eHealth, Inc.
Form 10-Q
August 05, 2011
Table of Contents

UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-Q

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

For the quarterly period ended June 30, 2011

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 x 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 x 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 x
Non-accelerated filer ¨	Smaller reporting company ¨

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

The number of shares of the registrant s common stock, par value $0.001 per share, outstanding as of July 29, 2011 was 21,406,832 shares.

Table of Contents

EHEALTH, INC. FORM 10-Q

TABLE OF CONTENTS

		PAGE
	PART I FINANCIAL INFORMATION	
Item 1.	Financial Statements (unaudited)	1
	Condensed Consolidated Balance Sheets at December 31, 2010 and June 30, 2011	1
	Condensed Consolidated Statements of Income for the three and six months ended June 30, 2010 and 2011	2
	Condensed Consolidated Statements of Cash Flows for the six months ended June 30, 2010 and 2011	3
	Notes to Condensed Consolidated Financial Statements	4
Item 2.	Management s Discussion and Analysis of Financial Condition and Results of Operations	12
Item 3.	Quantitative and Qualitative Disclosures About Market Risk	30
Item 4.	Controls and Procedures	31
	PART II OTHER INFORMATION	
Item 1.	Legal Proceedings	32
Item 1A.	Risk Factors	33
Item 2.	Unregistered Sales of Equity Securities and Use of Proceeds	55
Item 6.	Exhibits	56
	Signatures	57

Table of Contents

PART I

FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands)

	December 31, 2010	June 30, 2011 (unaudited)
Assets		
Current assets:		
Cash and cash equivalents	$ 128,074	$ 135,893
Accounts receivable	10,810	4,998
Deferred income taxes	5,347	4,227
Prepaid expenses and other current assets	4,361	3,582
Total current assets	148,592	148,700
Property and equipment, net	4,528	4,582
Deferred income taxes	3,119	3,311
Other assets	3,248	5,482
Acquired intangible assets, net	12,262	11,408
Goodwill	14,096	14,096
Total assets	$ 185,845	$ 187,579
Liabilities and stockholders equity		
Current liabilities:		
Accounts payable	$ 3,573	$ 2,405
Accrued compensation and benefits	7,523	6,854
Accrued marketing expenses	3,644	3,414
Deferred revenue	2,785	656
Other current liabilities	2,672	1,636
Total current liabilities	20,197	14,965
Other non-current liabilities	3,451	3,636
Stockholders equity:		
Common stock	26	26
Additional paid-in capital	203,231	209,110
Treasury stock, at cost	(56,202)	(59,998)
Retained earnings	14,937	19,650
Accumulated other comprehensive income	205	190
Total stockholders equity	162,197	168,978
Total liabilities and stockholders equity	$ 185,845	$ 187,579

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

Table of Contents

EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF INCOME

(In thousands, except per share amounts, unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Revenue:				
Commission	$ 31,872	$ 30,079	$ 63,645	$ 60,839
Other	4,384	6,107	8,600	12,902
Total revenue	36,256	36,186	72,245	73,741
Operating costs and expenses:				
Cost of revenue	881	2,555	1,859	5,206
Marketing and advertising	13,883	11,668	28,701	24,577
Customer care and enrollment	3,902	4,610	7,848	10,020
Technology and content	4,999	5,415	9,580	10,885
General and administrative	6,554	6,661	12,321	13,382
Amortization of acquired intangible assets	285	427	285	854
Total operating costs and expenses	30,504	31,336	60,594	64,924
Income from operations	5,752	4,850	11,651	8,817
Interest and other income (expense), net	(12)	(21)	16	(40)
Income before income taxes	5,740	4,829	11,667	8,777
Provision for income taxes	2,699	2,097	5,393	4,064
Net income	$ 3,041	$ 2,732	$ 6,274	$ 4,713
Net income per share:				
Basic	$ 0.13	$ 0.13	$ 0.27	$ 0.22
Diluted	$ 0.13	$ 0.12	$ 0.26	$ 0.21
Weighted-average number of shares used in per share amounts:				
Basic	23,529	21,390	23,493	21,371
Diluted	24,266	22,119	24,306	22,079

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

Table of Contents

EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands, unaudited)

