For the three and six months ended June 30, 2017 and 2018, 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 loss per share as their effect would have been anti-dilutive. The number of outstanding anti-dilutive shares that were excluded from the computation of diluted net income loss per share consisted of the following (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Common stock options	841	1,021	916	1,013
Restricted stock units	1,094	1,632	1,109	1,581
Total	1,935	2,653	2,025	2,594

Note 8 - Commitments and Contingencies

Legal Proceedings

On January 26, 2017, a purported class action lawsuit was filed against us in the Superior Court of the State of California, County of Santa Clara. The complaint alleges that we negligently failed to take necessary precautions required to protect from unauthorized disclosure of personally identifiable information contained on 2016 Form W-2s for current and

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

former employees. The complaint purports to allege causes of action against us for negligence, violation of Section 17200 et seq. of the California Business & Professions Code, declaratory relief and breach of implied contract. The complaint seeks actual damages, punitive damages, statutory damages, costs, including experts' fees and attorneys' fees, pre-judgment and post-judgment interest as prescribed by law and equitable, injunctive and declaratory relief as appropriate. In April 2017, an additional purported class action lawsuit was filed against us in the Superior Court of State of California, County of Santa Clara, relating to the same circumstances. The second complaint purports to allege causes of action against us for negligence, violation of California Customer Records Act (California Civil Code Section 1798.80 et seq.), violation of the California Confidentiality of Medical Information Act (California Civil Code Section 56 et seq.), invasion of privacy by public disclosure of private facts, breach of confidentiality and violation of the California Unfair Competition Law (California Business & Professions Code Section 17200 et seq.). The causes of action for violations of the California Customer Records Act and the California Confidentiality of Medical Information Act were dismissed without prejudice. The second complaint seeks actual damages, statutory damages, restitution, disgorgement, equitable, injunctive and declaratory relief, costs, including experts' fees and attorneys' fees and costs of prosecuting the action, and pre-judgment and post-judgment interest as prescribed by law. In July 2017, we entered into a binding settlement term sheet where we and the plaintiffs in each of the above-described cases agreed to enter into a settlement, pursuant to which we would receive a release of all claims that were or could have been alleged related to the unauthorized disclosure at issue in each of the cases. In exchange for the release, we agreed to (i) pay, subject to an aggregate cap of $250,000, up to $2,500 to each impacted individual for reasonable, documented out-of-pocket losses or expenses related to the data security incident; (ii) offer to individuals who signed up for identity theft protection that we offered at the time of the incident a one-year extension of the identity theft protection; (iii) offer to individuals who did not sign up for identity theft protection that we offered at the time of the incident three-years of identity theft protection; and (iv) not oppose a request by class counsel for attorneys' fees, costs and class representative enhancements of up to $245,000 in the aggregate. In December 2017, we entered into a joint stipulation for settlement of class action consistent with the settlement term sheet. The court entered an order preliminarily approving the settlement on April 23, 2018. As a result, notice of the settlement was sent to members of the class informing them of the settlement and the possible relief available to them thereunder. The settlement is subject to final approval of the court after the notice has been sent to the class and after a hearing before the court. As of June 30, 2018, we maintained an accrual in our consolidated financial statements for estimated potential damages and other amounts we expect to be required to pay in connection with the matter.

On April 6, 2018, a former California employee filed a complaint against us in the Superior Court of the State of California for the County of Sacramento. The plaintiff's complaint was filed pursuant to the California Labor Code Private Attorneys General Act of 2004 ("PAGA"), purportedly on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The complaint alleges that we violated a number of wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing uninterrupted meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The complaint seeks allegedly unpaid wages, civil penalties and costs, expenses and attorneys' fees. Discovery has only recently commenced, and as a result we cannot estimate the likelihood of liability or the amount of potential damages.

On May 8, 2018, an individual filed a putative class action complaint against us. The complaint alleges that we violated the Telephone Consumer Protection Act, 47 U.S.C. § 227(c) and certain provisions of 47 C.F.R. § 64.1200 promulgated thereunder by initiating or causing to be initiated telephone solicitations to telephone subscribers who registered their respective telephone numbers on the National Do Not Call Registry. The complaint alleges, among

other things, that we (i) made more than one unsolicited telephone call to Plaintiff and putative class members within a 12-month period without express consent to place such calls in violation of 47 U.S.C. § 227(c)(5); and (ii) initiated calls for telemarketing purposes without instituting procedures that comply with regulatory minimum standards for implementing Do Not Call in violation of 47 C.F.R. § 64.1200(d). The complaint seeks (i) an order certifying a class of individuals in the United States who (A) received more than one telephone call made by or on behalf of eHealth within a 12-month period; and (B) to a telephone number that had been registered with the National Do Not Call Registry for at least 30 days; (ii) an award of actual and statutory damages for each negligent violation to each member of the class pursuant to 47 U.S.C. § 227(b)(3)(B); (iii) an award of actual and statutory damages for each knowing and/or willful violation to each member of the class pursuant to 47 U.S.C. § 227(b)(3)(A); (iv) an injunction requiring us and our agents to cease all unsolicited telephone activities and otherwise protecting the interest of the class pursuant to 47 U.S.C. § 227(b)(3)(A); and (v) pre-judgment and post-judgment interest on monetary relief. Due to the preliminary nature of this matter and uncertainty of litigation, we are unable at this time to estimate the likelihood of liability or the amount of potential damages.

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

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

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 January 2028. Certain of these leases have free or escalating rent payment provisions. We recognize rent expense on our operating leases on a straight-line basis over the terms of the leases, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

On April 25, 2018, we entered into a lease agreement to lease approximately 32,492 square feet of office space located in Santa Clara, California. We entered into this lease agreement as a result of the upcoming expiration of one of our leases in Mountain View, California on August 31, 2018. The term of the lease is approximately one hundred twenty-three months, commencing on an estimated date of October 1, 2018 and ending on an estimated date of December 31, 2028. Future minimum lease payments under this lease are expected to be $17.7 million.

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

In March 2018, we entered into an agreement to lease approximately 27,000 square feet of office space in Austin, Texas. The term of this lease agreement is ninety months, commencing on an estimated date of July 15, 2018 and ending on approximately January 15, 2026. Future minimum lease payments under this lease will be approximately $4.5 million.

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

In connection with our Mountain View, California lease agreement in March 2012, we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced in increments of 25% of the original amount thereof on the first, second and third anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease. The remaining balance on the

financial guarantee is $0.1 million as of June 30, 2018.

Service and Licensing Obligations

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

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and contractual service and licensing obligations as of June 30, 2018 (in thousands):

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

For the Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2018	$ 2,177	$ 963	$ 3,140
2019	4,966	1,681	6,647
2020	5,238	719	5,957
2021	3,769	—	3,769
2022	3,881	—	3,881
Thereafter	13,852	—	13,852
Total	$ 33,883	$ 3,363	$ 37,246

Note 9 - Operating Segments, Geographic Information and Significant Customers

Operating Segments

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

•Medicare
•Individual, Family and Small Business

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

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

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

results.

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

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

The following table presents summary results of our operating segments for the three and six months ended June 30, 2017 and 2018 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Revenue				
Medicare	$24,162	$25,468	$49,572	$56,231
Individual, Family and Small Business	10,404	7,189	26,550	19,496
Total revenue	$34,566	$32,657	$76,122	$75,727
Segment profit (loss)				
Medicare segment profit (loss)	$(2,013)	$(1,473)	$(2,942)	$1,707
Individual, Family and Small Business segment profit (loss)	2,065	(617)	8,835	2,871
Total segment profit (loss)	52	(2,090)	5,893	4,578
Corporate	(6,940)	(7,994)	(13,739)	(15,848)
Stock-based compensation expense	(2,569)	(3,131)	(4,702)	(5,681)
Depreciation and amortization	(751)	(631)	(1,513)	(1,250)
Change in fair value of earnout liability	—	(2,500)	—	(2,500)
Restructuring charges	—	(9)	—	(1,865)
Acquisition costs	—	(18)	—	(76)
Amortization of intangible assets	(260)	(547)	(520)	(998)
Other income (expense), net	298	296	575	480
Loss before benefit from income taxes	$(10,170)	$(16,624)	$(14,006)	$(23,160)

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

Geographic Information

Our long-lived assets consisted primarily of property and equipment and internally-developed software. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area as of December 31, 2017 and June 30, 2018 were as follows (in thousands):

	Dec 31, 2017	June 30, 2018
United States	$11,211	$12,973
China	550	469
Total	$11,761	$13,442

EHEALTH, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(unaudited)

Significant Customers

Substantially all revenue for the three and six months ended June 30, 2017 and 2018 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue for the three and six months ended June 30, 2017 and 2018 are presented in the table below:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
UnitedHealthcare [1]	21%	24%	22%	23%
Humana	16%	14%	16%	14%

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

As of June 30, 2018, our total outstanding commissions receivable balance was $267.4 million. Our contracts with the above carriers expose us to credit risk that a financial loss could be incurred if the counterparty does not fulfill its financial obligation. While we are exposed to credit losses due to the non-performance of our counterparties, we consider the risk of this remote. We estimate our maximum credit risk in determining the commissions receivable amount recorded on the balance sheet.

Note 10 - Restructuring Charges

In February 2018, our Board of Directors approved a plan to close our sales call center in Massachusetts and to terminate the employment of other employees in certain other locations. As part of this plan, we eliminated approximately 110 full-time positions, representing approximately 10% of our workforce, primarily within customer care and enrollment, and to a lesser extent, in our marketing and advertising and general and administrative groups. We recognized $1.9 million in pre-tax restructuring charges, which included approximately $1.6 million for employee termination benefits and $0.3 million in non-cash accelerated stock based compensation in the six months ended June 30, 2018. The restructuring activities comprising the plan were completed during the three months ended June 30, 2018.

The following table summarizes the total cash and non-cash restructuring charges recognized during the six months ended June 30, 2018 (in thousands):

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

The following table summarizes the accrued restructuring charges activity during the six months ended June 30, 2018 (in thousands):

	Six Months Ended June 30, 2018

	Beginning balance	Charges	Payments	Ending balance
Employee termination costs	$—	$1,605	$(1,490)	$ 115
Accrued restructuring charges - current	$—	$1,605	$(1,490)	$ 115

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

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to submitted and approved applications, membership and lifetime value of commissions; our expectations relating to revenue, sources of revenue, cost of revenue, the collectability of our accounts receivable, operating expenses and profitability; our expectations regarding our strategy and investments including our acquisition of GoMedigap, and impact to our operating results; growth opportunities in our business; our expectations regarding the impact of healthcare reform on our business; our ability to enroll and plans relating to the enrollment of individuals and families into qualified health plans through government health insurance exchanges ; our expectations regarding commission rates, payment rates, conversion rates, membership retention rates and membership acquisition costs; our expectations regarding the supply and demand of individual and family health insurance, including short-term health insurance; our expectations relating to the seasonality of our business; our expectations relating to marketing and advertising expense and expected contributions from our marketing partner channel; the timing of our receipt of commission payments; our critical accounting policies and related estimates; our belief that cash generated from operations and our current cash and cash equivalents will be sufficient to fund operations for the next twelve months; future capital requirements; expected competition from government-run health insurance exchanges and other sources; political, legislative, regulatory and legal challenges; the merits or potential impact of any lawsuits filed against us; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those risks associated with the impact of healthcare reform; our ability to retain existing members and enroll a large number of new members during the annual healthcare reform open enrollment period and Medicare annual enrollment period; the impact of annual enrollment period for the purchase of individual and family health insurance and its timing on our recognition of revenue; our ability to sell qualified health insurance plans to subsidy-eligible individuals and to enroll subsidy eligible individuals through government-run health insurance exchanges; the success of our sale of short-term health insurance and benefit packages; our ability to comply with CMS guidance and impact on conversion rates as a result of the federal exchange changes to enrollment; competition, including competition from government-run health insurance exchanges; seasonality of our business and the fluctuation of our operating results; our ability to retain existing members and limit member turnover; changes in consumer behaviors and their selection of individual and family health insurance products, including the selection of products for which we receive lower commissions; product offerings among carriers and the resulting impact on our commission revenue; carriers exiting the market of selling individual and family health insurance and the resulting impact on our supply and commission revenue; our ability to execute on our growth strategy in the Medicare and small business health insurance markets; the impact of increased health insurance costs on demand; our ability to timely receive and accurately predict the amount of commission payments from health insurance carriers; medical loss ratio requirements; delays in our receipt of items required to recognize Medicare revenue; changes in member conversion rates; our ability to accurately estimate membership and lifetime value of commissions; our relationships with health insurance carriers; customer concentration and consolidation of the health insurance industry; our success in marketing and selling health insurance plans and our unit cost of acquisition; our ability to hire, train and retain licensed health insurance agents and other employees; the need for health insurance carrier and regulatory approvals in connection with the marketing of Medicare-related insurance products; costs of acquiring new members; scalability of the Medicare business; lack of membership growth and retention rates; consumers satisfaction of our service; our ability to attract and to convert online visitors into paying members; changes in products offered on our ecommerce platform; changes in commission rates; maintaining and enhancing our brand identity; our ability to derive desired benefits from investments in our business, including membership growth initiatives; dependence on acceptance of the Internet as a marketplace for the purchase and sale of health insurance; reliance on marketing partners; the impact of our direct-to-consumer email, telephone and television marketing efforts; timing of receipt and accuracy of commission reports; payment practices

of health insurance carriers; our ability to successfully make and integrate acquisitions; dependence on our operations in China; changes in laws and regulations, including in connection with healthcare reform and/or with respect to the marketing and sale of Medicare plans; compliance with insurance and other laws and regulations; exposure to security risks and our ability to safeguard sensitive data; and the performance, reliability and availability of our ecommerce platform and underlying network infrastructure. Other risks include the risks discussed under the heading “Risk Factors” in Part II, Item 1A. of this report and those discussed in our other Securities and Exchange Commission filings. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2018, and the audited consolidated financial statements and related notes contained therein. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements.

Overview

We are a leading private health insurance exchange for individuals, families and small businesses. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com, www.PlanPrescriber.com and www.GoMedigap.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for and purchase Medicare-related, individual and family, small business and ancillary health insurance plans. 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.

On January 22, 2018, we completed our acquisition of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. GoMedigap has built a leading consumer acquisition and engagement platform focused on meeting the Medicare Supplement insurance needs of its individual customers with a technology-enabled, consumer-centric approach that aligns with our mission and operations. This strategic acquisition significantly enhances our growing presence in the Medicare Supplement market, puts us in a stronger position with carriers and strategic partners and allows us to accelerate our projected Medicare plan enrollment growth in 2018 and beyond. For more information on our acquisition of GoMedigap, see Note 2 - Acquisition in the Notes to Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q.

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

We operate as two distinct reporting segments:

•Medicare
•Individual, Family and Small Business.

For more information regarding our segments, see Note 9 - Operating Segments, Geographic Information and Significant Customers in the Notes to Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q.

Adoption of Accounting Standard Update No. 2014-09, Revenue from Contracts with Customers (Topic 606)

In May 2014, the Financial Accounting Standards Board ("FASB") issued ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606). The standard is a comprehensive new revenue recognition model requiring an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. Effective January 1, 2018, we adopted Topic 606 using the full retrospective method, which required us to revise our historical financial information to be consistent with the new standard. The adoption had a material impact on our consolidated financial statements. The most significant impact of the standard was on our commission revenue. We now recognize revenue based on an estimate of the lifetime value of commissions we expect to collect from Medicare-related, individual and family and ancillary health insurance plans at the time the carrier approves the plans, and for small business health insurance plans, the estimated commissions we expect to collect from the plan over the following 12-months. For additional information on the change in our revenue recognition policy and the related impact to our previously reported results, see Note 1 - Summary of Business and Significant Accounting Policies in the Notes to Condensed

Consolidated Financial Statements of this Quarterly Report on Form 10-Q.

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 changed and will continue to change the health insurance industry in substantial ways. We have described various aspects of health care reform in Part I, Item 1, Business - Health Care Reform, in our Annual Report on Form 10-K for the year ended December 31, 2017, which was filed with the Securities and Exchange Commission on March 19, 2018, and Part II, Item 1A, Risk Factors, in this Quarterly Report on Form 10-Q. The implementation of health care reform has significantly reduced our individual and family health insurance membership and commission revenue and could continue to have a material adverse effect on our business and results of operations.