	Six Months Ended June 30,	
	2010	**2011**
Operating activities		
Net income	$ 6,274	$ 4,713
Adjustments to reconcile net income to net cash provided by operating activities:		
Deferred income taxes	4,936	3,664
Depreciation and amortization	1,043	1,266
Amortization of acquired intangible assets	285	854
Amortization and accretion on marketable securities, net	50	
Stock-based compensation expense	3,249	3,798
Excess tax benefits from stock-based compensation	(5,237)	(2,553)
Deferred rent	2	(20)
Loss on disposal of property and equipment	6	3
Changes in operating assets and liabilities:		
Accounts receivable	101	6,577
Prepaid expenses and other current assets	687	1,525
Other assets	91	26
Accounts payable	1	(1,169)
Accrued compensation and benefits	676	(679)
Accrued marketing expenses	258	(230)
Deferred revenue	23	(2,129)
Other current liabilities	(1,188)	(1,055)
Net cash provided by operating activities	11,257	14,591
Investing activities		
Purchases of property and equipment	(1,344)	(1,239)
Acquisition of PlanPrescriber, net of cash acquired	(27,203)	
Purchase of other assets		(3,769)
Maturities of marketable securities	22,100	
Net cash used in investing activities	(6,447)	(5,008)
Financing activities		
Proceeds from exercise of common stock options	464	72
Cash used to net-share settle equity awards	(557)	(544)
Excess tax benefits from stock-based compensation	5,237	2,553
Repurchases of common stock		(3,796)
Principal payments in connection with capital lease	(21)	(30)
Net cash provided by (used in) financing activities	5,123	(1,745)
Effect of exchange rate changes on cash and cash equivalents	6	(19)
Net increase in cash and cash equivalents	9,939	7,819
Cash and cash equivalents at beginning of period	131,339	128,074

Cash and cash equivalents at end of period	$ 141,278	$ 135,893

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

Table of Contents

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) offers Internet-based health insurance agency services for individuals families and small businesses in the United States, as well as technology licensing and Internet advertising services. Our services and technology enable individuals, families and small businesses to compare and purchase health insurance plans from health insurance carriers across the nation. We began actively marketing the availability of Medicare related insurance plans during 2010 and we 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. The revenue we have generated in our Medicare plan business is primarily referral fees paid to us based on leads generated by our online platforms that are delivered and sold to third parties. We are licensed to market and sell health insurance in all 50 states and the District of Columbia.

Book of Business Transfers In November 2010 we entered into an agreement with a partner, whereby the partner transferred certain of its existing Medicare insurance members to us as the broker of record on the underlying policies. Total consideration of $3.3 million is being amortized to cost of revenue in the consolidated statements of income and comprehensive income as we recognize commission revenue related to the transferred members over a period of up to five years. In May 2011, we entered into a similar agreement with the same partner, whereby the partner transferred certain of its existing Medicare insurance members to us as the broker of record on the underlying policies. Total arrangement consideration of $3.0 million paid to the partner is being amortized to cost of revenue as we recognize commission revenue related to the transferred members over a period of up to five years.

Basis of Presentation The accompanying condensed consolidated balance sheet as of June 30, 2011, the condensed consolidated statements of income for the three and six months ended June 30, 2010 and 2011 and the condensed consolidated statements of cash flows for the six months ended June 30, 2010 and 2011, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2010 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2010, which was filed with the Securities and Exchange Commission on March 15, 2011. The accompanying statements should be read in conjunction with the audited consolidated financial statements and related notes contained in our Annual Report on Form 10-K.

The accompanying condensed consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles, or U.S. GAAP, for interim financial information. Accordingly, they do not include all of the financial information and footnotes required by U.S. GAAP for complete financial statements. The unaudited condensed consolidated financial statements have been prepared on the same basis as the audited consolidated financial statements in our Annual Report on Form 10-K for the year ended December 31, 2010, and include all adjustments necessary for the fair presentation of eHealth s statement of financial position as of June 30, 2011, its results of operations for the three and six months ended June 30, 2010 and 2011 and its cash flows for the six months ended June 30, 2010 and 2011. All adjustments are of a normal recurring nature. The results for the three months ended June 30, 2011 are not necessarily indicative of the results to be expected for any subsequent quarter or for the fiscal year ending December 31, 2011.

Revenue Recognition In October 2009, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2009-13 *Revenue Recognition (Topic 605): Multiple-Deliverable Revenue Arrangements* (ASU 2009-13). ASU 2009-13 addresses how to measure and allocate arrangement consideration to one or more units of accounting within certain multiple-deliverable arrangements. ASU 2009-13 modifies the requirements for determining whether a deliverable can be treated as a separate unit of accounting by removing the criterion that objective evidence of fair value must exist for the undelivered elements. ASU 2009-13 was effective for us prospectively for revenue arrangements entered into or materially modified on or after January 1, 2011.

In accordance with ASU 2009-13, effective January 1, 2011, we allocate revenue to all units of accounting within an arrangement with multiple deliverables at the inception of the arrangement using the relative selling price method. The relative selling price method allocates any discount in an arrangement proportionally to each deliverable on the basis of each deliverable s relative selling price. The relative selling price established for each deliverable is based on vendor-specific objective evidence of fair value (VSOE) if available, third-party evidence of selling price if VSOE is not available, or best estimate of selling price if neither VSOE nor third-party evidence is available. When used, the best estimate of selling price reflects our best estimates of what the selling prices of certain deliverables would be if they were sold regularly on a stand-alone basis.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

Our process for determining best estimate of selling price for deliverables without VSOE or third-party evidence of selling price considers multiple factors that may vary depending upon the unique facts and circumstances related to each deliverable. Key factors considered by us in developing the relative selling prices for our technology licensing fees include prices charged by us for similar offerings and our historical pricing practices. We may also consider additional factors as appropriate, including competition.

A deliverable constitutes a separate unit of accounting when it has stand-alone value and there are no customer-negotiated right of refunds for the delivered elements. If the arrangement includes a customer-negotiated right of refund relative to the delivered item, and the delivery and performance of the undelivered item is considered probable and substantially in our control, the delivered element constitutes a separate unit of accounting. In circumstances when the aforementioned criteria are not met, the deliverable is combined with the undelivered elements, and the allocation of the arrangement consideration and revenue recognition is determined for the combined unit as a single unit. Allocation of the consideration is determined at the inception of the arrangement on the basis of each unit s relative selling price. The new standards do not generally change the units of accounting for our revenue transactions.

After the arrangement consideration has been allocated to each unit of accounting within an arrangement with multiple deliverables based on their relative selling prices, we apply revenue recognition criteria separately to each respective unit of accounting in the arrangement in accordance with applicable accounting guidance. Our multiple-element arrangements primarily consist of ecommerce technology licensing agreements, which typically include delivery of a customized website, maintenance and support services to host the website and professional services. Since our recognition of technology licensing revenue in accordance with ASU 2009-13 is not materially different from our recognition of technology licensing revenue prior to the adoption of ASU 2009-13, the adoption of ASU 2009-13 did not have a material impact on our results of operations and cash flows for the three and six months ended June 30, 2011. We cannot reasonably estimate the effect of adopting ASU 2009-13 on future financial periods as the impact will vary depending on the nature and volume of new or materially modified agreements in any given period.

Recent Accounting Pronouncements In May 2011, the Financial Accounting Standards Board (FASB) issued updated accounting guidance related to fair value measurements and disclosures that result in common fair value measurements and disclosures between GAAP and International Financial Reporting Standards. This guidance includes amendments that clarify the intent about the application of existing fair value measurements and disclosures, while other amendments change a principle or requirement for fair value measurements or disclosures. This guidance is effective for interim and annual periods beginning after December 15, 2011. The new guidance is to be adopted prospectively and early adoption is not permitted. We do not believe the adoption of this guidance will have a material impact on our consolidated financial statements.

In June 2011, the FASB issued authoritative guidance related to the presentation of comprehensive income. The guidance requires that all non-owner changes in stockholders equity be presented in a single continuous statement of comprehensive income or in two separate but consecutive statements. The guidance does not change the items that must be reported in other comprehensive income or when an item of other comprehensive income must be reclassified to net income. This guidance is effective for interim and annual periods beginning after December 15, 2011. The new guidance is to be applied retrospectively and early adoption is permitted. We will adopt the guidance in beginning in the first quarter of 2012 and we do not believe the adoption of this guidance will have a material impact on our consolidated financial statements.

Note 2 Cash and Cash Equivalents

Cash and Cash Equivalents We invest our cash and cash equivalents with major banks and financial institutions and such investments are often in excess of federally insured limits. As of December 31, 2010 and June 30, 2011, our cash and cash equivalent balances were invested as follows (in thousands):

	December 31, 2010	June 30, 2011
Cash	$ 11,663	$ 14,510

Money market funds (1)	116,411	121,383
Total cash and cash equivalents	$ 128,074	$ 135,893

(1) At December 31, 2010 and June 30, 2011, money market accounts were invested primarily in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

At December 31, 2010 and June 30, 2011, our cash equivalents carried no unrealized gains or losses and we did not realize any significant gains or losses on sales of cash equivalents during the three and six months ended June 30, 2010 and 2011.