The Trump administration and Republican leadership have repeatedly communicated their intention to alter or repeal the Affordable Care Act, but their efforts to do so have so far been unsuccessful. As a part of the tax reform law that came into effect in December 2017, the tax penalty for violating the individual mandate to maintain qualifying health insurance was reduced to zero effective in 2019, essentially repealing it. The essential repeal of the individual mandate could have a further adverse impact on the individual and family health insurance market. In addition to the repeal of the mandate, the Trump administration issued an executive order in October 2017 that directed the executive branch of the government to consider proposing regulations and revising guidance to expand access to association health plans, expand the availability of short-term health insurance and increase the usability of health reimbursement arrangements. As a result of the executive order, new regulations have been adopted that would facilitate association-based health insurance plans and promote the sale of more short-term health insurance. The regulations relating to association health plans allow small businesses to join industry or geographically-based associations and collectively purchase large group health insurance plans. Unlike small group health insurance, large group health insurance is not subject to many of the provisions of the Affordable Care Act, including the requirement that health insurance plans cover all of the essential health benefits defined under the Affordable Care Act. The goal of the regulation is to reduce the cost of insurance for individuals who receive their health insurance under associations. The regulations relating to short-term health insurance plans extend the initial duration of short-term health insurance from three months to less than one year and allow for short-term health insurance plans to be renewed as long as the total duration of the plan does not exceed thirty six months. The expansion of the use of short-term health insurance may cause individuals and families to purchase short-term health insurance instead of individual and family health insurance. The regulations relating to association-based health insurance and short-term health insurance could present new business opportunities for us, but also may reduce the size of the individual, family and small business health insurance markets that we address or otherwise adversely impact our business and operating results.

Summary of Selected Metrics

In addition to traditional financial metrics, we rely upon certain metrics to estimate and recognize commission revenue, evaluate our business performance and facilitate strategic planning. Our commission revenue is influenced by a number of factors including:

- the number of individuals on applications for Medicare-related, individual and family, small business and ancillary health insurance plans we submit to and are approved by the relevant health insurance carriers, and

- the constrained lifetime value of approved members for Medicare-related, individual and family and ancillary health insurance plans we sell as well as the estimated annual value of approved members for small business plans we sell.

Submitted Applications

Applications are counted as submitted when the applicant completes the application and either clicks the submit button on our website or provides verbal authorization to submit the application. The applicant may have additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information. In addition, an applicant may submit more than one application.

The following table shows submitted applications by product for the three and six months ended June 30, 2017 and 2018:

	Submitted Applications Three Months Ended June 30,			Submitted Applications Six Months Ended June 30,		
	2017	2018	Percent Change	2017	2018	Percent Change
Medicare [1]						
Medicare Advantage	23,071	23,149	— %	44,870	47,945	7 %
Medicare Supplement	4,157	6,868	65 %	8,697	13,256	52 %
Medicare Part D	3,938	3,739	(5)%	8,876	7,584	(15)%
Total Medicare	31,166	33,756	8 %	62,443	68,785	10 %
Individual and Family [2]						
Non-Qualified Health Plans	4,098	1,309	(68)%	18,362	5,195	(72)%
Qualified Health Plans	1,327	1,037	(22)%	9,074	3,721	(59)%
Total Individual and Family	5,425	2,346	(57)%	27,436	8,916	(68)%
Ancillary [3]						
Short-term	22,414	25,779	15 %	46,699	45,274	(3)%
Dental	16,734	9,324	(44)%	40,112	22,317	(44)%
Vision	6,204	4,209	(32)%	16,061	9,793	(39)%
Other	6,796	8,777	29 %	11,495	22,118	92 %
Total Ancillary	52,148	48,089	(8)%	114,367	99,502	(13)%
Small Business [4]	1,280	1,672	31 %	2,442	3,392	39 %
Total	90,019	85,863	(5)%	206,688	180,595	(13)%

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

(2) Major medical Individual and Family plan ("IFP") health insurance applications submitted on our website during the period. An applicant may submit more than one application. We define our IFP offerings as major medical individual and family health insurance plans, which does not include Medicare-related, small business or ancillary plans.

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

(4) Applications for small business health insurance applications are counted as submitted when the applicant completes the application, the employees complete their applications, the applicant submits the application to us and we submit the application to the carrier.

Medicare submitted applications grew 8% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 and 10% in the six months ended June 30, 2018 compared to the six months ended June 30, 2017. The increases were primarily due to growth in Medicare Supplement plan submitted applications as a result of our acquisition of GoMedigap in January 2018 and our subsequent investment in their platforms and call center capabilities. Individual and family plan submitted applications declined 57% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 and declined 68% in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, due to the continuing turmoil in the individual and family plan market as a result of the Affordable Care Act, including the continuing rise in individual and family health insurance premiums and reduced availability of individual and family health insurance that occurred after its passage. The decline in individual and family plan submitted applications also limited our ability to cross-sell ancillary plans, resulting in a decline of 8% and 13% in submitted applications for all ancillary products combined in the three and six

months ended June 30, 2018 compared to the three and six months ended June 30, 2017, respectively. At the same time, short-term health insurance submitted applications grew 15% year-over-year in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to our focus on offering viable health insurance solutions to consumers who cannot afford major medical individual and family health insurance. Small business submitted applications grew 31% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 and 39% in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 due to progress in implementing a focused marketing strategy for this market, technology enhancements and an increased conversion rate.

Approved Members

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

The following table shows approved members by product for the three and six months ended June 30, 2017 and 2018:

	Approved Members Three Months Ended June 30,			Approved Members Six Months Ended June 30,		
	2017	2018	Percent Change	2017	2018	Percent Change
Medicare						
Medicare Advantage	21,893	20,818	(5)%	43,358	45,438	5 %
Medicare Supplement	3,179	5,267	66 %	7,378	10,683	45 %
Medicare Part D	4,163	3,417	(18)%	9,295	7,719	(17)%
Total Medicare	29,235	29,502	1 %	60,031	63,840	6 %
Individual and Family						
Non-Qualified Health Plans	4,161	1,275	(69)%	28,960	10,488	(64)%
Qualified Health Plans	3,486	1,214	(65)%	20,090	15,900	(21)%
Total Individual and Family	7,647	2,489	(67)%	49,050	26,388	(46)%
Ancillary						
Short-term	18,470	25,964	41 %	39,721	46,960	18 %
Dental	15,679	9,302	(41)%	40,413	23,464	(42)%
Vision	6,593	4,444	(33)%	17,346	11,039	(36)%
Other	5,604	7,485	34 %	10,632	16,731	57 %
Total Ancillary	46,346	47,195	2 %	108,112	98,194	(9)%
Small Business	2,455	3,464	41 %	5,939	8,758	47 %
Total	85,683	82,650	(4)%	223,132	197,180	(12)%

Medicare total approved members grew 1% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017. Approved Medicare Supplement plan members grew 66%, approved Medicare Advantage members declined 5% and approved members on Medicare Part D prescription drug plans declined 18% during the same period. The growth in Medicare Supplement plan approved members was as a result of our acquisition of GoMedigap and our subsequent investment in their platforms and call center capabilities. The decline in approved Medicare Advantage and Medicare Part D prescription drug members during the period resulted from reduced marketing spend with certain marketing partners as we attempted to reduce our cost of acquisition and generate more demand from our direct and paid search advertising channels. We believe the decline in Medicare Advantage and Medicare Part D prescription drug plan members will reverse during the fourth quarter driven in part by an increased contribution from our marketing partner channel.

In the first and second quarters of 2018, we also experienced a shift in the mix of our Medicare approved members to higher-value Medicare Advantage and Medicare Supplement members. For the six months ended June 30, 2018 compared to the six months ended June 30, 2017, approved Medicare Supplement members grew 45%, approved Medicare Advantage members grew 5% and approved members on Medicare Part D prescription drug plans declined 17%. The increase in approved Medicare Supplement members was primarily due to our acquisition of GoMedigap in January 2018. In addition the growth in Medicare Advantage approved members was driven by our marketing

initiatives in the direct channel including direct response television, direct mail and search engine optimization. During the remainder of 2018, we expect to see a higher contribution from our strategic marketing partner channel driven by the seasonality of marketing partner budgets, which is expected to result in higher approved member growth.

Individual and family plan approved members declined 67% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 and 46% in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 due to the state of the individual and family health insurance plan market. Ancillary approved members grew 2% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, primarily due to growth in short-term plan approved members as we focused on offering viable solutions to consumers who cannot afford major medical individual and family health coverage. The growth in short-term plan approved members was partially offset by a decline in our ability to cross-sell dental and vision plans to individual and family health insurance plan approved members. Ancillary plan approved members declined 9% in the six months ended June 30, 2018 compared to the six months ended June 30, 2017. The decline was driven by a decline in the sale of individual and family health insurance plans and our reduced ability to cross-sell dental and vision ancillary plans to individual and family health insurance plan approved members. Small business approved members grew 41% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 and 47% in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 due to improved focus on key partnerships, technology enhancements and an increased conversion rate.

Constrained Lifetime Value of Commissions Per Approved Member

The following table shows our estimated constrained lifetime value of commissions per approved member by product for the three months ended June 30, 2017 and 2018:

	Three Months Ended June 30,			
	2017	2018	Percentage Change	
Medicare				
Medicare Advantage [1]	$851	$851	—	%
Medicare Supplement [1]	$908	$1,026	13	%
Medicare Part D [1]	$289	$294	2	%
Individual and Family				
Non-Qualified Health Plans [1]	$129	$125	(3	)%
Qualified Health Plans [1]	$121	$100	(17	)%
Ancillary				
Short-term [1]	$56	$57	2	%
Dental [1]	$58	$64	10	%
Vision [1]	$43	$46	7	%
Small Business [2]	$163	$164	1	%

(1) Constrained lifetime value of commissions per approved member represents commissions estimated to be collected over the estimated life of an approved member's policy after applying constraints in accordance with our revenue recognition policy. The estimate is driven by multiple factors, including but not limited to, contracted commission rates, carrier mix, expected policy churn and applied constraints. These factors may result in varying values from period to period. For additional information on constraints see Note 1 - Summary of Business and Significant Accounting Policies in the Notes to Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q.

(2) For small business the amount represents the estimated commissions we expect to collect from the plan over the following 12-months. The estimate is driven by multiple factors, including but not limited to, contracted

commission rates, carrier mix, expected policy churn and applied constraints. These factors may result in varying values from period to period.

The constrained lifetime value of commissions per approved member improved for Medicare Supplement, dental and vision products in the three months ended June 30, 2018 compared to the three months ended June 30, 2017. The improvement in constrained lifetime value of commissions per Medicare Supplement approved member was driven by the more favorable lifetime value of commissions per approved member for Medicare Supplement plans sold since our acquisition of GoMedigap in January 2018. The improvement in constrained lifetime value of commissions per dental plan approved member was driven by an improvement in commission rates. The improvement in constrained lifetime value of commissions per vision plan approved member was driven by lower churn rates in the three months ended June 30, 2018 compared to the three months ended June 30, 2017. The constrained lifetime value of commissions per qualified health plan approved member decreased 17% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 driven by the timing of the open enrollment period for coverage effective in 2018, which ran through December 2017, versus the open enrollment period for coverage effective in 2017, which ran through January 2017. Enrollments during the open enrollment period tend to have higher constrained lifetime value than enrollments outside of the open enrollment period. Since the open enrollment period for coverage effective in 2018 did not continue into the first quarter of 2018, the constrained lifetime value declined compared to the first quarter of 2017.

Estimated Membership

Estimated membership represents the estimated number of members active as of the date indicated based on the number of members for whom we have received or applied a commission payment during the month of estimation.

The following table shows estimated membership by product as of June 30, 2017 and 2018:

	As of June 30,		
	2017	2018	Percent Change
Medicare [1]			
Medicare Advantage	185,819	226,048	22 %
Medicare Supplement	26,533	61,316	131 %
Medicare Part D	88,021	106,573	21 %
Total Medicare	300,373	393,937	31 %
Individual and Family [2]	244,897	168,278	(31)%
Ancillary [3]			
Short-term	23,555	17,008	(28)%
Dental	177,818	150,823	(15)%
Vision	84,626	75,696	(11)%
Other	23,361	34,964	50 %
Total Ancillary	309,360	278,491	(10)%
Small Business [4]	31,172	37,010	19 %
Total Estimated Membership	885,802	877,716	(1)%

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

(2) To estimate the number of members on Individual and Family health insurance plans, we take the sum of (i) the number of IFP members for whom we have received or applied a commission payment for a month that is up to six months prior to the date of estimation after reducing that number using historical experience for assumed member cancellations over the period being estimated; and (ii) the number of approved members over that period (after reducing that number by the percentage of members who do not accept their approved policy from the same month of the previous year for estimated member cancellations through the date of the estimate). To the extent we determine we have received substantially all of the commission payments related to a given month during the period being estimated, we will take the number of members for whom we have received or applied a commission payment during the month of estimation. For IFP health insurance plans, a member who purchases and is active on multiple standalone insurance plans will be counted as a member more than once. For example, a member who is active on both an individual and family health insurance plan and a standalone dental plan will be counted as two continuing members.

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

reducing that number using historical experience for an assumed number of members who do not accept their approved policy from the same month of the previous year and for estimated member cancellations through the date of the estimate). To the extent we determine we have received substantially all of the commission payments related to a given month during the period being estimated, we will take the number of members for whom we have received or applied a commission payment during the month of estimation. The one to three-month period varies by insurance product and is largely dependent upon the timeliness of commission payment and related reporting from the related carriers.

(4) For small business health insurance plans, we estimate the number of members using the number of initial members at the time the group is approved, and we update this number for changes in membership if such changes are reported to us by the group or carrier in the period it is reported. However, groups generally notify the carrier directly of policy cancellations and increases or decreases in group size without informing us. Health insurance carriers often do not communicate policy cancellation information or group size changes to us. We often are made aware of policy cancellations and group size changes at the time of annual renewal and update our membership statistics accordingly in the period they are reported.

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

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

Medicare membership grew 31% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 primarily due to 131% growth in Medicare Supplement membership as a result of our acquisition of GoMedigap in January 2018, as well as accumulated growth in our Medicare Advantage and Medicare Part D prescription drug plan membership. Individual and family plan approved members declined 31% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to the state of the individual and family plan market as a result of health care reform. Ancillary plan membership declined 10% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 as a result of the decline in our ability to cross-sell dental and vision plans as a result of the decline in individual and family plan membership, partially offset by growth in short-term, fixed indemnity and a new plan offering for us that combines dental, vision and hearing insurance into a single plan. Small business approved members grew 19% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to improved focus on technology enhancements and an increased conversion rate.

Member Acquisition

Marketing initiatives are an important component of our strategy to increase revenue. Our marketing initiatives are focused on three primary member acquisition channels: direct, marketing partners and online advertising and are primarily designed to encourage consumers to complete an application for health insurance. In addition, we incur customer care and enrollment expenses in assisting applicants during the enrollment process.

The following table shows the variable marketing cost per approved member and the customer care and enrollment expense per approved member metrics for the three months ended June 30, 2017 and 2018:

	Three Months Ended June 30,		
	2017	2018	Percent Change
Variable marketing cost per approved member			
Medicare variable marketing cost per approved Medicare Advantage ("MA")-equivalent member [1]	$416	$337	(19)%
Individual and Family Plan ("IFP") variable marketing cost per approved IFP-equivalent member [2]	$25	$48	92 %
Customer care and enrollment ("CC&E") expense per approved member			
Medicare CC&E expense per approved MA-equivalent member [3]	$358	$410	15 %
IFP CC&E expense per approved IFP-equivalent member [4]	$131	$106	(19)%

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

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

(3) Medicare CC&E expense per approved MA-equivalent member is equal to the CC&E expense of our Medicare business included in our operating costs and reported in our condensed consolidated statements of operations divided by MA-equivalent approved members in a given period. MA-equivalent approved members is a derived metric and is equal to the sum of Medicare Part D approved members divided by 4, the number of Medicare Advantage approved members and the number of Medicare Supplement approved members in the given period.

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

Variable marketing cost per approved MA-equivalent member declined 19% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to our focus on marketing optimization efforts to optimize the quality of demand we generate and enhance conversions through our direct and paid search advertising channels while reducing marketing spend with certain marketing partners. Variable marketing cost per approved IFP-equivalent member increased in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to higher marketing spend to drive growth in short-term plans.