At December 31, 2010 and June 30, 2011, our cash equivalents were invested in money market funds and were classified as Level 1 within the fair market valuation hierarchy. 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.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

Note 3 Stockholders Equity and Stock Plans

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

	Shares Available for Grant (1)	Number of Option Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (2)
Balance at December 31, 2010	3,283	3,491	$ 11.62	4.69	$ 16,349
Additional shares authorized (3)	863				
Options granted	(214)	214	$ 12.48		
Restricted stock units granted (4)	(323)				
Options exercised		(10)	$ 6.74		
Options cancelled	94	(94)	$ 15.07		
Restricted stock units cancelled	16				
Balance at June 30, 2011	3,719	3,601	$ 11.59	4.27	$ 14,700

(1) Shares available for grant exclude treasury stock of 3,956,128 shares and 4,271,021 shares at December 31, 2010 and June 30, 2011, respectively, which could be granted if we determined to do so.

(2) The aggregate intrinsic value is calculated as the difference between eHealth s closing stock price as of December 31, 2010 and June 30, 2011 and the exercise price of in-the-money options as of those dates.

(3) On January 1, 2011, the number of shares authorized for issuance under the 2006 Plan was automatically increased by 862,989 shares, pursuant to the terms of the 2006 Plan.

(4) Includes a grant of 115,080 restricted stock units with both service and performance-based vesting criteria to our executive officers.

The total grant date fair value of stock options vested during the three and six months ended June 30, 2011 was $1.4 million and $2.9 million, respectively. The total grant date fair value of stock options vested during the three and six months ended June 30, 2010 was $0.9 million and $2.1 million, respectively.

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

	Number Outstanding	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)

Balance as of December 31, 2010	370	2.22	$	5,254
Granted (2)	323			
Vested	(137)			
Cancelled	(16)			
Balance as of June 30, 2011	540	2.15	$	7,219

(1) The aggregate intrinsic value is calculated as eHealth s closing stock price as of December 31, 2010 and June 30, 2011 multiplied by the number of restricted stock units outstanding as of December 31, 2010 and June 30, 2011.

(2) Includes the grant of 115,080 restricted stock units with both service and performance-based vesting criteria to our executive officers.

The total grant date fair value of restricted stock units vested during the three and six months ended June 30, 2011 was $0.2 million and $1.7 million, respectively. The total grant date fair value of restricted stock units vested during the three and six months ended June 30, 2010 was $0.1 million and $1.7 million, respectively.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

Stock Repurchase Program On July 27, 2010, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock. In January 2011, we completed this stock repurchase program, having repurchased in the aggregate 2,297,705 shares for approximately $30.0 million at an average price of $13.06 per share including commissions. The cost of the repurchased shares was funded from available working capital. Shares repurchased under this program complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended.

On June 14, 2011, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to an additional $30 million of our common stock. Repurchases under this program began in the third quarter of 2011. Purchases under the repurchase program may be made in open market or unsolicited negotiated transactions and are expected to comply with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The timing of purchases and the exact number of shares to be purchased will depend upon market conditions. The repurchase program does not require us to acquire a specific number of shares, and the repurchase program may be suspended from time to time or discontinued at any time. The cost of the repurchased shares will be funded from available working capital.

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

Stock repurchase activity under our stock repurchase programs as of December 31, 2010 and June 30, 2011 and during the six months ended June 30, 2011 is summarized as follows (in thousands, except share and per share amounts):

	Total Number of Shares Purchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2010 (1)	3,904,652	$ 14,39	$ 56,202
Repurchases of common stock	270,903	$ 14.01	3,796
Cumulative balance at June 30, 2011 (1)	4,175,555	$ 14.37	$ 59,998

(1) Cumulative balances at December 31, 2010 and June 30, 2011 include shares repurchased in connection with our stock repurchase program announced on July 27, 2010, as well as a previous stock repurchase plan announced in 2008.
(2) Average price paid per share includes commissions.

In addition to the 4,175,555 shares repurchased under our repurchase programs as of June 30, 2011, we have in treasury 95,466 shares that were surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2010 and June 30, 2011, we had a total of 3,956,128 shares and 4,271,021 shares, respectively, held in treasury.