Medicare CC&E expense per approved MA-equivalent member increased 15% in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to our efforts to prepare for the annual enrollment period by increasing sales agent and training costs, particularly relating to Medicare Supplement plans following our acquisition of GoMedigap. IFP CC&E expense per approved IFP-equivalent member declined in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to a reduction of sales agents as a result

of the continuing adverse market conditions in the individual and family plan market.

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;
- Business Combinations;
- Realizability of Long-Lived Assets and;
- Accounting for Income Taxes.

Except for our revenue recognition accounting policy, which we revised as a result of adopting ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606), there have been no changes to our significant accounting policies described in our Annual Report on Form 10-K for the year ended December 31, 2017, filed with the SEC on March 19, 2018, that have had a material impact on our condensed consolidated financial statements and related notes. Please refer to Management's Discussion and Analysis of Financial Condition and Results of Operations contained in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2017, for a complete discussion of our other critical accounting policies and estimates other than our revenue recognition policy. For a discussion of our revenue recognition policy, please see Note 1 - Summary of Business and Significant Accounting Policies in the Notes to Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q.

Results of Operations

The following table sets forth our operating results and related percentage of total revenues for the three and six months ended June 30, 2017 and 2018 (in thousands):

	Three Months Ended June 30,				Six Months Ended June 30,			
	2017		2018		2017		2018	
Revenue								
Commission	$32,451	94 %	$30,646	94 %	$71,288	94 %	$71,353	94 %
Other	2,115	6 %	2,011	6 %	4,834	6 %	4,374	6 %
Total revenue	34,566	100 %	32,657	100 %	76,122	100 %	75,727	100 %
Operating costs and expenses:								
Cost of revenue	56	— %	151	— %	237	— %	303	— %
Marketing and advertising	14,240	41 %	14,606	45 %	29,295	38 %	29,608	39 %
Customer care and enrollment	12,012	35 %	13,219	40 %	24,121	32 %	26,458	35 %
Technology and content	7,932	23 %	7,287	22 %	16,004	21 %	15,628	21 %
General and administrative	10,534	30 %	11,240	34 %	20,526	27 %	21,931	29 %
Change in fair value of earnout liability	—	— %	2,500	8 %	—	— %	2,500	3 %
Restructuring charges	—	— %	9	— %	—	— %	1,865	2 %
Acquisition costs	—	— %	18	— %	—	— %	76	— %
Amortization of intangible assets	260	1 %	547	2 %	520	1 %	998	1 %
Total operating costs and expenses	45,034	130 %	49,577	152 %	90,703	119 %	99,367	131 %
Loss from operations	(10,468)	(30)%	(16,920)	(52)%	(14,581)	(19)%	(23,640)	(31)%
Other income (expense), net	298	1 %	296	1 %	575	1 %	480	1 %
Loss before benefit for income taxes	(10,170)	(29)%	(16,624)	(51)%	(14,006)	(18)%	(23,160)	(31)%
Benefit for income taxes	(8,664)	(25)%	(4,610)	(14)%	(13,580)	(18)%	(6,301)	(8)%
Net loss	$(1,506)	(4)%	$(12,014)	(37)%	$(426)	(1)%	$(16,859)	(22)%

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
Marketing and advertising	$220	$553	$435	$923
Customer care and enrollment	124	206	136	371
Technology and content	274	383	668	726
General and administrative	1,951	1,989	3,463	3,661
Restructuring	—	—	—	251
Total stock-based compensation expense	$2,569	$3,131	$4,702	$5,932

Three and Six Months Ended June 30, 2017 and 2018

Revenue

The following table presents our commission revenue, other revenue and total revenue for the three and six months ended June 30, 2017 and 2018 and the dollar and percentage changes from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Commission	$32,451	$30,646	$(1,805)	(6)%	$71,288	$71,353	$65	— %
Percentage of total revenue	94 %	94 %			94 %	94 %		
Other	2,115	2,011	(104)	(5)%	4,834	4,374	(460)	(10)%
Percentage of total revenue	6 %	6 %			6 %	6 %		
Total revenue	$34,566	$32,657	$(1,909)	(6)%	$76,122	$75,727	$(395)	(1)%

Three Months Ended June 30, 2018 and 2017 — Commission revenue decreased $1.8 million, or 6%, in the three months ended June 30, 2018 compared to three months ended June 30, 2017 due to a $2.7 million, or 30%, decrease in commission revenue from the Individual, Family and Small Business segment, partially offset by $0.9 million, or 4%, increase in commission revenue from the Medicare segment. The decrease in commission revenue from the Individual, Family and Small Business segment was primarily due to a 67% decrease in individual and family health insurance approved members in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to the state of the individual and family health insurance plan market as a result of health care reform. The increase in commission revenue from the Medicare segment was primarily attributable to a 66% increase in Medicare Supplement approved members in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, as well as an increase in the constrained lifetime value of commissions per Medicare Supplement approved member. The growth in Medicare Supplement approved members and favorable lifetime value of commissions per Medicare Supplement approved members was driven by our acquisition of GoMedigap in January 2018.

Other revenue decreased $0.1 million, or 5%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to a $0.3 million decrease in licensing revenue, partially offset by a $0.1 million increase in online sponsorship and advertising revenue and $0.1 million increase in lead generation revenue.

Six Months Ended June 30, 2018 and 2017 — Commission revenue was flat in the six months ended June 30, 2018 compared to six months ended June 30, 2017. Commission revenue from the Individual, Family and Small Business segment decreased $5.5 million, or 24%, offset by a $5.6 million, or 12%, increase in commission revenue from the Medicare segment. The decrease in commission revenue from the Individual, Family and Small Business segment was primarily due to a 46% decrease in individual and family health insurance approved members in the six months ended June 30, 2018 compared to the six months ended June 30, 2017. The increase in commission revenue from the Medicare segment was primarily attributable to a 6% increase in Medicare approved members in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, primarily driven by growth in Medicare Supplement approved members as well as an increase in the constrained lifetime value of commissions per Medicare Supplement approved member, following our acquisition of GoMedigap in January 2018.

Other revenue decreased $0.5 million, or 10%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 due to a $0.9 million decrease in licensing revenue, partially offset by a $0.3 million increase in online sponsorship and advertising revenue and $0.2 million increase in lead generation revenue.

40

Cost of Revenue

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

The following table presents our cost of revenue for the three and six months ended June 30, 2017 and 2018 and the dollar and percentage changes from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Cost of revenue	$56	$151	$95	170 %	$237	$303	$66	28 %
Percentage of total revenue	— %	— %			— %	— %		

Three Months Ended June 30, 2018 and 2017 — Cost of revenue increased $0.1 million in the three months ended June 30, 2018 compared to three months ended June 30, 2017 due to an increase in payments to marketing partners with whom we have revenue-sharing arrangements due to higher volumes of approved members in that channel.
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Six Months Ended June 30, 2018 and 2017 — Cost of revenue increased $0.1 million, or 28%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 due to an increase in payments to marketing partners with whom we have revenue-sharing arrangements due to higher volumes of approved members in that channel.

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.

The following table presents our marketing and advertising expenses for the three and six months ended June 30, 2017 and 2018 and the dollar and percentage changes from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Marketing and advertising	$14,240	$14,606	$366	3 %	$29,295	$29,608	$313	1 %
Percentage of total revenue	41 %	45 %			38 %	39 %		

Three Months Ended June 30, 2018 and 2017 — Marketing and advertising expenses increased $0.4 million in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, primarily due to increases of $1.5 million in personnel costs due to additional headcount, $0.3 million in stock-based compensation and $0.1 million increase in facility related costs, partially offset by a decrease of $1.6 million in variable marketing costs. The decrease in variable marketing costs was attributed to a decrease of $2.9 million in online advertising costs and marketing partner referral fees, partially offset by an increase of $1.3 million in direct marketing costs, driven primarily by our strategy to shift our demand generation in the Medicare market to more cost-effective channels.

Six Months Ended June 30, 2018 and 2017 — Marketing and advertising expenses increased $0.3 million in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, primarily due to increases of $3.1 million in personnel costs due to additional headcount, $0.3 million in consulting expenses, $0.5 million in stock-based compensation and $0.3 million in facility related costs, partially offset by a decrease of $3.8 million in variable marketing costs. The decrease in variable marketing costs was attributed to a decrease of $8.7 million in online advertising costs and marketing partner referral fees, partially offset by an increase of $4.9 million in direct marketing costs.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits costs for personnel engaged in assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the enrollment process.

The following table presents our customer care and enrollment expenses for the three and six months ended June 30, 2017 and 2018 and the dollar and percentage changes from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Customer care and enrollment	$12,012	$13,219	$1,207	10 %	$24,121	$26,458	$2,337	10 %
Percentage of total revenue	35 %	40 %			32 %	35 %		

Three Months Ended June 30, 2018 and 2017 — Customer care and enrollment expenses increased $1.2 million, or 10%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, primarily due to increases of $0.8 million in personnel costs and $0.3 million in insurance agent licensing costs associated with higher headcount, primarily as a result of the GoMedigap acquisition, and $0.1 million in stock-based compensation.

Six Months Ended June 30, 2018 and 2017 — Customer care and enrollment expenses increased $2.3 million, or 10%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, primarily due a $1.9 million increase in personnel costs associated with higher headcount, primarily as a result of the GoMedigap acquisition and $0.2 million in stock-based compensation.

Technology and Content

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

The following table presents our technology and content expenses for the three and six months ended June 30, 2017 and 2018 and the dollar and percentage changes from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Technology and content	$7,932	$7,287	$(645)	(8)%	$16,004	$15,628	$(376)	(2)%
Percentage of total revenue	23 %	22 %			21 %	21 %		

Three Months Ended June 30, 2018 and 2017 — Technology and content expenses decreased $0.6 million, or 8%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 primarily due to a $0.9 million decrease in personnel costs as a result of restructuring activities as discussed in Note 10 - Restructuring Charges, partially offset by increases of $0.1 million in consulting costs and $0.1 million in stock-based compensation.

Six Months Ended June 30, 2018 and 2017 — Technology and content expenses decreased $0.4 million, or 2%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 primarily due to a $1.0 million decrease in personnel costs, partially offset by increases of $0.4 million in consulting costs, $0.1 million in telephone and network related costs and $0.1 million in stock-based compensation.

42

General and Administrative

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

The following table presents our general and administrative expenses for the three and six months ended June 30, 2017 and 2018 and the dollar and percentage changes from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
General and administrative	$10,534	$11,240	$706	7 %	$20,526	$21,931	$1,405	7 %
Percentage of total revenue	30 %	34 %			27 %	29 %		

Three Months Ended June 30, 2018 and 2017 — General and administrative expenses increased $0.7 million, or 7%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, primarily due to increases of $0.7 million in accounting and tax professional fees.

Six Months Ended June 30, 2018 and 2017 — General and administrative expenses increased $1.4 million, or 7%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, primarily due to increases of $0.8 million in personnel costs and $0.8 million in accounting and tax professional fees, partially offset by a decrease of $0.3 million in legal fees.

Change in Fair Value of Earnout Liability

During the three and six months ended June 30, 2018, we recorded $2.5 million of additional earnout consideration expense due to an adjustment in the estimated fair value of the earnout liability related to the acquisition of GoMedigap, which was completed on January 22, 2018.

Acquisition Costs

During the three and six months ended June 30, 2018, we incurred $18,000 and $0.1 million, respectively, of costs associated with our acquisition of GoMedigap, which was completed on January 22, 2018.

Restructuring Charges

In February 2018, our Board of Directors approved a plan to close our sales call center in Massachusetts and to terminate the employment of other employees in certain other locations. As part of the plan, we eliminated approximately 110 full-time positions in the United States, representing approximately 10% of our workforce primarily in our customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. We incurred $1.9 million for employee termination benefits and related costs in the six months ended June 30, 2018. The restructuring activities comprising the plan were completed during the three months ended June 30, 2018.

The following table presents our restructuring charges for the three and six months ended June 30, 2017 and 2018 and the dollar change from the prior year (dollars in thousands):

	Change	Change

	Three Months Ended June 30,				Six Months Ended June 30,			
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Restructuring charges	$—	$9	$9	100 %	$—	$1,865	$1,865	100 %
Percentage of total revenue	—%	—%			—%	2 %		

Amortization of Intangible Assets

The following table presents our intangible asset amortization expense for the three and six months ended June 30, 2017 and 2018 and the dollar change from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Amortization of intangible assets	$260	$547	$287	110 %	$520	$998	$478	92 %
Percentage of total revenue	1 %	2 %			1 %	1 %		

Amortization expense related to intangible assets purchased through our acquisitions of PlanPrescriber and GoMedigap. Amortization expense for the three and six months ended June 30, 2018 increased year over year due to the amortization of intangible assets from the GoMedigap acquisition, which was completed on January 22, 2018.

Other Income (Expense), Net

The following table presents our other income (expense), net for the three and six months ended June 30, 2017 and 2018 and the dollar change from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Other income (expense), net	$298	$296	$(2)	(1)%	$575	$480	$(95)	(17)%
Percentage of total revenue	1 %	1 %			1 %	1 %		

Other income (expense), net, for the three months ended June 30, 2017 and 2018 primarily consisted of margin earned on commissions received from Medicare plan members transferred to us in 2010 through 2012 by a broker partner, whereby we became the broker of record on the underlying policies. In addition, other income (expense), net included interest income earned on our invested cash, cash equivalents and marketable securities balances, offset by administrative bank fees, investment management fees and interest expense on capital lease obligations.

Other income (expense), net remained relatively unchanged in the three months ended June 30, 2018 compared to the three months ended June 30, 2017.

Other income (expense), net decreased $0.1 million in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, primarily due to a decline in the margin earned on commissions received from Medicare plan members transferred to us by the broker partner due to member attrition.

Benefit from Income Taxes

The following table presents our benefit for income taxes for the three and six months ended June 30, 2017 and 2018 and the dollar change from the prior year (dollars in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Benefit from income taxes	$(8,664)	$(4,610)	$4,054	(47)%	$(13,580)	$(6,301)	$7,279	(54)%
Percentage of total revenue	(25)%	(14)%			(18)%	(8)%		

For the three months ended June 30, 2018, we recognized a benefit from income taxes of $4.6 million, representing an effective tax rate of 28%, which was higher than the statutory federal tax rate due primarily to stock-based compensation adjustments, non-deductible lobbying expenses, and foreign income inclusions, partially offset by research and development credits. For the three months ended June 30, 2017, we recognized a benefit from income taxes of $8.6 million, representing an effective tax rate of 85%, which was higher than the statutory federal rate due primarily to the release of a liability for unrecognized tax benefits, research and development credits and stock-based compensation adjustments, partially offset by non-deductible lobbying expenses.

For the six months ended June 30, 2018, we recognized a benefit from income taxes of $6.3 million, representing an effective tax rate of 27%, which was higher than the statutory federal tax rate due primarily to stock-based compensation adjustments, non-deductible lobbying expenses, and foreign income inclusions, partially offset by research and development credits. For the six months ended June 30, 2017, we recognized a benefit from income taxes of $13.6 million, representing an effective tax rate of 97%, which was higher than the statutory federal tax rate due primarily to the release of a liability for unrecognized tax benefits, research and development credits and stock-based compensation adjustments, partially offset by non-deductible lobbying expenses.

As a result of our adoption of Topic 606 using the full retrospective method, we recognized a significant deferred tax liability in our recasted opening balance sheet due to the resulting acceleration of revenue recognition while revenue for tax purposes will continue to be recognized as we collect cash. This deferred tax liability is a source of income that can be used to support the realizability of our deferred tax assets. As a result of the significantly increased deferred tax liability, we reversed the valuation allowance recorded against our U.S. deferred tax assets as of January 1, 2015, the earliest period to which the retrospective adoption of Topic 606 was applied. We continue to recognize all our deferred tax assets as of June 30, 2018 as we believe it is more likely than not that the net deferred tax assets will be fully realized.