Comprehensive Income The following table sets forth the activity for each component of comprehensive income, net of related taxes, for the three and six months ended June 30, 2010 and 2011 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011

Comprehensive income:				
Net income	$ 3,041	$ 2,732	$ 6,274	$ 4,713
Change in unrealized gain on investments, net of taxes	8		(11)	
Foreign currency translation adjustment, net of taxes	6	(8)	8	(15)
Total comprehensive income	$ 3,055	$ 2,724	$ 6,271	$ 4,698

As of December 31, 2010 and June 30, 2011, accumulated other comprehensive income, net of related taxes, was comprised solely of foreign currency translation adjustments, net of taxes.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

Note 4 Stock-Based Compensation

In the three months ended June 30, 2011, we issued restricted stock units representing 115,080 shares of common stock with both service and performance-based vesting criteria to our executive officers. The performance-based contingency period for these restricted stock units is fiscal 2011 ending December 31, 2011, and the measurement of achievement is based on our 2011 revenue, non-GAAP operating earnings and EBITDA results. These performance-based restricted stock units were granted pursuant to the terms of our 2006 Plan. Shares which are earned and eligible to vest following our 2011 results will vest one-third annually in 2012, 2013 and 2014.

The fair value of stock options granted to employees for the three and six months ended June 30, 2010 and 2011 was estimated using the following weighted average assumptions:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Expected term	4.7 years	4.6 years	4.6 years	4.6 years
Expected volatility	52.0%	48.9%	52.8%	49.0%
Expected dividend yield	0%	0%	0%	0%
Risk-free interest rate	2.45%	2.05%	2.44%	2.02%
Weighted-average fair value	$ 5.62	$ 5.35	$ 7.32	$ 5.34

The fair value of the restricted stock units is based on eHealth s stock price on the date of grant, and compensation expense is recognized on a straight-line basis over the vesting period.

The following table summarizes stock-based compensation expense recorded during the three and six months ended June 30, 2010 and 2011 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Common stock options	$ 1,008	$ 1,001	$ 1,944	$ 2,048
Restricted stock units	588	936	1,305	1,750
Total stock-based compensation expense	$ 1,596	$ 1,937	$ 3,249	$ 3,798

The following table summarizes stock-based compensation expense by operating function for the three and six months ended June 30, 2010 and 2011 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Marketing and advertising	$ 201	$ 276	$ 408	$ 522
Customer care and enrollment	88	74	181	181

Technology and content	413	470	856	925
General and administrative	894	1,117	1,804	2,170
Total stock-based compensation expense	$ 1,596	$ 1,937	$ 3,249	$ 3,798

Note 5 Income Taxes

During the three and six months ended June 30, 2011, we recorded a provision for income taxes of $2.1 million and $4.1 million, respectively, representing effective tax rates of approximately 43.4% and 46.3%, respectively. During the three and six months ended June 30, 2010, we recorded a provision for income taxes of $2.7 million and $5.4 million, respectively, representing effective tax rates of approximately 47.0% and 46.2%, respectively. Our effective tax rates in the three and six months ended June 30, 2010 and 2011 were higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

During the three and six months ended June 30, 2011, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $1.5 million and $2.6 million, respectively, in additional paid-in capital in the condensed consolidated balance sheet. During the three and six months ended June 30, 2010, we utilized excess federal and state tax benefits related to share-based payments, which resulted in increases of $2.6 million and $5.2 million, respectively, in additional paid-in capital in the condensed consolidated balance sheet. These amounts are classified in the condensed consolidated statements of cash flows as both financing cash inflows and operating cash outflows.