The Tax Cuts and Jobs Act ("Jobs Act") legislation was passed in December 2017, which has various implications on our income tax provision accrual. The main impact of the Jobs Act on our provision (benefit) for income taxes is the decrease in our statutory federal income tax rate from 35% to 21% and the change in the deferred income tax rate used in determining deferred tax balances. Our estimated annual effective tax rate has been adjusted for the impact of the Jobs Act including, among other things, certain limitations on deductions and taxes on Global Intangible Low-Taxed Income ("GILTI") earned by our China subsidiary. Given the complexity of the GILTI provisions, we are still evaluating their effects and as of June 30, 2018, we have included GILTI related to current-year operations only in our estimated annual effective tax rate and have not provided for additional GILTI on deferred items. The effects of other provisions of the tax reform legislation are not expected to have a material impact on our condensed consolidated financial statements. However, the final impact of the Jobs Act may differ from our estimates, due to, among other things, changes in our interpretations and assumptions, additional guidance that may be issued, and resulting actions we may take.

Segment Information

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

•Medicare and
•Individual, Family and Small Business.

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

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

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

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

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

The following table presents summary results of our operating segments for the three and six months ended June 30, 2017 and 2018 (in thousands):

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2017	2018	Amount	Percent	2017	2018	Amount	Percent
Revenue								
Medicare	$24,162	$25,468	$1,306	5 %	$49,572	$56,231	$6,659	13 %
Individual, Family and Small Business	10,404	7,189	(3,215)	(31)%	26,550	19,496	(7,054)	(27)%
Total revenue	$34,566	$32,657	$(1,909)	(6)%	$76,122	$75,727	$(395)	(1)%
Segment profit (loss)								
Medicare segment profit (loss)	$(2,013)	$(1,473)	$540	(27)%	$(2,942)	$1,707	$4,649	(158)%
Individual, Family and Small Business segment profit (loss)	2,065	(617)	(2,682)	(130)%	8,835	2,871	(5,964)	(68)%
Total segment profit (loss)	52	(2,090)	(2,142)	(4,119)%	5,893	4,578	(1,315)	(22)%
Corporate	(6,940)	(7,994)	(1,054)	15 %	(13,739)	(15,848)	(2,109)	15 %
Stock-based compensation expense	(2,569)	(3,131)	(562)	22 %	(4,702)	(5,681)	(979)	21 %
Depreciation and amortization	(751)	(631)	120	(16)%	(1,513)	(1,250)	263	(17)%
Change in fair value of earnout liability	—	(2,500)	(2,500)	100 %	—	(2,500)	(2,500)	100 %
Restructuring charges	—	(9)	(9)	100 %	—	(1,865)	(1,865)	100 %
Acquisition costs	—	(18)	(18)	100 %	—	(76)	(76)	100 %
Amortization of intangible assets	(260)	(547)	(287)	110 %	(520)	(998)	(478)	92 %
Other income (expense), net	298	296	(2)	(1)%	575	480	(95)	(17)%
Loss before benefit from income taxes	$(10,170)	$(16,624)	$(6,454)	63 %	$(14,006)	$(23,160)	$(9,154)	65 %

Revenue

Three Months Ended June 30, 2018 and 2017 — Revenue from our Medicare segment increased $1.3 million, or 5%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 due to a $1.0 million increase in commission revenue and a $0.3 million increase in other revenue. The increase in commission revenue from the Medicare segment was primarily attributable to a 66% increase in Medicare Supplement approved members in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, as well as an increase in the constrained lifetime value of commissions per Medicare Supplement approved member, partially offset by a decline in approved members on Medicare Advantage plans of 5% and approved members on Medicare Part D plans of 18%. The growth in Medicare Supplement approved members and the favorable lifetime value of commissions per Medicare Supplement approved members was driven by our acquisition of GoMedigap in January 2018.

Revenue from our Individual, Family and Small Business segment decreased $3.2 million, or 31%, in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 primarily attributable to a $2.8 million decrease in commission revenue and a $0.4 million decrease in other revenue. The decrease in commission revenue was primarily due to a 67% decrease in individual and family health insurance approved members in the three months ended June 30, 2018 compared to the three months ended June 30, 2017, partially offset by a 41% increase in small business health insurance approved members. The decrease in other revenue was attributed to decreases in both licensing revenue and online sponsorship and advertising revenue.

47

Six Months Ended June 30, 2018 and 2017 — Revenue from our Medicare segment increased $6.7 million, or 13%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 due to a $5.7 million increase in commission revenue and a $1.0 million increase in other revenue. The increase in commission revenue was primarily attributable to a 45% increase in Medicare Supplement plan approved members in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, as well as an increase in the constrained lifetime value of commissions per Medicare Supplement plan approved member. Growth in Medicare Supplement plan approved members and favorable lifetime value of commissions per Medicare Supplement plan approved members was driven by our acquisition of GoMedigap in January 2018, partially offset by a 17% decline in Medicare Part D approved members during the period.

Revenue from our Individual, Family and Small Business segment decreased $7.1 million, or 27%, in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 primarily attributable to a $5.6 million decrease in commission revenue and a $1.5 million decrease in other revenue. The decrease in commission revenue was primarily due to a 46% decrease in individual and family health insurance approved members in the six months ended June 30, 2018 compared to the six months ended June 30, 2017, partially offset by a 47% increase in small business health insurance approved members. The decrease in other revenue was attributed to decreases in both licensing revenue and online sponsorship and advertising revenue.

Segment Profit (Loss)

Three Months Ended June 30, 2018 and 2017 — Loss from our Medicare segment was $1.5 million in the three months ended June 30, 2018, a $0.5 million, or 27%, improvement compared to a loss of $2.0 million in the three months ended June 30, 2017. The improvement in the Medicare segment in the three months ended June 30, 2018 was primarily due to a $1.3 million increase in revenue, partially offset by a $0.8 million increase in operating expenses, excluding stock-based compensation, depreciation and amortization expenses and amortization of intangible assets. The increase in operating expenses was attributable to an increase in personnel costs associated with higher headcount, primarily as a result of the GoMedigap acquisition completed on January 22, 2018.

Loss from our Individual, Family and Small Business segment was $0.6 million in the three months ended June 30, 2018, a $2.7 million, or 130%, decrease compared to profit of $2.1 million from the Individual, Family and Small Business segment in the three months ended June 30, 2017. The decrease in profit from the Individual, Family and Small Business segment in the three months ended June 30, 2018 compared to the three months ended June 30, 2017 was primarily due to a $3.2 million decrease in revenue, partially offset by a $0.5 million decrease in operating expenses, excluding stock-based compensation, depreciation and amortization expenses and amortization of intangible assets.

Six Months Ended June 30, 2018 and 2017 — Profit from our Medicare segment was $1.7 million in the six months ended June 30, 2018, a $4.6 million, or 158%, improvement compared to a loss of $2.9 million in the six months ended June 30, 2017. The improvement in the Medicare segment in the six months ended June 30, 2018 was primarily due to a $6.7 million increase in revenue, partially offset by a $2.1 million increase in operating expenses, excluding stock-based compensation, depreciation and amortization expenses and amortization of intangible assets. The increase in operating expenses was attributable to an increase in personnel costs associated with higher headcount, primarily as a result of the GoMedigap acquisition completed on January 22, 2018.

Profit from our Individual, Family and Small Business segment was $2.9 million in the six months ended June 30, 2018, a $6.0 million, or 68%, decrease compared to profit of $8.8 million from the Individual, Family and Small Business segment in the six months ended June 30, 2017. The decrease in profit from the Individual, Family and Small Business segment in the six months ended June 30, 2018 compared to the six months ended June 30, 2017 was primarily due to a $7.1 million decrease in revenue, partially offset by a $1.1 million decrease in operating expenses, excluding stock-based compensation, depreciation and amortization expenses and amortization of intangible assets.

Liquidity and Capital Resources

At June 30, 2018, our cash and cash equivalents totaled $30.8 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, 2017, our cash and cash equivalents totaled $40.3 million. The decrease in cash and cash equivalents reflects $10.4 million provided by operating activities, offset by $18.8 million used to acquire GoMedigap and to purchase property and equipment and other assets, including capitalized internal-use software and website development costs, and $1.1 million used in the net-share settlement of equity awards, net of proceeds from the exercise of common stock options.

As of June 30, 2018, we had in treasury 660,493 shares that were previously surrendered by employees to satisfy tax withholdings in connection with the vesting of certain restricted stock units. As of December 31, 2017 and June 30, 2018, we had a total of 11,237,995 shares and 11,324,381 shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the six months ended June 30, 2017 and 2018 (in thousands):

	Six Months Ended June 30,	
	2017	2018
Net cash provided by operating activities	7,460	10,436
Net cash used in investing activities	(2,770)	(18,814)
Net cash used in financing activities	(409)	(1,126)

Operating Activities

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

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

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

Six Months Ended June 30, 2018 — Cash provided by operating activities was $10.4 million in the six months ended June 30, 2018, primarily consisting of cash provided by changes in net operating assets and liabilities of $21.7 million and adjustments for non-cash items of $5.6 million, partially offset by a net loss of $16.9 million. Adjustments for non-cash items primarily consisted of $5.9 million of stock-based compensation expense, $2.0 million of amortization of intangible assets and internally-developed software, $1.3 million of depreciation and amortization and $0.4 million of other non-cash items, partially offset by a $6.5 million decrease in deferred income taxes. Cash provided by changes in net operating assets and liabilities during the six months ended June 30, 2018 primarily consisted of decreases of $27.5 million in commissions receivable and $0.6 million in accounts receivable and an increase of $1.1 million accrued expenses and other liabilities, partially offset by decreases of $3.6 million in accrued compensation and benefits, $2.0 million in accrued marketing expenses, $1.2 million in accounts payable and an increase of $1.1

million in prepaid expenses and other assets.

Six Months Ended June 30, 2017 — Cash provided by operating activities was $7.5 million in the six months ended June 30, 2017, primarily consisting of cash provided by operating assets and liabilities of $12.7 million offset by net loss of $0.4 million and adjustments for non-cash items of $4.8 million. Cash provided by changes in net operating assets and liabilities during the six months ended June 30, 2017 primarily consisted of decreases of $20.1 million in commissions receivable and $1.4 million in accounts receivable, partially offset by decreases of $2.8 million in accrued marketing expenses, $2.8 million in accounts payable, $0.8 million in accrued compensation and benefits, and $1.9 million in accrued expenses and other liabilities. Adjustments for non-cash items primarily consisted of $4.7 million of stock-based compensation expense, $1.2

million of amortization of internally-developed software and intangible assets, and $1.5 million of depreciation and amortization, partially offset by a $12.1 million decrease in deferred income taxes.

Investing Activities

Our investing activities primarily consist of purchases of computer hardware and software to enhance our website and customer care operations, leasehold improvements related to facilities expansion, capitalized internal-use software and website development costs and cash used to acquire a business.

Six Months Ended June 30, 2018 — Net cash used in investing activities of $18.8 million in the six months ended June 30, 2018 was due to $14.9 million of net cash used to acquire GoMedigap, $2.8 million in capitalized internal-use software and website development costs and $1.1 million used to purchase property and equipment and other assets.

Six Months Ended June 30, 2017 — Net cash used in investing activities of $2.8 million during the six months ended June 30, 2017 was due to $1.7 million in capitalized internal-use software and website development costs and $1.1 million used to purchase property and equipment and other assets.

Financing Activities

Six Months Ended June 30, 2018 — Net cash used in financing activities of $1.1 million for the six months ended June 30, 2018 was primarily due to $1.7 million used to net-share settle equity awards, partially offset by $0.7 million of proceeds from the exercise of common stock options.

Six Months Ended June 30, 2017 — Net cash used in financing activities of $0.4 million for the six months ended June 30, 2017 was primarily due to $0.4 million used to net-share settle equity awards.

Future Needs

On January 22, 2018, we completed our acquisition of Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, a technology-enabled provider of Medicare Supplement enrollment services. This strategic acquisition significantly enhances our growing presence in the Medicare Supplement market, puts us in a stronger position with carriers and strategic partners and allows us to accelerate our projected Medicare plan enrollment growth in 2018 and beyond. The acquisition price paid at closing of the transaction consisted of cash of $15.0 million, less $0.1 million cash acquired, and approximately 294,637 shares of our common stock. In addition, we are obligated to pay up to an additional $20 million in cash and 589,275 shares of our common stock, subject to the terms of the acquisition agreement and upon final determination of the achievement of certain milestones in 2018 and 2019.

We believe that cash generated from operations and our current cash and cash equivalents will be sufficient to fund our operations, including the additional amounts we are obligated to pay subject to the terms of the acquisition agreement with GoMedigap, for at least twelve months after the filing date of this Quarterly Report on Form 10-Q. Our future capital requirements will depend on many factors, including our expected membership and retention rates, our level of investment in technology, marketing and advertising and our customer care initiatives. In addition, our cash position could be impacted by further acquisitions and investments we make to pursue our growth strategy. 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 or we otherwise desire to raise additional funds, we may raise additional capital through bank debt, line of credit facilities or public or private equity or debt financing to the extent such funding sources are available.

50

Contractual Obligations and Commitments

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and contractual service and licensing obligations as of June 30, 2018 (in thousands):

For the Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2018	$ 2,177	$ 963	$ 3,140
2019	4,966	1,681	6,647
2020	5,238	719	5,957
2021	3,769	—	3,769
2022	3,881	—	3,881
Thereafter	13,852	—	13,852
Total	$ 33,883	$ 3,363	$ 37,246

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 January 2026. Certain of these leases have free or escalating rent payment provisions. We recognize rent expense on our operating leases on a straight-line basis over the terms of the leases, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

On April 25, 2018, we entered into a lease agreement to lease approximately 32,492 square feet of office space located in Santa Clara, California. We entered into this lease agreement as a result of the upcoming expiration of one of our leases in Mountain View, California on August 31, 2018. The term of the lease is approximately one hundred twenty-three months, commencing on an estimated date of October 1, 2018 and ending on an estimated date of December 31, 2028. Future minimum lease payments under this lease are expected to be $17.7 million.

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

In March 2018, we entered into an agreement to lease on approximately 27,000 square feet of office space in Austin, Texas. The term of this lease agreement is ninety months, commencing on an estimated date of July 15, 2018 and ending on approximately January 15, 2026. Future minimum lease payments under this lease will be approximately $4.5 million.

In connection with our Austin, Texas office lease agreement, effective March 30, 2018 we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced on the third and subsequent anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease.

In connection with our Mountain View, California lease agreement in March 2012, we entered into a financial guarantee consisting of a standby letter of credit for $0.6 million, which may be reduced in increments of 25% of the original amount thereof on the first, second and third anniversaries of the commencement date, subject to our compliance with the applicable conditions to such reductions set forth in the lease. The remaining balance on the

financial guarantee is $0.1 million as of June 30, 2018.

Service and Licensing Obligations

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

Off-Balance Sheet Arrangements

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

Recent Accounting Pronouncements

See Note 1 - Summary of Business and Significant Accounting Policies in the Notes to Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q for recently issued accounting standards that could have an effect on us.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash and cash equivalents and accounts receivable. As of December 31, 2017 and June 30, 2018, our cash and cash equivalents were invested as follows (in thousands):

	December 31, 2017	June 30, 2018
Cash [1]	$ 5,098	$7,396
Money market funds [2]	35,195	23,378
Total cash and cash equivalents	$ 40,293	$30,774

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

(2) At December 31, 2017 and June 30, 2018 money market funds consisted of investments in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

Significant Customers

Substantially all revenue for the three and six months ended June 30, 2017 and 2018 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue for the three and six months ended June 30, 2017 and 2018 are presented in the table below:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2017	2018	2017	2018
UnitedHealthcare [1]	21%	24%	22%	23%

Humana	16%	14%	16%	14%

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

As of June 30, 2018, our total outstanding commissions receivable balance was $267.4 million. Our contracts with the above carriers expose us to credit risk that a financial loss could be incurred if the counterparty does not fulfill its financial obligation. While we are exposed to credit losses due to the non-performance of our counterparties, we consider the risk of this

remote. We estimate our maximum credit risk in determining the commissions receivable amount recorded on the balance sheet.

Foreign Currency Exchange Risk

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

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

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

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

Changes in Internal Control over Financial Reporting

Except for the implementation of certain internal controls related to the adoption of ASU No. 2014-09, Revenue from Contracts with Customers (Topic 606), there were no changes in our internal control over financial reporting that occurred during the three months ended June 30, 2018 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting. We implemented certain internal controls to ensure we adequately evaluated our contracts and properly assessed the impact of the new revenue recognition standard on our financial statements to facilitate its adoption effective January 1, 2018. In addition, we have made some changes to certain controls to reflect new processes that were implemented as a result of the adoption of ASU 2014-09.

Inherent Limitations on Effectiveness of Controls

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

Table of Contents

PART II

ITEM 1. LEGAL PROCEEDINGS

On January 26, 2017, a purported class action lawsuit was filed against us in the Superior Court of the State of California, County of Santa Clara. The complaint alleges that we negligently failed to take necessary precautions required to protect from unauthorized disclosure of personally identifiable information contained on 2016 Form W-2s for current and former employees. The complaint purports to allege causes of action against us for negligence, violation of Section 17200 et seq. of the California Business & Professions Code, declaratory relief and breach of implied contract. The complaint seeks actual damages, punitive damages, statutory damages, costs, including experts' fees and attorneys' fees, pre-judgment and post-judgment interest as prescribed by law and equitable, injunctive and declaratory relief as appropriate. In April 2017, an additional purported class action lawsuit was filed against us in the Superior Court of State of California, County of Santa Clara, relating to the same circumstances. The second complaint purports to allege causes of action against us for negligence, violation of California Customer Records Act (California Civil Code Section 1798.80 et seq.), violation of the California Confidentiality of Medical Information Act (California Civil Code Section 56 et seq.), invasion of privacy by public disclosure of private facts, breach of confidentiality and violation of the California Unfair Competition Law (California Business & Professions Code Section 17200 et seq.). The causes of action for violations of the California Customer Records Act and the California Confidentiality of Medical Information Act were dismissed without prejudice. The second complaint seeks actual damages, statutory damages, restitution, disgorgement, equitable, injunctive and declaratory relief, costs, including experts' fees and attorneys' fees and costs of prosecuting the action, and pre-judgment and post-judgment interest as prescribed by law. In July 2017, we entered into a binding settlement term sheet where we and the plaintiffs in each of the above-described cases agreed to enter into a settlement, pursuant to which we would receive a release of all claims that were or could have been alleged related to the unauthorized disclosure at issue in each of the cases. In exchange for the release, we agreed to (i) pay, subject to an aggregate cap of $250,000, up to $2,500 to each impacted individual for reasonable, documented out-of-pocket losses or expenses related to the data security incident; (ii) offer to individuals who signed up for identity theft protection that we offered at the time of the incident a one-year extension of the identity theft protection; (iii) offer to individuals who did not sign up for identity theft protection that we offered at the time of the incident three-years of identity theft protection; and (iv) not oppose a request by class counsel for attorneys' fees, costs and class representative enhancements of up to $245,000 in the aggregate. In December 2017, we entered into a joint stipulation for settlement of class action consistent with the settlement term sheet. The court entered an order preliminarily approving the settlement on April 23, 2018. As a result, notice of the settlement was sent to members of the class informing them of the settlement and the possible relief available to them thereunder. The settlement is subject to final approval of the court after the notice has been sent to the class and after a hearing before the court. As of June 30, 2018, we maintained an accrual in our consolidated financial statements for estimated potential damages and other amounts we expect to be required to pay in connection with the matter.

On April 6, 2018, a former California employee filed a complaint against us in the Superior Court of the State of California for the County of Sacramento. The plaintiff's complaint was filed pursuant to the California Labor Code Private Attorneys General Act of 2004 ("PAGA"), purportedly on behalf of all current and former hourly-paid or non-exempt employees who work or have worked for us in California. The complaint alleges that we violated a number of wage and hour laws with respect to these non-exempt employees, including, among other things, the failure to comply with California law as to (i) the payment of overtime wages; (ii) the payment of minimum wages; (iii) providing uninterrupted meal and rest periods, (iv) the payment of wages earned during employment and owed upon the termination of employment; (v) providing complete and accurate wage statements, (vi) keeping of accurate payroll records; and (vii) the proper reimbursement for necessary business-related expenses and costs. The complaint seeks allegedly unpaid wages, civil penalties and costs, expenses and attorneys' fees. Discovery has only recently commenced, and as a result we cannot estimate the likelihood of liability or the amount of potential damages.

On May 8, 2018, an individual filed a putative class action complaint against us. The complaint alleges that we violated the Telephone Consumer Protection Act, 47 U.S.C. § 227(c) and certain provisions of 47 C.F.R. § 64.1200 promulgated thereunder by initiating or causing to be initiated telephone solicitations to telephone subscribers who registered their respective telephone numbers on the National Do Not Call Registry. The complaint alleges, among other things, that we (i) made more than one unsolicited telephone call to Plaintiff and putative class members within a 12-month period without express consent to place such calls in violation of 47 U.S.C. § 227(c)(5); and (ii) initiated calls for telemarketing purposes without instituting procedures that comply with regulatory minimum standards for implementing Do Not Call in violation of 47 C.F.R. § 64.1200(d). The complaint seeks (i) an order certifying a class of individuals in the United States who (A) received more than one telephone call made by or on behalf of eHealth within a 12-month period; and (B) to a telephone number that had been registered with the National Do Not Call Registry for at least 30 days; (ii) an award of actual and statutory damages for each negligent violation to each member of the class pursuant to 47 U.S.C. § 227(b)(3)(B); (iii) an award of actual and statutory damages for each knowing and/or willful violation to each member of the class pursuant to 47 U.S.C. § 227(b)(3)(A);

(iv) an injunction requiring us and our agents to cease all unsolicited telephone activities and otherwise protecting the interest of the class pursuant to 47 U.S.C. § 227(b)(3)(A); and (v) pre-judgment and post-judgment interest on monetary relief. Due to the preliminary nature of this matter and uncertainty of litigation, we are unable at this time to estimate the likelihood of liability or the amount of potential damages.

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

ITEM 1A. RISK FACTORS

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

Risks Related to Our Business

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

Our business depends upon the private sector of the United States health insurance system, its relative role in financing health care delivery and health insurance carriers' use of, and payment of commissions to, agents and brokers to market health insurance plans. In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have and will continue to change the industry in which we operate in substantial ways. Among several other provisions, health care reform includes a mandate that individuals have qualifying health insurance or face a tax penalty, although the tax penalty is set at zero beginning in 2019; 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; creation of multi-state health insurance plans to be offered on the exchanges and with oversight from the Office of Personnel Management; 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. The implementation of health care reform has increased and could further increase our competition and could reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals, families or small businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause a substantial reduction in our membership and revenue; cause us to incur increased expense across our business and cause health insurance carriers to reduce our commissions and other amounts they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. In addition, various aspects of health care reform have caused and could continue to cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to reduce or eliminate the commissions we receive from them as a result of our sale of health insurance plans, to exit the business of selling individual and family and small business health insurance plans in particular jurisdictions or altogether, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower or no commissions, any of which could materially harm our business, operating results and financial condition.

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

lose their health insurance plans and will need to shop for and purchase individual and family health insurance from another health insurance carrier if they desire to maintain individual and family health insurance. These circumstances have resulted and could in the future result in decreased retention rates in our membership, a reduction in our commission revenue and otherwise harm our business, operating results and financial condition. In addition, many health insurance carriers have increased premiums on the individual and family health insurance that they sell as a result of health care reform. As a result of premium inflation, we have experienced and could in the future experience decreased retention of our members and a reduction in demand for the individual and family health insurance that we sell, which could cause us to suffer a substantial reduction in our membership, and materially harm our business, operating results and financial condition. Moreover, compared to the increased cost of individual and family health insurance plans, government subsidies to purchase health insurance may not be sufficient enough to drive a substantial number of new entrants into the individual and family health insurance market or incentivize our existing members to maintain their individual and family health insurance plans, which could contribute to a decline in our membership and materially harm our business, operating results and financial condition.

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

In addition to eliminating the penalty for violating the individual mandate, the Trump administration issued an executive order in October 2017 that directed the executive branch of the government to consider proposing regulations and revising guidance to expand access to association health plans, expand the availability of short-term health insurance and increase the usability of health reimbursement arrangements. As a result of the executive order, new regulations were adopted in July and August 2018, respectively, that would facilitate association-based health insurance plans and promote the sale of more short-term health insurance. The regulations relating to short-term health insurance plans extend the initial duration of short-term health insurance from three months to less than one year and allow for short-term health insurance plans to be renewed as long as the total duration of the plan does not exceed thirty six months. The expansion of the availability of short-term health insurance may cause individuals and families to purchase short-term health insurance instead of individual and family health insurance, which could adversely impact our business, operating results and financial condition if any reduction in our sales of individual and family health insurance is not offset by increased revenue from sales of short-term health insurance. The regulations relating to association health plans allow small businesses, including sole proprietors and other self-employed individuals, to join industry or geographically-based associations and collectively purchase large group health insurance plans. Large group health insurance is not subject to many of the provisions of the Affordable Care Act, including the requirement that health insurance plans cover all of the essential health benefits defined under the Affordable Care Act. The goal of the new regulation is to create a new health insurance option for small businesses, sole proprietors and other self-employed individuals and to reduce the cost of insurance for association members. While the regulation could present new business opportunities for us, it also may reduce the size of the individual, family and small business health insurance markets that we are able to address, which would harm our business, operating results and financial condition. In light of the current state of the individual and family health insurance market, it appears likely that the Trump administration will continue to attempt to make changes to the Affordable Care Act and its implementing regulations. If the changes do not stabilize the individual and family health insurance market and encourage health insurance carriers to sell affordable individual and family health insurance, our individual and family health insurance business will continue to be adversely impacted.

If we do not retain our existing members and enroll a large number of individuals and families into health insurance plans during enrollment periods, our business will be harmed.

Medicare Advantage and Medicare Part D prescription drug plans are required to be purchased during an annual enrollment period, subject to certain exceptions. As a result of health care reform, individual and family health insurance is required to be purchased during an open enrollment period. Our cash flows from operations depend in large part on the number of paying individual and family and Medicare-related health insurance members we are successful in retaining, including during the enrollment periods. Our revenue depends upon the number individual and family and Medicare-related health insurance members we acquire during the enrollment periods and the constrained lifetime value of commissions we expect to receive for selling the plans to the members we acquire, which is impacted by our member retention rates. We may not be successful in retaining or acquiring members for a number of reasons. If we are unsuccessful, our business, operating results and financial condition would be harmed. For example, we have experienced a decrease in our individual and family

membership retention rates since the implementation of health care reform. We also experienced significantly lower individual and family health insurance application volumes during the last several open enrollment periods. These circumstances have significantly reduced our individual and family health insurance plan membership. An open enrollment period of limited duration in the individual and family health insurance market has resulted, and may in the future result in a reduction in our membership and revenue; an increase in our expenses, particularly during the open enrollment period; and otherwise may harm our business, operating results and financial condition.

It is difficult for the health insurance agents we employ and our systems and processes to handle the increased volume of health insurance transactions that occur in a short period of time during the health care reform annual open enrollment period and the Medicare annual enrollment period. We contract with outsourced call centers and hire additional employees on a temporary or seasonal basis in a limited period of time to address the expected increase in the volume of health insurance transactions during the Medicare annual enrollment period. We must ensure that our employee health insurance agents and the health insurance agent employees of outsourced call centers are timely licensed, trained and certified and have the appropriate authority to sell health insurance in a number of states and for a number of different health insurance carriers. We depend upon state departments of insurance, government exchanges and health insurance carriers for licensing, certification and appointment. If our ability to market and sell Medicare-related health insurance and individual and family health insurance is constrained during an enrollment period for any reason, such as technology failures, reduced allocation of resources, any inability to timely license, train, certify and authorize our employees and contractors to sell health insurance, interruptions in the operation of our website or systems, or issues with government-run health insurance exchanges, we could acquire fewer members, suffer a reduction in our membership and our business, operating results and financial condition could be harmed. The Centers for Medicare and Medicaid Services, or CMS, reduced the length of the open enrollment period for individual and family health insurance so that it runs from November 1 to December 15, which could continue to amplify the risks we face as a result of open enrollment periods. Reduction in the amount of time we have to enroll individuals and families during the open enrollment period could result in a reduction in our membership and harm our business, operating results and financial condition.

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

In an attempt to attract and enroll a large number of individuals during the Medicare annual enrollment period and the health care reform open enrollment period, we may invest in areas of our business, including technology and content, customer care and enrollment, and marketing and advertising. We have in the past made investments in areas of our business in advance of enrollment periods that have not resulted in the results we expected when making those investments. Any investment we make in either the Medicare annual enrollment period or the health care reform open enrollment period may not result in a significant number of approved and paying members. If it does not, our business, operating results and financial condition would be harmed.

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

In order to offer the qualified health plans that individuals and families must purchase to receive Affordable Care Act subsidies, agents and brokers must meet certain conditions, such as receiving permission to do so from the applicable government health insurance exchange, entering into an agreement with the health insurance exchange, ensuring that the enrollment and subsidy application is completed through the health insurance exchange and complying with privacy, security and other standards, some of which 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 requirements. To the extent we enroll individuals and families into qualified health plans, we do so through our relationship with the Federally Facilitated Marketplace, or FFM, which runs all or part of the health insurance exchange in 36 states. We have not focused on enrolling

individuals into qualified health plans through exchanges in states operating their own health insurance exchanges. We may experience difficulty in satisfying the conditions and requirements to offer qualified health plans to our existing members and new potential members and in enrolling them through the FFM. If we are not able to satisfy these conditions and requirements, or if we are not able to successfully adopt and maintain solutions that allow us to enroll large numbers of individuals and families in qualified plans over the Internet both during and outside of open enrollment periods, we will lose existing members and new members, and may incur additional expense, which would harm our business, operating results and financial condition. In addition, if we are not able to adopt or contract with and maintain solutions to integrate with government-run health insurance exchanges or if the health insurance exchange websites and other processes are unstable or not consumer friendly, efficient and compatible with the process we have adopted for enrolling individuals and families into qualified health plans through the exchanges, we would not be successful in retaining and acquiring members, and our business, operating results and financial condition would be harmed. The FFM may at any time cease allowing us to enroll

individuals in qualified health plans or change the requirements for doing so. If it does so or if the FFM platform does not function properly, our ability to retain existing members and add new members could be negatively impacted, which would harm our business, operating results and financial condition.

CMS has broad authority over the requirements that we must meet in order to enroll individuals into qualified health plans through the FFM, and in addition to issuing new requirements, has the authority to interpret existing requirements. CMS directed us to alter our method of enrolling subsidy eligible individuals into qualified health insurance plans beginning in February 2016. The change required us to cease using the online process we developed for enrolling individuals into qualified health plans through the FFM and use a prescribed FFM “double redirect” process that required that our customers visit the FFM website in the middle of purchasing health insurance to receive a subsidy eligibility determination. The FFM process resulted in a reduction in the rate at which individuals and families starting the application process for qualified health plans and subsidies became members and a reduction in our membership. If we are forced to use this process, we could continue to experience loss of existing members and new potential members and a reduction in our individual and family health insurance plan membership and commission revenue, which would harm our business, operating results and financial condition.

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

CMS issued guidance in May 2017 that makes it possible for us to implement a process for subsidy-eligible individuals to enroll into qualified health insurance plans and apply for advanced payment of premium tax credits through the FFM without leaving our website. In October 2017, we entered into an agreement with CMS that permits us to use this improved process if we ensure that the user experience meets several regulatory requirements. In addition, we must comply with numerous privacy and security requirements. The new enrollment process also has limitations, including the inability to purchase less expensive catastrophic health insurance and an inability to process certain more complex qualified health plans and subsidy eligibility applications for which we are required to use the “double redirect” process that is cumbersome and difficult for consumers to navigate. In addition, CMS may make changes that could affect our ability to process health insurance applications efficiently using this new enrollment process. If we cannot successfully maintain use of a process that allows us to enroll subsidy eligible individuals into qualified health insurance plans through the FFM in a manner where the individual does not have to navigate back and forth between the platforms we use and the FFM, we could experience loss of existing members and new potential members, and a reduction in our individual and family health insurance plan membership and commission revenue, which would harm our business, operating results and financial condition. In addition, if a significant percentage of consumers who come to our platform are complex cases that must use the "double redirect" process, we will not realize the benefit of the new process and our conversion rates and individual and family health insurance membership and revenue may decline.