Note 6 Net Income Per Share

Basic net income per share is computed by dividing net income by the weighted-average number of common shares outstanding for the period (excluding shares subject to repurchase). Diluted net income per share is computed by dividing the net income for the period by the weighted average number of common and common equivalent shares outstanding during the period. Diluted net income per share is computed giving effect to all potential dilutive common stock, including options, restricted stock and restricted stock units. The computation of diluted net income per share includes restricted stock units with both service and performance-based vesting criteria that will be earned and eligible to vest based on the assumption that the current amount of revenue, non-GAAP operating earnings and EBITDA will remain unchanged until the end of the performance-based contingency period on December 31, 2011. The dilutive effect of outstanding awards is reflected in diluted earnings per share by application of the treasury stock method.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Basic:				
Numerator:				
Net income allocated to common stock	$ 3,041	$ 2,732	$ 6,274	$ 4,713
Denominator:				
Weighted average number of common stock shares	25,456	25,661	25,409	25,621
Weighted average number of common stock shares held in treasury	(1,927)	(4,271)	(1,916)	(4,250)
Net weighted average number of common stock shares	23,529	21,390	23,493	21,371
Net income per share basic:	$ 0.13	$ 0.13	$ 0.27	$ 0.22
Diluted:				
Numerator:				
Net income allocated to common stock	$ 3,041	$ 2,732	$ 6,274	$ 4,713
Denominator:				
Net weighted average number of common stock shares	23,529	21,390	23,493	21,371
Weighted average number of options	721	692	782	679
Weighted average number of restricted stock units	16	37	31	29
Total common stock shares used in per share calculation	24,266	22,119	24,306	22,079

Net income per share diluted:	$ 0.13	$ 0.12	$ 0.26	$ 0.21

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

For each of the three and six months ended June 30, 2010 and 2011, we had securities outstanding that could potentially dilute earnings per share, but the shares from the assumed conversion or exercise of these securities were excluded in the computation of diluted net income per share as their effect would have been anti-dilutive. The number of outstanding weighted average anti-dilutive shares that were excluded from the computation of diluted net income per share consisted of the following (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Common stock options	1,604	1,863	1,318	1,892
Restricted stock units	350	217	386	90
Total	1,954	2,080	1,704	1,982

Note 7 Geographic Information and Significant Customers

Geographic Information As of December 31, 2010 and June 30, 2011, our long-lived assets consisted primarily of property and equipment, goodwill and other indefinite-lived intangible assets and finite-lived intangible assets. Our long-lived assets are attributed to the geographic location in which they are located. Long-lived assets by geographical area were as follows (in thousands):

	As of December 31, 2010	As of June 30, 2011
United States	$ 33,495	$ 35,039
China	639	529
Total	$ 34,134	$ 35,568

Significant Customers Substantially all revenue for all periods presented was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in any of the three- and six-month periods ended June 30, 2010 and 2011 are presented in the table below.

	Percentage of Total Revenue			
	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
UnitedHealthcare (1)	14%	15%	15%	14%
WellPoint (2)	14%	12%	14%	12%
Aetna	15%	8%	15%	10%

(1) UnitedHealthcare includes other carriers owned by UnitedHealthcare.

(2) Wellpoint includes other carriers owned by Wellpoint.

Commission revenue attributable to major medical individual and family health insurance plans was approximately 89% and 90% of our total commission revenue in the three and six months ended June 30, 2011, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 91% of our total commission revenue in both the three and six months ended June 30, 2010. We define our individual and family plan offerings as major medical individual and family health insurance plans, which do not include small business, short-term major medical, stand-alone dental, life, student and Medicare-related health insurance plan offerings.

We do not require collateral or other security for our accounts receivable. As of June 30, 2011, two customers represented 43% and 19%, respectively, for a total of 62% of our $5.0 million outstanding accounts receivable. No other customers represented 10% or more of our total accounts receivable. We believe the potential for collection issues with any of our customers is minimal as of June 30, 2011. Accordingly, our allowance for uncollectible amounts at June 30, 2011 was not material.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS (Continued)

(unaudited)

Note 8 Subsequent Event

On July 8, 2011, we entered into an amendment to our lease agreement for our headquarters office in Mountain View, California, which extends the lease for an additional seven years through August 2018. This amendment has escalating rent payment provisions of 3% per year for each year of the lease. Future minimum payments under this non-cancellable operating lease amendment are presented in the table below (in thousands):

Years Ending December 31,	Lease Extension Obligation
2011 (September - December)	$ 174
2012	527
2013	542
2014	559
2015	575
Thereafter (January 2016 August 2018)	1,619
Total	$ 3,996

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.