The laws, regulations and requirements applicable to enrolling individuals in qualified health plans through government-run health insurance exchanges are evolving. For example, CMS has indicated that it intends to abandon support of the improved qualified health plan enrollment process in favor of another new process that allows qualified entities to access the database of information relating to health plans and subsidy eligibility through an application programming interface. While we believe this process is better than the existing and improved process, CMS has indicated that entities must satisfy numerous additional privacy and security requirements to be able to use it. We intend to outsource certain aspects of the qualified health plan online enrollment process to a third party in light of the expense and burden associated with the additional requirements. If the entity we use to perform these functions does not meet these requirements and pass an audit in time for the upcoming open enrollment period, and if CMS abandons the existing improved process, we could be required to use the "double redirect" process for qualified health plan enrollment, which would result in our experiencing a reduction in our individual and family health insurance plan membership and revenue and harm our business, operating results and financial condition.

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

We compete with government-run health insurance exchanges, among others, with respect to our sale of Medicare-related and individual and family health insurance. The federal government operates a website where Medicare beneficiaries can shop for and purchase Medicare Advantage and Medicare Part D Prescription Drug plans. Medicare beneficiaries can also obtain assistance from the federal government in connection with their purchase of a Medicare Advantage and Medicare Part D Prescription Drug plan. The exchanges in the individual and family health insurance market created by the Affordable Care Act may elect whether or not we are able to enroll subsidy-eligible individuals in qualified health plans through them and determine the manner in which we may do so. The Affordable Care Act exchanges have websites where individuals and small businesses can shop for and purchase health insurance, and they also have offline customer support and enrollment capabilities. Individuals who are eligible for government subsidies in the form of premium tax credits and cost sharing reductions must apply for their subsidy and purchase qualified health plans through a government exchange to receive their subsidy. In the aggregate, government exchanges have greater resources and greater public outreach capability than we do and they or the government agencies that run them may in the future impact the process we use to enroll individuals and families in a manner that results in a reduction in our membership. In addition, individuals who utilize our platform and services to apply for subsidies and health insurance through Affordable Care Act exchanges receive marketing and communications from the exchanges after they do so. In the event our existing members purchase health insurance directly through health insurance exchanges without using us as their health insurance agent, as a result of their being eligible for a subsidy or otherwise, we will no longer receive commission payments as a result of our sale of health insurance to them. Under regulations adopted as a part of health care reform under the Affordable Care Act, government-run health insurance exchanges are required to automatically re-enroll individuals and families into a qualified health insurance plan purchased through the exchange if the individuals or families do not take affirmative action, which may contribute to a reduction in our membership. Competitive pressure from government-run health insurance exchanges has resulted, and may in the future result, in our experiencing increased marketing costs, decreased traffic to our website, a reduction in our membership and revenue and may otherwise harm our business, operating results and financial condition.

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

We recognize revenue for Medicare-related, individual and family and ancillary health insurance plan approved members based upon the total expected commissions we expect to receive over the life of the underlying polices, net of a constraint. We recognize small business health insurance plan commission revenue at the time the application for the plan is approved by the carrier and when it renews each year thereafter, equal to the estimated commissions we expect to collect over the following 12-months. The constrained lifetime value for each product line is an estimate and is based on a number of assumptions, which include, but are not limited to, estimates of the conversion rates of approved members into paying members, forecasted member churn and forecasted commission amounts we expect to receive per approved member. These assumptions are based on historical trends and incorporate management’s judgment. Changes in our historical trends will result in changes to our constrained lifetime value estimates in future periods and therefore could adversely affect our revenue and financial results in those future periods. As a result, negative changes in the factors upon which we estimate constrained lifetime values, such as reduced conversion of approved members to paying members, increased member churn or a reduction in the lifetime commission amounts we expect to receive for selling the plan to a member, would harm our business, operating results and financial condition. In addition, if we ultimately receive commission payments that are less than the amount we estimated when we recognized commission revenue, we would need to write-off of the remaining commission receivable balance, which would harm our business, operating results, cash flows and financial condition.

The rate at which approved members become paying members is a significant factor in our estimation of constrained lifetime values. For example, during the first open enrollment period under the Affordable Care Act, we experienced a

decline in the rate at which members approved for individual and family health insurance turned into paying members, which harmed our operating results. To the extent we experience a similar decline in the rate at which approved members turn into our paying members, our business, operating results, cash flows and financial condition would be harmed.

We receive commissions from health insurance carriers for health insurance plans sold through us. When one of these plans is canceled, or if we otherwise do not remain the agent on the policy, we no longer receive the related commission payment. Our estimate of constrained lifetime value is net of an estimated annual health insurance plan cancellation rate based on our historical experience by plan type. As a result, an increase in our annual health insurance plan cancellation rate would harm our business, operating results, cash flows and financial condition.

Commission rates are a significant factor in our estimation of constrained lifetime values. The commission rates we receive are impacted by a variety of factors, including the particular health insurance plans chosen by our members, the carriers

offering those plans, our members' states of residence, the laws and regulations in those jurisdictions, the average premiums of plans purchased through us and health care reform. Our commission revenue per member has in the past decreased, and could in the future decrease, as a result of reductions in contractual commission rates, a change in the mix of carriers whose products we sell during a given period, and increased member churn, all of which are beyond our control and may occur on short notice. To the extent these and other factors cause our commission revenue per member to decline, our revenue may decline and our business, operating results cash flows and financial condition would be harmed. Given that Medicare-related and individual and family health insurance purchasing is concentrated during enrollment periods, we may experience a shift in the mix of Medicare-related and individual and family health insurance products selected by our members over a short period of time. Any reduction in our average commission revenue per member during the open enrollment period caused by such a shift or otherwise would harm our business, operating results, cash flows and financial condition.

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

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

Health insurance carriers can unilaterally amend the commission rates that they pay to us. Given the significant losses that carriers have sustained in connection with their sale of individual and family health insurance as a result of health care reform, many health insurance carriers with which we have a relationship, including large national health insurance carriers, reduced or eliminated our commissions for selling individual and family health insurance, and in a limited number of cases, our renewal commissions. As a result, we have experienced a meaningful reduction in our average commission rates for our aggregate individual and family health insurance plan membership. In addition, the reduction in contractual commission rates and these carriers' desire to not sell individual and family health insurance has reduced the number of plans that we are able to offer on our websites, which has resulted in less consumer demand for the individual and family health insurance that we sell and a reduction in our membership. In the future and as a result of health care reform or for other reasons, an increasing number of health insurance carriers may decide to reduce our commissions, rely on their own internal distribution channels to sell their own plans, determine not sell individual and family health insurance or otherwise limit or prohibit us from selling their plans on our ecommerce

platforms. In addition to reducing commission rates, health insurance carriers may determine to exit the individual and family health insurance business in certain states or increase premiums to a significant degree, which could cause our members' health insurance to be terminated or our members to purchase new health insurance or determine not to pay for health insurance at all. If we lose these members, our business, operating results and financial condition could be harmed. In addition, if the number of individual and family health insurance products that we are able to offer does not increase, we will continue to experience reduced demand for our services and a reduction in our membership, which would harm our, business, operating results and financial results.

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

Our success is dependent upon our ability to attract and retain qualified personnel for all areas of our organization. We may not be successful in attracting and retaining personnel on a timely basis, on competitive terms or at all. If we are unable to attract and retain the necessary personnel, our business would be harmed. Our success depends upon the performance of our executive officers and key personnel. Our executive officers and employees can terminate their employment at any time. We have recently experienced significant changes in our senior management. David Francis, our former chief financial officer appointed in July 2016, most recently became our chief operating officer in January 2018. In June 2018, Derek Yung became our chief financial officer, allowing Mr. Francis to focus on his responsibilities as chief operating officer. In addition to these changes, other senior executive officers have left us, and we have hired additional senior executives, including Tim Hannan, chief marketing officer, Ian Kalin, chief technology officer, and David Nicklaus, senior vice president, sales and operations. The change in leadership we have experienced has been significant and has occurred over a short period of time. The transition and the departure of members of our senior management could result in further attrition in our senior management and key personnel and the significant change in leadership over a short period of time could harm our business, operating results and financial condition.

The loss of the services of any of our executive officers or key employees could harm our business. For example, we appoint a single writing agent with each insurance carrier. A small number of our employees act as writing agent and each employee that acts as writing agent does so for a number of carriers. Robert Hurley is the writing agent in a large number of our carrier relationships. 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 business may be harmed if we are not successful in executing on our strategic investments and initiatives.

In 2016 we conducted a strategic review of our business operations and examined potential areas of investment and strategic emphasis. As part of our strategy, we have determined to invest in initiatives to accelerate growth in our Medicare product sales, including Medicare Advantage and Medicare Supplement plans. We also plan to invest resources in efforts to grow our small business group insurance business and pursue cross-selling and adjacent revenue opportunities in our Medicare and small business group business. Further, we have introduced a number of insurance benefit packages that may include a short-term health insurance product and/or other ancillary health insurance products, and we otherwise intend to invest in the sale of short-term health insurance. Pursuing and investing in these initiatives will require significant investments in marketing and advertising, technology and product offerings, and customer care and enrollment, among others. Our pursuit of and investment in these initiatives involves risks and uncertainties described elsewhere in this Risk Factors section, including the initiatives resulting in insufficient revenue to offset any expenses associated with these new investments, inadequate return of capital on our investments, legal and regulatory compliance risks, potential changes in laws and regulations and other issues that could cause us to fail to realize the anticipated benefits of our investments and incur unanticipated liabilities. Our pursuit of these strategic initiatives may not be successful. If we are not successful in executing on our business strategy, our future profitability would be negatively impacted and our business, operating results and financial condition would be harmed.

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

The health insurance industry in the United States has experienced a substantial amount of consolidation, resulting in a decrease in the number of health insurance carriers. Consolidation in the health insurance industry could cause a loss of or changes in our relationship with carriers and reduction in our commission or other revenue, which could harm our business, operating results and financial condition. In the future, we may be forced to offer health insurance from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. Revenue derived from carriers owned by UnitedHealthcare represented approximately 22% and 23% of our total revenue for the six months ended June 30, 2017 and 2018, respectively. Revenue derived from Humana represented approximately 16% and 14% of our total revenue for the six months ended June 30, 2017 and 2018, respectively. We have several agreements that govern our sale of health insurance plans with these health insurance carriers. They may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact or cause the termination of the commission payments that we receive from these health insurance carriers, including commissions on plans that we have already sold, which could materially harm our business, operating results and financial condition. Our revenue could be adversely impacted if we are unable to maintain currently-existing levels of business

with any of our significant health insurance carriers if we are unable to offset any loss of business with alternative health insurance carriers. We expect that a small number of health insurance carriers will account for a significant portion of our revenue for the foreseeable future and any impairment of our relationship with, or the material financial impairment of, these health insurance carriers could adversely affect our business.

Seasonality may cause fluctuations in our financial results.

The seasonality of our business is outside of our control. For example, prior to the last open enrollment period for individual and family health insurance coverage, the open enrollment period spanned portions of the fourth calendar quarter of the year and the first calendar quarter of the following year. In the fourth quarter of 2017, the individual and family health insurance open enrollment period for coverage effective in 2018 began on November 1, 2017 and ended on December 15, 2017, which again changed the seasonality of our individual and family business. We expect the open enrollment period to continue to occur during this time frame. We generally expect the number of approved members for individual and family health insurance to be higher in the fourth quarter as a result. A significant portion of our marketing and advertising expenses is driven by the number of health insurance applications submitted through us. Since our marketing and advertising costs are expensed and generally paid as incurred and commissions from approved members are paid to us over time, our operating cash flows could be adversely impacted by a substantial increase in marketing expense as a result of a higher volume of applications submitted during a quarter or positively impacted by a substantial decline in marketing expense as a result of lower volume of applications submitted during a quarter. During the Medicare annual enrollment period, which occurs during the fourth quarter of the year, we experience an increase in the number of submitted Medicare-related health insurance applications and marketing and advertising expenses compared to outside of Medicare annual enrollment periods. Similarly, during open enrollment periods for individual and family health insurance plans, we experience an increase in the number of submitted individual and family plan health insurance applications and marketing and advertising expenses compared to outside of open enrollment periods. The timing of open enrollment periods for individual and family health insurance and the Medicare annual enrollment period for Medicare-related health insurance impacts our operating cash flow.

The seasonality of our business could change in the future due to other factors, including as a result of changes in timing of the Medicare or individual and family health plan annual open enrollment periods and changes in the laws and regulations that govern the sale of health insurance. We may not be able to timely adjust to changes in the seasonality of our business. If the timing of the open enrollment periods for Medicare-related health insurance or individual and family health insurance change, we may not be able to timely adapt to changes in customer demand. If we are not successful in responding to changes in the seasonality of our business, our business, operating results and financial condition could be harmed.

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

Our estimated individual and family health insurance plan membership has declined substantially since the implementation of health care reform. We receive commissions from health insurance carriers who pay to us for health insurance plans sold through us. When one of these plans is canceled, or if we otherwise do not remain the agent on the plan, we no longer receive the related commission payment. Our members may choose to discontinue their health insurance plans for a variety of reasons. For example, our members may replace a health insurance plan purchased through us with a health insurance plan 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 plans through other sources or use a different agent. Consumers may also purchase individual and family and Medicare-related health insurance plans directly from government-run health insurance exchanges, including as a result of the requirement that subsidy-eligible individuals must purchase qualified health plans through government-run health insurance exchanges to be able to receive a subsidy under health care reform, and we would not remain the agent on the policy. Health insurance carriers have in the past and may in the future terminate health insurance plans purchased and held by our

members. Any decrease in the amount of time we retain our members could adversely impact the lifetime value we use for purposes of recognizing revenue, which could harm our business, operating results and financial condition. Moreover, if we are not able to successfully retain existing members and limit member turnover, our cash flows from operations will be adversely impacted and our business, operating results and financial condition would be harmed. In addition, the Medicare-related commission rates that we receive may be higher in the first calendar year of a plan if the plan is the first Medicare-related plan issued to the member. The individual and family commission rates that we receive are typically higher in the first twelve months of a policy. After the first twelve months, they generally decline significantly. As a result, if we do not add a sufficient number of members to new plans, our cash flows will also be negatively impacted. If we experience higher member turnover than we estimated when we recognized commission revenue, we may not collect all of the related commission receivable, resulting in a write-off of the remaining commission receivable balance, which would harm our business, operating results, cash flows and financial condition.

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

The Affordable Care Act contains provisions requiring health insurance carriers to maintain specified medical loss ratios. The medical loss ratio requirements for both individual and family and small business health insurance require health insurance companies to spend 80% of their premium revenue in each of their individual and small group health insurance businesses on reimbursement for clinical services and activities that improve health care quality. The medical loss ratio requirement for Medicare Advantage plans is 85%. If a health insurance carrier fails to meet medical loss ratio requirements, the health insurance carrier is required to rebate a portion of its premium revenue to its members to make up for the difference.

Carrier reaction to the individual and family medical loss ratio requirements was to significantly reduce the commissions we receive in connection with the sale of individual and family health insurance. Health insurance carriers may determine to reduce or further reduce our Medicare Advantage plan, individual and family, or small group commissions as a result of the medical loss ratio requirements or other aspects of health care reform, including any increased expenses in complying with or dealing with the impact of health care reform, which would harm our business, operating results and financial condition. The implementation of medical loss ratio requirements has caused and could further cause health insurance carriers to reduce the amount they are willing to spend in connection with our sponsorship and advertising and technology licensing businesses, which also could harm our business, operating results and financial condition.

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

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

In addition, we may temporarily or permanently lose the ability to market and sell Medicare plans for our Medicare plan carriers. For instance, a carrier may terminate our relationship. Moreover, CMS heavily regulates the sale of Medicare Advantage and Medicare Part D prescription drug plans and has and will continue to penalize health insurance carriers for certain regulatory violations by suspending or terminating the carrier's ability to market and sell Medicare plans for significant periods of time. CMS also may require the carrier to terminate its membership and allow its members to move to other plans. Given the concentration of our Medicare plan sales in a small number of carriers, if we lose a relationship with a health insurance carrier to market their Medicare plans temporarily or permanently or if the health insurance carrier loses its Medicare product membership, our sales as a health insurance agent and Medicare plan related revenue could be reduced significantly, and our business, operating results and financial condition would be harmed. The agreements that we have with health insurance carriers to sell Medicare plans may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact, or cause the termination of, the commission payments that we receive for selling their Medicare plans, including commissions on plans that we have already sold, which could materially harm our business operating results and financial condition.