Table of Contents

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 potential for collection issues; the impact of health care reform laws on the health insurance industry and on our business; impact of medical loss ratio regulations and commission rate changes; our expectations and projections relating to our commission rates; our expectations relating to revenue, our Medicare lead referral business, cost of revenue, seasonality, marketing and advertising expenses, customer care and enrollment expenses, technology and content expenses, general and administrative expenses, and stock-based compensation expense; estimates relating to critical accounting policies and related impact on our financial statements; our expectations regarding future dividends; the sufficiency of our cash, cash equivalents and marketable securities; future capital requirements; expenditures related to the development of our business; our projections relating to future revenue growth and earnings per share; our plans and expectations relating to our Medicare business and factors impacting its success; reduction of our cost of acquiring new members; our future competitors; expansion into new business areas and additional geographic regions; the duration of our federal government contract; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those discussed in this report, and in particular, the risks discussed under the heading Risk Factors in Part II, Item 1A of this report and those discussed in our other Securities and Exchange Commission filings. The following discussion should be read in conjunction with our Annual Report on Form 10-K as filed with the Securities and Exchange Commission in March 2011, and the audited consolidated financial statements and related notes contained therein. We undertake no obligation to revise or publicly release the results of any revision to these forward-looking statements. Given these risks and uncertainties, you are cautioned not to place undue reliance on such forward-looking statements.

Overview

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

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

We generate revenue primarily from commissions we receive from health insurance carriers whose individual, family and small business policies are purchased through our ecommerce platform. Commission revenue represented 83% of total revenue for both the three and six months ended June 30, 2011, and represented 88% of total revenue for both the three and six months ended June 30, 2010. The commission payments we receive are typically a percentage of the premium on an individual, family or small business health insurance policy that we sold and are made to us on a monthly basis for as long as a policy remains active with us. As a result, much of our revenue for a given financial reporting period relates to policies that we sold prior to the beginning of the period and is recurring in nature. Additionally, health insurance pricing, which is set by the health insurance carrier and approved by state regulators, is not subject to negotiation or discounting by health insurance carriers or our competitors.

Table of Contents

We began actively marketing the availability of Medicare-related health insurance plans during 2010 through our online Medicare plan platforms (*www.eHealthMedicare.com* and *www.PlanPrescriber.com)*. In April 2010, we acquired PlanPrescriber, Inc., a privately-held provider of online tools to help Medicare eligible individuals navigate Medicare health insurance options. Our Medicare plan platforms enable consumers to research and compare Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. The revenue we have generated in our Medicare plan business is primarily referral fees paid to us based on leads generated by our online platforms that are delivered and sold to third parties. In 2010 we also launched online application capabilities for certain Medicare plans, and telephonic enrollment capabilities through our customer care center in Salt Lake City, Utah. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, we generate revenue from commissions we receive from health insurance carriers. These Medicare commissions are included in commission revenue.

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

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

Sources of Revenue

Commission Revenue

Our commission revenue generally represents a percentage of the insurance premium and, to a much lesser extent, commission override payments that insurance carriers pay us for achieving sales volume thresholds or other objectives. Commission rates vary by carrier and by the type of plan purchased by a member. Commission rates also can vary based upon the amount of time that the policy has been active, with commission rates for individual and family policies typically being higher in the first twelve months of the policy. After the first twelve months, commission rates generally decline significantly. As a result, if we do not add a sufficient number of members on new policies, our revenue growth will be negatively impacted. Individuals, families and small businesses purchasing health insurance through us typically pay their premiums on a monthly basis. Insurance carriers typically pay commissions to us monthly, after they receive the premium payment from the member. For certain Medicare health insurance policies, we receive an annual commission payment in the first year after the policy is issued and a monthly commission payment beginning the second year of the policy for up to an additional five years. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. As a result, the majority of our commission revenue is recurring in nature.

Although our membership base grew 7% from June 30, 2010 to June 30, 2011, our individual and family health insurance plan commission revenue was adversely impacted in the three and six months ended June 30, 2011 due to the reduction in the commission rates that we are paid on new policies as a result of our selling individual and family health insurance plans subsequent to the implementation of the new medical loss ratio requirements beginning in 2011.

Commission rate changes due to the implementation of the new medical loss ratio requirements apply prospectively to applicable commissions earned on or after January 1, 2011 and the majority of the changes applied only to commissions earned on new members approved in 2011 and thereafter. We define a member as an individual covered by an insurance plan for which we are entitled to receive compensation. For the majority of members that were approved prior to the effective date of the commission rate changes, we are being paid commissions at the rates in effect prior to the changes. As a

13

Table of Contents

result, the adverse impact to our overall commission rate structure will phase in over time. Our future commission rates will depend on the mix between members approved prior to the commission rate changes and those approved after the changes, and the mix of new approved members by state, health insurance carrier and plan, among other factors. Additionally, other programs that health insurance carriers have supported, such as commission overrides and sponsorship advertising programs, have also been reduced as carriers look to reduce costs to comply with the new medical loss ratio requirements. Based on information currently available to us, we expect commission revenue to decrease in absolute dollars and as a percentage of total revenue in 2011 compared to 2010.