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

Health insurance carriers whose Medicare plans we sell approve our websites, much of our marketing material and our call center scripts. We must receive these approvals in order for us to be able to generate Medicare plan demand and sell Medicare plans to Medicare-eligible individuals as a health insurance agent. Many of these materials also must be filed with CMS. In the event that CMS or a health insurance carrier requires change to, disapproves, or delays approval of our websites, our marketing material or call center scripts, we could lose a significant source of Medicare plan demand and our ability to sell Medicare plans would be adversely impacted, which would harm our business, operating results and financial condition. The rules and regulations relating to the approval and submission of marketing material also apply to marketing material of our marketing partners. If we are not successful in timely submitting these marketing materials to health insurance carriers for approval, in gaining that approval and in filing the marketing material with CMS, our Medicare plan marketing could become less effective, which would harm our business, operating results and financial condition. If a marketing partner of ours does not consent to having its website or other marketing material filed with CMS, does not make changes required by carriers or CMS or does not comply with the CMS marketing guidelines or other Medicare program related laws, rules and regulations, we may

lose the ability to receive referrals of individuals interested in purchasing Medicare plans from that marketing partner or our ability to receive referral could be delayed and our business, operating results and financial condition would be harmed.

If we or our marketing partners substantively change our websites or call center scripts after they are filed with CMS, we may need to resubmit them to health insurance carriers and have them re-filed with CMS. We are not permitted to make CMS filings ourselves. Given the review cycles our scripts, websites and other marketing material undergo, it is very difficult and time consuming to make changes to them, and our inability to timely make changes to these marketing materials, whether to comply with new rules and regulations or otherwise could adversely impact our ability to sell Medicare plans, which could adversely impact our business, operating results and financial condition. In addition, if a change to scripts or websites is required by CMS or health insurance carriers, we may be prevented from using the marketing material until the change is made and approved, which would harm our business, operating results, and financial condition, particularly if it occurred during the annual enrollment period.

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

In addition to our websites, we rely upon our customer care centers and outsourced call centers to sell Medicare plans. The success of our customer care center operations is largely dependent on licensed health insurance agents and other employees. In order to sell Medicare-related health insurance plans, our health insurance agent employees and employees of third-party call centers must be licensed by the states in which they are selling plans and certified and appointed with the health insurance carrier that offers the plans in each state that the Medicare-related health insurance product is being sold by the agent. Because a significant number of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period, we retain and train a significant number of additional employees and employees of third-party call centers on a temporary or seasonal basis in a limited period of time. It may be difficult for the health insurance agents we employ and contract with and our systems and processes to handle the increased volume of health insurance transactions that occur in a short period of time during the Medicare annual enrollment period. We must also ensure that our health insurance agents are timely licensed in a significant number of states and certified and appointed with the health insurance carriers whose products we sell. We depend upon state departments of insurance and health insurance carriers for the licensing, certification and appointment of our health insurance agents. We may not be successful in timely hiring a sufficient number of additional licensed agents or other employees or engaging with outsourced call center agents for the Medicare annual enrollment period, and even if we are successful, these health insurance agents may experience delays in obtaining health insurance licenses and certifications and health insurance carrier appointments with our health insurance carrier partners. These temporary or seasonal health insurance agents may not perform to the standard we expect of them, which could result in lower than expected conversion rates and revenue and higher costs of acquisition per member. In addition, we may not be able to staff sufficient licensed agents from third-party call centers to handle the volume of calls we receive during the peak selling times of the annual enrollment period. If we are not successful in these regards, our ability to sell Medicare-related health insurance plans will be impaired during the annual enrollment period, which would harm our business, operating results and financial condition.

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

The success of our Medicare plan customer care center operations is dependent upon information technology systems. The vast majority of our Medicare plan members utilize our customer care center in connection with their purchase of a Medicare plan. CMS rules require that our health insurance agent employees utilize CMS-approved scripts in connection with the sale of Medicare plans and that we record and maintain the recording of telephonic interactions relating to the sale of Medicare plans. We rely on telephone, call recording, customer relationship management and other systems and technology in our Medicare customer care center operations, and we are

dependent upon third parties for some of them, including our telephone and call recording systems. These systems have failed temporarily in the past. The effectiveness and stability of our Medicare customer care center systems and technology are critical to our ability to sell Medicare plans, particularly during the Medicare annual enrollment period, and the failure or interruption of any of these systems and technology or any inability to handle increased volume during the annual enrollment period would harm our business, operating results and financial condition.

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

We determined to enter into the Medicare plan market, because we believe the number of individuals becoming eligible for Medicare is increasing and these individuals are increasingly using the Internet to shop for health insurance plans.

We also believe that, on average, member retention rates and the commissions that health insurance carriers pay in connection with the sale of Medicare plans compare favorably to the member retention rates and commissions we receive in connection with our sale of individual and family health insurance. Should we prove to be wrong, or should these circumstances reverse, our success in marketing Medicare plans would be materially and adversely impacted, which could harm our business, operating results and financial condition. For instance, CMS has in the past determined to reduce the payments it makes to health insurance carriers in connection with the sale of Medicare Advantage plans and it may do so again in the future. These reductions have caused, and could in the future cause, the cost of Medicare Advantage plans to increase or the benefits under Medicare Advantage plans to decrease, either of which would impair our ability to sell Medicare Advantage plans and our business, operating results and financial condition could be harmed. They also may cause health insurance carriers to reduce our compensation, which would harm our business, operating results and financial condition.

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

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

- our ability to continue to adapt our ecommerce platforms to market Medicare plans, including our development or acquisition of marketing tools and features important in the sale of Medicare plans online and the effective modification of our user experience;

- our success in marketing to Medicare-eligible individuals, including television advertising and direct mail marketing, and in entering into marketing partner relationships to drive Medicare-eligible individuals to our ecommerce platforms on a cost-effective basis;

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

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

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

- our ability to leverage technology in order to sell, and otherwise become more efficient at selling, Medicare-related plans over the telephone;

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

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

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

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

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

As a result of the laws, regulations and guidelines relating to the sale of Medicare plans, we have altered, and likely will have to continue to alter, our websites and sales process to comply with several requirements that are not applicable to our sale of non-Medicare-related health insurance plans. For instance, many aspects of our online platforms and our marketing material and processes, as well as changes to these platforms, materials and processes, including call center scripts, must be filed on a regular basis with CMS and reviewed and approved by health insurance carriers in light of CMS requirements. In addition, certain aspects of our Medicare plan marketing partner relationships have been in the past, and will be in the future, subjected to CMS and health insurance carrier review. Changes to the laws, regulations and guidelines relating to Medicare plans, their interpretation or the manner in which they are enforced could be incompatible with these relationships, our platforms or our sale of Medicare plans. For instance, a change in sales and marketing guidelines issued by CMS resulted in our making changes to our Medicare product sales and marketing processes during the third quarter of 2016 that impacted the effectiveness of our call center agents in converting leads into submitted applications. In February 2015 CMS issued guidance indicating that third party websites and marketing material must be filed with CMS, which has impacted our marketing partner relationships. Given the resources and review required of us and health insurance carriers prior to CMS filing, we may not have all of our marketing partner websites and material filed with CMS, which could harm our business, operating results and financial condition. Our marketing partner websites and marketing material that are filed with CMS also may not make it through the review process in time for the Medicare annual enrollment period. Moreover, under CMS guidance, websites and marketing material must be refiled with CMS if changed, which makes it difficult to adapt and optimize our own websites and marketing material as well as our marketing partner websites and marketing material in a short amount of time and could harm our business, operating results and financial condition.

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

CMS has in the past adopted rules relating to the timing and nature of the compensation of agents in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans. The effect of these rules was to reduce our compensation as a health insurance agent in connection with the sale of these plans or had other adverse consequences. In the event CMS adopts regulations that have the effect of reducing the compensation that we receive in connection with the sale of Medicare Advantage and Medicare Part D prescription drug plans, our business, operating results and financial condition would be harmed. In the event the actions of the federal government, state governments or other circumstances decrease the demand for the Medicare related health insurance that we sell, or result in a reduction in the amount paid to us or impact the timing of our revenue recognition in connection with the sale of these plans, our business, operating results and financial condition could be harmed.

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

The market for selling health insurance plans is highly competitive. We compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our competitors include local insurance agents across the United States who sell health insurance plans in their communities. There also are a number of companies that operate websites, provide an online shopping experience for consumers interested in purchasing health insurance and act as a health insurance agent in connection with that purchase. Some local agents also use Internet advertising and "lead aggregator" services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to health insurance agents or carriers. Many health insurance carriers also directly market and sell their plans to consumers through call centers, Internet advertising and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. In connection with our marketing of Medicare plans, we compete with the original Medicare program. CMS also offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans. We compete with the FFM and state health insurance exchanges implemented as a result of health care reform in marketing individual and family health insurance products. Health care reform also has resulted in health insurance plan cost and benefit data being more readily accessible, which has facilitated additional competition.

To remain competitive against our current and future competitors, we will need to market our services effectively and continue to improve the online shopping experience and functionalities of our website and other platforms that our current and future customers may access to purchase health insurance products from us. If we cannot predict, develop and deliver the right shopping experience and functionality in a timely and cost-effective manner, or if we are not effective in cost-effectively driving a substantial number of consumers interested in purchasing health insurance to our website and customer care centers, we may not be able to compete successfully against our current or future competitors and our business, operating results and financial condition may be adversely affected.

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

- undertake more extensive marketing campaigns for their brands and services;
- devote more resources to website and systems development and other aspects of their operations to comply with applicable laws, regulations and rules;
- negotiate more favorable commission rates and commission override payments; and
- make more attractive offers to potential employees, marketing partners and third-party service providers.

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

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

Our growth depends in large part upon growth in approved members in a given period. The rate at which consumers visiting our ecommerce platform and customer care centers seeking to purchase health insurance are converted into approved members directly impacts our revenue in a given period. In addition, the rate at which consumers who are approved become paying members impacts the lifetime value of our approved members, which impacts the revenue that we are able to recognize. A number of factors have influenced, and could in the future influence, these conversion rates for any given period, some of which are outside of our control. These factors include:

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

- the quality of and changes to the consumer experience on our ecommerce platform or with our customer care center;
- regulatory requirements, including those that make the experience on our online platforms cumbersome or difficult to navigate;
- the variety, competitiveness and affordability of the health insurance plans that we offer;
- system failures or interruptions in the operation of our ecommerce platform or call center operations;
- changes in the mix of consumers who are referred to us through our direct, marketing partner and online advertising member acquisition channels;
- health insurance carriers offering the health insurance plans for which consumers have expressed interest, and the degree to which our technology is integrated with those carriers;
- health insurance carrier guidelines applicable to applications submitted by consumers, the amount of time a carrier takes to make a decision on that application and the percentage of submitted applications approved by health insurance carriers; and
- our ability to enroll subsidy-eligible individuals in qualified health plans through government-run health insurance exchanges and the efficacy of the process we are required to use to do so.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels. We may make changes to our ecommerce platforms in response to regulatory requirements or undertake other initiatives in an attempt to improve consumer experience or for other reasons. These changes have in the past, and may in the future have the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platforms or telephonically via our customer care centers and are converted into approved and paying members could cause an increase in our cost of acquiring members on a per member basis and impact our revenue in any given period. To the extent the rate at which we convert consumers visiting our ecommerce platforms or telephonically via our customer care centers into members suffers, our membership may decline, which would harm our business, operating results and financial condition.

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

The demand for health insurance marketed through our ecommerce platforms is impacted by, among other things, the variety, quality and price of the health insurance plans we offer. Many health insurance carriers, including major national health insurance carriers, have exited the individual and family health insurance market in a large number of states where we have historically represented their insurance plans or determined to pay reduced or no commissions for the sale of their plans. We have determined not to sell health insurance products for which we do not receive commissions. As a result of these circumstances, the number of individual and family health insurance plans we offer to sell on our website has reduced significantly and there are many states and zip codes we do not offer any individual and family health insurance. This reduction in supply has adversely impacted, and may in the future adversely impact, demand for the individual and family health insurance we sell. If our ability to sell a variety of high-quality, affordable health insurance plans in the Medicare, individual and family, small business and ancillary product markets is impaired, or our health insurance plan offerings are limited or terminated as a result of consolidation in the health insurance industry, health care reform or otherwise, our sales or average commission rate per member may decrease and our business, operating results and financial condition could be harmed. In addition, the cost of health insurance has increased substantially in many states as a result of health care reform implementation, which has reduced demand

for individual and family health insurance. To the extent these conditions persist or worsen, our business, operating results and financial condition would be harmed.

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

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

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

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

Our operating results are likely to fluctuate as a result of a variety of factors, including the factors described elsewhere in this Risk Factors section, many of which are outside of our control. Among these factors, the assumptions underlying our estimates of commission revenue as required by Accounting Standards Update 2014-09, Revenue from Contracts with Customers (Topic 606), may vary over time. As a result, comparing our operating results on a period-to-period basis may not be meaningful and you should not rely on our past results as an indication of our future performance, particularly in light of the fact that our business and industry are undergoing substantial change as a result of health care reform and initiatives we determined to pursue. If our revenue or operating results differ from our guidance or fall below the expectations of investors or securities analysts, the price of our common stock could decline substantially. In the past, when our revenue and operating results differed from our guidance and the expectations of investors or securities analysts, the price of our common stock was impacted.

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

The performance, reliability and availability of our ecommerce platforms and underlying network infrastructures are critical to our financial results, our brand and our relationship with members, marketing partners and health insurance carriers. Although we regularly attempt to enhance our ecommerce 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, 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.

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

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

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

We purchase paid advertisements on search engines in order to attract consumers to our website. We typically pay a search engine for prominent placement of our website when particular health insurance-related terms are searched for on the search engine, regardless of the algorithmic search result listings. The prominence of the placement of our advertisement is determined by a combination of factors, including the amount we are willing to pay and algorithms designed to determine the relevance of our paid advertisement to a particular search term. As with algorithmic search result listings, search engines may revise the algorithms relevant to paid advertisements and websites other than our ecommerce platform may become more optimized for the algorithms. These changes may result in our having to pay increased amounts to maintain our paid advertisement placement in response to a particular search term. We could also have to pay increased amounts should the market share of major search engines continue to become more concentrated with a single search engine. Additionally, we bid against our competitors and others for the display of these paid search engine advertisements. Many of our competitors, including many health insurance carriers and government-run health insurance exchanges, have greater resources with which to bid and better brand recognition than we do. We have experienced increased competition from health insurance carriers, government health insurance exchanges and some of our marketing partners for both algorithmic search result listings and for paid advertisements. The competition has increased the cost of paid internet search advertising and has increased our marketing and advertising expenses. The competition increases substantially during the open enrollment periods for individual and family health insurance and Medicare related health insurance. If paid search advertising costs increase or become cost prohibitive, whether as a results of competition, algorithm changes or otherwise our advertising expenses could rise significantly or we could reduce or discontinue our paid search advertisements, either of which would harm our business, operating results and financial condition.

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

relationships with new marketing partners.

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

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

- the continued positive market presence, reputation and growth of the marketing partner;
- the effectiveness of the marketing partner in marketing our website and services, including whether the marketing partner is successful in maintaining the prominence of its website in algorithmic search result listings and paid Internet advertisements;
- the compliance of our marketing partners, and of the manner marketing partners refer consumers to our platforms, with applicable laws, regulations and guidelines;
- the interest of the marketing partner's customers in the health insurance plans that we offer on our ecommerce platform;
- the contractual terms we negotiate with the marketing partner, including the marketing fees we agree to pay a marketing partner;
- the percentage of the marketing partner's customers that submit applications or purchase health insurance policies through our ecommerce platform;
- the ability of a marketing partner to maintain efficient and uninterrupted operation of its website; and
- our ability to work with the marketing partner to implement website changes, launch marketing campaigns and pursue other initiatives necessary to maintain positive consumer experiences and acceptable traffic volumes.

For instance, we partner with Internet lead aggregators who refer a significant number of consumers to our online platforms. Major search engines have in the past and may in the future determine not to list lead aggregator websites prominently in search result listings for various reasons, which would cause a significant reduction in the number of consumers referred to us through our marketing partner channel. While we have relationships with a large number of marketing partners, we depend upon referrals from a limited number of marketing partners for a significant portion of the submitted applications we receive from our marketing partner customer acquisition channel.

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

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

To the extent that health care reform makes it less profitable or desirable for marketing partners to promote us to their customers, we may lose relationships with existing marketing partners or those marketing partners may refer fewer individuals to us. We may also have difficulty entering into relationships with new marketing partners. Competition for referrals from our marketing partners has increased particularly during the open enrollment periods for Medicare-related health insurance and individual and family health insurance. We may lose marketing partner referrals if our competitors pay marketing partners more than we do or be forced to pay increased fees to our marketing partners, which could harm our business, operating results and financial condition. If we lose marketing partner referrals during the Medicare or individual and family health insurance annual open enrollment periods, the

adverse impact on our business would be particularly pronounced. In addition, the promulgation of laws, regulations or guidelines, or the interpretation of existing laws, regulations and guidelines, by state departments of insurance or by CMS, could cause our relationships with our marketing partners to be in non-compliance with those laws, regulations and guidelines. In addition, we have relationships with hospitals and pharmacy chains that utilize aspects of our platform and tools. Our relationships with these hospitals and pharmacy chains result in the referral of a significant number of individuals to us who are interested in purchasing Medicare-related health insurance plans. If CMS or state departments of insurance were to change existing laws, regulations or guidelines, or interpret existing laws, regulations or guidelines, to prohibit these arrangements, or if hospitals or pharmacy partners otherwise decided to no longer utilize aspects of our platform and tools, we could experience a significant decline in the number of Medicare-eligible individuals who are referred to our platforms and customer care centers, which would harm our business, operating results and financial condition.

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

We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission rates per member, prepare our financial reports, projections and budgets and direct our marketing and other operating efforts based on the reports we receive from health insurance carriers. There have been instances where we have determined that policy cancellation data reported to us by a health insurance carrier has not been accurate. The extent to which health insurance carriers are inaccurate in their reporting of policy cancellations could cause us to change our cancellation estimates, which could adversely impact our revenues. We apply judgment and make estimates based on historical data and current trends to independently determine whether or not carriers are accurately reporting commissions due to us. Our revenue recognition policy changed in the first quarter of 2018 as a result of our adoption of Accounting Standards Update 2014-09, Revenue from Contracts with Customers (Topic 606), as discussed in Note 1-Summary of Business and Significant Accounting Policies in the Notes to Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q. Prospectively, to the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, our estimates of constrained lifetime value may be adversely impacted, which would harm our business, operating results and financial condition. In addition, any inaccuracies in the reports would adversely impact our commission revenue for future periods which is based on historical trends of factors including the trends in contracted commission rates and expected member churn.

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

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

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

of our membership estimates. Additionally, health insurance carriers may require us to return commission payments paid in a prior period due to policy cancellations for members we previously estimated as being active. For these and other reasons, including if current trends in membership cancellation are inconsistent with past cancellation trends that we use to estimate our membership or if carriers subsequently report changes to the commission payments that they previously reported to us, our actual membership could be different from our estimates, perhaps materially. If our actual membership is different from our estimates, the lifetime value component of our revenue recognition could also be inaccurate, including as a result of an inaccurate estimate of the average amount of time our members maintain their health insurance plans.

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

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

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

There are many risks associated with our operations in China.

A portion of our operations is conducted 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. From time-to-time we receive inquiries from health insurance carriers relating to our operations in China and the security measures we have implemented to protect data that our employees in China may be able to access. As a part of these inquiries, we have implemented additional security measures relating to our operations in China. We may be required to implement further security measures to continue aspects of our operations in China, which could be time consuming and expensive and harm our operating results and financial condition. If we are required to move aspects of our operations from China to our offices in the United States as a result of inquiries from health insurance carriers or for other reasons, it could harm our business, operating results and financial condition. Our operations in China also expose us to different and unfamiliar laws, rules and regulations, including different intellectual property laws, which are not as

protective of our intellectual property as the laws in the United States, 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 China. If competition for personnel increases further, our compensation expenses could rise considerably or, if we determine to not increase compensation levels, our ability to attract and retain qualified personnel in China may be impaired, which could harm our business, operating results and financial condition. These risks could cause us to incur increased expenses and could harm our ability to effectively and successfully manage our operations in China, which in turn could cause our business, operating results and financial condition to suffer.

Our sponsorship and advertising business may not be successful.

We sell advertising space to health insurance carriers on our website through our sponsorship and advertising program. Our sponsorship and advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. Health insurance carriers have generally determined not to spend on individual and family health insurance advertising through our sponsorship and advertising program as a result of the impact of health care reform on the profitability of their individual and family health insurance businesses. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for advertising on our ecommerce platform, our sponsorship and advertising program will be adversely impacted. Since much of our sponsorship revenue depends upon the number of applications we submit to health insurance carriers, a reduction in demand for the carrier's product (such as outside open enrollment periods) would reduce our sponsorship revenue and our business, operating results and financial condition could be harmed. The success of our sponsorship and advertising program depends on a number of other factors, including the effectiveness of the sponsorship and advertising program as a cost-effective method for carriers to obtain additional members, consumer and health insurance carrier adoption of the Internet and our ecommerce platform as a medium for the purchase and sale of health insurance, our ability to attract consumers visiting our ecommerce platform and convert those consumers into members, the existence of a relationship between us and a diverse group of carriers that offer a number of health insurance plans in the markets in which we attempt to sell advertising, the cost, benefit and brand recognition of the health insurance plan that is the subject of the advertising, the impact the advertising has on the sale of the health insurance plan that is the subject of the advertising and the effectiveness of the carrier's other means of advertising. In addition, while our practice of selling advertising is described on our ecommerce platform, it could cause consumers to perceive us as not objective, which could harm our brand and result in a decline in our health insurance sales. It also could adversely impact our relationship with health insurance carriers that do not purchase our advertising. As a result, our business, operating results and financial condition could be harmed.

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

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

We believe that our intellectual property is an essential asset of our business and that our technology currently gives us a competitive advantage in the distribution of Medicare-related, individual and family and small business health insurance. We rely on a combination of copyright, trademark and trade secret laws as well as confidentiality procedures and contractual provisions to establish and protect our intellectual property rights in the United States. The efforts we have taken to protect our intellectual property may not be sufficient or effective, and our trademarks may be held invalid or unenforceable. Moreover, the law relating to intellectual property is not as developed in China, and our intellectual property rights may not be as respected in China as they are in the United States. We may not be effective in policing unauthorized use of our intellectual property, trade secrets and other confidential information, and even if we do detect violations, litigation may be necessary to enforce our intellectual property rights. Any enforcement efforts we undertake, including litigation, could be time-consuming and expensive, could divert our management's attention and may result in a court determining that our intellectual property or other rights are unenforceable. If we

are not successful in cost-effectively protecting our intellectual property rights, trade secrets and confidential information, our business, operating results and financial condition could be harmed.

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

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

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

We provide information on our website, through our customer care centers 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. 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 or impaired and regulators could attempt to subject us to penalties, revoke our licenses to transact health insurance business in a particular jurisdiction, and/or compromise the status of our licenses to transact health insurance business in other jurisdictions, which could result in our loss of our commission revenue. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints without significant financial cost, we cannot guarantee that we will be able to do so in the future. Our recent focus in selling short-term health insurance that does not have the same benefits as major medical health insurance may increase our risks of receiving complaints regarding our marketing and business practice due to the potential for consumer confusion between short-term health insurance and major medical health insurance. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management's attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. We also have become, and may in the future become, involved in litigation 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 cause us to lose our commission revenue, and our business, operating results and financial condition would be materially harmed. In addition, if regulators believe our websites are not compliant with applicable laws or regulations, we could be forced to stop using our websites or certain aspects of them until the issue is resolved, which would harm our business, operating results and financial condition.

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

We recently acquired Wealth, Health and Life Advisors, LLC, more commonly known as GoMedigap, in January 2018 and in the future may decide to acquire other businesses, products and technologies. Our ability as an organization to successfully make and integrate acquisitions is unproven. Acquisitions could require significant capital infusions and could involve many risks, including the following:

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

- an acquisition undertaken for strategic business purposes may negatively impact our results of operations;

- we may encounter difficulties in assimilating and integrating the business, technologies, products, personnel or operations of companies that we acquire, particularly if key personnel of the acquired company decide not to work for us;

- an acquisition may disrupt our ongoing business, divert resources, increase our expenses and distract our management;

- we may be required to implement or improve internal controls, procedures and policies appropriate for a public company at a business that prior to the acquisition lacked these controls, procedures and policies;

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

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

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

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

As part of our initiative to expand our presence in the Medicare supplement market, we acquired GoMedigap in January 2018. We may not be able to realize anticipated synergies and opportunities as a result of the acquisition, and the business may not perform as planned as a result of many of the risks and uncertainties that apply to the rest of our business. We may also encounter difficulties in integrating GoMedigap into our existing business. If anticipated synergies and opportunities are not realized, our business, operating results and financial condition would be harmed.

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

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

the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected. We cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations, or result in material misstatements in our financial statements. Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002

and the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

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

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections, changes in the valuation of our deferred tax assets and liabilities, lapses in the research and development tax credit laws, tax effects of share-based compensation, outcomes as a result of tax examinations or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof.

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

On December 22, 2017, the Tax Cuts and Jobs Act of 2017, or the "Jobs Act", was signed into law resulting in significant changes to the Internal Revenue Code. The Jobs Act reduces the federal corporate income tax rate from 35% to 21% effective for tax years beginning after December 31, 2017, changes U.S international taxation from a worldwide tax system to a territorial system, and implements a one-time transition tax on the mandatory deemed repatriation of cumulative foreign earnings as of December 31, 2017. While we are able to make reasonable estimates of the impact of the reduction in corporate rates and other changes, the final impact of the Jobs Act may differ from these estimates, as a result of, among other things, changes in our interpretations and assumptions, additional guidance that may be issued by the internal revenue service and resulting actions we may take.

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 adopted and will continue to adopt new laws and regulations in response to health care reform legislation. It is difficult to predict how these new laws and regulations will impact our business, but in some cases such laws and regulations could amplify the adverse impacts of health care reform, or states may adopt new

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

adopted that adversely impact our sale of short-term health insurance, they could harm our business, operating results and financial condition.

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

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

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

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

Due to the complexity, periodic modification and differing interpretations of insurance laws and regulations, we may not have always been, and we may not always be, in compliance with them. New insurance laws, regulations and guidelines also may not be compatible with the sale of health insurance over the Internet or with various aspects of our platform or manner of marketing or selling health insurance plans. Failure to comply with insurance laws, regulations and guidelines or other laws and regulations applicable to our business could result in significant liability, additional department of insurance licensing requirements, the revocation of licenses in a particular jurisdiction and/or our inability to sell health insurance plans, which could significantly increase our operating expenses, result in the loss of our commission revenue and otherwise harm our business, operating results and financial condition. Moreover, an adverse regulatory action in one jurisdiction could result in penalties and adversely affect our license status or reputation in other jurisdictions due to the requirement that adverse regulatory actions in one jurisdiction be reported

to other jurisdictions. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand. 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.

Government regulation of the Internet could adversely affect our business.

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

Our business could be harmed if we are unable to contact our consumers or market the availability of our products through specific channels.

We use email and telephone, among other channels, to market our services to potential members and as the primary means of communicating with our existing members. The laws and regulations governing the use of emails and telephone calls for marketing purposes continue to evolve, and changes in technology, the marketplace or consumer preferences may lead to the adoption of additional laws or regulations or changes in interpretation of existing laws or regulations. If new laws or regulations are adopted, or existing laws and regulations are interpreted or enforced, to impose additional restrictions on our ability to send email or telephone messages to our members or potential members, we may not be able to communicate with them in a cost-effective manner. In addition to legal restrictions on the use of email, Internet service providers, e-mail service providers and others attempt to block the transmission of unsolicited email, commonly known as “spam.” Many Internet and e-mail service providers have relationships with organizations whose purpose it is to detect and notify the Internet and e-mail service providers of entities that the organization believes is sending unsolicited e-mail. If an Internet or e-mail service provider identifies email from us as “spam” as a result of reports from these organizations or otherwise, we can be placed on a restricted list that will block our email to members or potential members. Similarly, various federal and state laws and regulations, including the Telephone Consumer Protection Act (TCPA) and its implementing regulations, restrict the telephone calls that businesses may make to consumers and increase the compliance costs for businesses making telephone calls to consumers. In addition, telephone carriers may block or put consumer warnings on calls originating from call centers. Consumers increasingly screen their incoming emails and telephone calls, including by using such tools and warnings, and therefore our members or potential members may not reliably receive our emails or telephone messages. If we are unable to communicate effectively by email or telephone with our members and potential members as a result of legislation, blockage, screening technologies or otherwise, our business, operating results and financial condition would be harmed.

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

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

Risks Related to the Ownership of Our Common Stock

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

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

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

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

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

Our actual operating results may differ significantly from our guidance.

From time to time, we have released, and may continue to release guidance in earnings conference calls, earnings releases, or otherwise, regarding our future performance that represents our management's estimates as of the date of release. This guidance, which includes forward-looking statements, has been and will be based on projections prepared by our management. These projections are not prepared with a view toward compliance with published guidelines of the American Institute of Certified Public Accountants, and neither our registered public accountants nor any other independent expert or outside party compiles or examines the projections. Accordingly, no such person expresses any opinion or any other form of assurance with respect to the projections.

Projections are based upon a number of assumptions and estimates that, while presented with numerical specificity, are inherently subject to significant business, economic and competitive uncertainties and contingencies, many of which are beyond our control and are based upon specific assumptions with respect to future business decisions, some of which will change. Among these factors, the assumptions underlying our estimates of commission revenue as required by Accounting Standards Update 2014-09, Revenue from Contracts with Customers (Topic 606), may vary over time. We may state possible outcomes as high and low ranges. Any range we provide is not intended to imply that actual results could not fall outside of the suggested ranges. The principal reason that we release guidance is to provide a basis for our management to discuss our business outlook with analysts and investors and we may decide to suspend guidance at any time. We do not accept any responsibility for any projections or reports published by any such third parties.

Guidance is necessarily speculative in nature, and it can be expected that some or all of the assumptions underlying the guidance furnished by us will not materialize or will vary significantly from actual results. Accordingly, our guidance is only an estimate of what management believes is realizable as of the date of release. Our actual results have, and may in the future, vary from our guidance and the variations may be material. In light of the foregoing, investors are urged not to rely upon our guidance in making an investment decision regarding our common stock.

Any failure to successfully implement our operating strategy or the occurrence of any of the events or circumstances set forth in this "Risk Factors" section in this Quarterly Report on Form 10-Q could result in the actual operating results being different from our guidance, and the differences may be adverse and material.

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

A small number of stockholders and their affiliated entities beneficially owned more than 50% percent of our outstanding common stock as of June 30, 2018. These stockholders, if they act together, could exert substantial influence over matters requiring approval by our stockholders, including the election of directors, the amendment of our certificate of incorporation and bylaws and the approval of mergers or other business combination transactions. This concentration of ownership may discourage, delay or prevent a change in control of our company, which could deprive our stockholders of an opportunity to receive a premium for their stock as part of a sale of our company and might reduce our stock price. These actions may be taken even if they are opposed by other stockholders.

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

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

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

advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders' meeting, which may discourage or deter a potential acquiror from conducting a solicitation of proxies to elect the acquiror's own slate of directors or otherwise attempting to obtain control of us.

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

Table of Contents

ITEM 6. EXHIBITS

(a) Exhibits

Except as so indicated in Exhibits 32.1 and 32.2, the following exhibits are filed as part of, or incorporated by reference into, this quarterly report on Form 10-Q.

Exhibit Number		Description of Exhibit	Incorporation by Reference Herein	
			Form	Date
10.1		Lease Agreement, dated April 25, 2018, between Augustine Bowers LLC and eHealthInsurance Services, Inc.	Current Report on Form 8-K (File No. 001-33071)	April 30, 2018
10.2	†*	Employment Agreement, dated June 4, 2018, between Derek Yung and eHealth, Inc.		
31.1	†	Certification of Scott N. Flanders, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
31.2	†	Certification of Derek N. Yung, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.		
32.1	‡	Certification of Scott N. Flanders, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.		
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101.SCH		XBRL Taxonomy Extension Schema Document		
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101.DEF		XBRL Taxonomy Extension Definition Linkbase Document		
101.LAB		XBRL Taxonomy Extension Label Linkbase Document		
101.PRE		XBRL Taxonomy Extension Presentation Linkbase Document		

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

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.
August 7, 2018

eHealth, Inc.

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

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