During both the three and six months ended June 30, 2011, we experienced a 13% decrease in the number of applications submitted through us for individual and family health insurance, compared to the three and six months ended June 30, 2010. Partially offsetting this decrease was an increase in the number of individuals per approved application for individual and family health insurance during both the three and six months ended June 30, 2011. As a result, the number of individuals approved for individual and family health insurance declined at a lower rate than applications submitted for individual and family health insurance in the three and six months ended June 30, 2011. The number of individuals approved for individual and family health insurance decreased 6% and 9%, respectively, in the three and six months ended June 30, 2011 compared to the three and six months ended June 30, 2010. We believe the decrease in the number of applications submitted through us for individual and family health insurance was impacted by certain healthcare reform provisions of the federal Patient Protection and Affordable Care Act, including a provision that allows individuals 18 to 26 years of age the option of staying on their parents policies. We also believe the decrease in the number of applications submitted through us for individual and family health insurance was impacted by our decision to reduce our marketing and advertising spending in our online advertising channel relating to those plans given the reduction in the commission rates that we are paid on new individual and family plans as a result of the implementation of the new medical loss ratio requirements beginning in 2011. We believe the increase in the number of individuals per approved application resulted in part from a provision in the federal Patient Protection and Affordable Care Act that prohibits health insurance carriers from denying applications for child-only health insurance plans for health reasons.

Many carriers have since dropped child-only plans from their offerings, which has caused us to receive fewer applications for child-only plans and more applications with an adult and a child together. We are also experiencing a higher growth rate in applications submitted by older individuals for individual and family health insurance. The growth rate in applications submitted by all individuals over 40 years of age was positive in the three months ended June 30, 2011, compared to the three months ended June 30, 2010. Individuals over 40 years of age typically choose products with higher premiums than children and young adults, which results in a higher premium base from which our commissions are calculated.

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

We began actively marketing the availability of Medicare-related health insurance plans during 2010 through our online Medicare plan platforms (*www.eHealthMedicare.com* and *www.PlanPrescriber.com)*. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, we generate revenue from commissions we receive from health insurance carriers, and these Medicare commissions are included in commission revenue.

Table of Contents

Commission revenue attributable to major medical individual and family health insurance plans represented approximately 91% and 89% of our total commission revenue in the three months ended June 30, 2010 and 2011, respectively, and represented approximately 91% and 90% of our total commission revenue in the six months ended June 30, 2010 and 2011, respectively. Major medical individual and family health insurance plans do not include small business, short-term, stand-alone dental, life, student and Medicare-related health insurance plans.

Other Revenue

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

Medicare Lead Referral. Our online Medicare plan platforms (*www.eHealthMedicare.com* and *www.PlanPrescriber.com),* enable consumers to research and compare Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. The revenue we have generated in our Medicare plan business is primarily referral fees paid to us based on leads generated by our online platforms that are delivered and sold to third parties. We are dependent upon a limited number of purchasers of our leads, and the majority of our lead referral revenue is generated during the Medicare annual enrollment period, which occurs during the fourth quarter of the calendar year. Although we expect to continue to sell a substantial number of Medicare leads to third parties in the future, we intend to perform services for an increasing number of Medicare leads ourselves as a health insurance agent. To the extent that we do so, we will be entitled to receive commissions rather than a one-time referral fee. Medicare commissions we receive are included in commission revenue.

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

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

Online Sponsorship Advertising. We derive revenue from our online sponsorship advertising program that allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications.

We expect other revenue to increase in absolute dollars and as a percentage of total revenue in 2011 compared to 2010 as a result of growth in our technology licensing and government systems business, as well as growth in revenue derived from fees paid to us through the generation and delivery of leads, primarily for Medicare-related insurance plans.

Member Acquisition

An important factor in our revenue growth is the growth of our member base. Our marketing initiatives are an important component of our strategy to grow our member base and are focused on three primary member acquisition channels: direct, marketing partners and online advertising. Our marketing initiatives are primarily designed to encourage consumers to complete an online application for health insurance on our ecommerce platform. In addition, we may refer Medicare-eligible individuals to third parties who may assist them in enrolling in a Medicare plan. Our marketing channels are as follows:

Direct. Our direct member acquisition channel consists of consumers who access our website addresses (*www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com* and *www.PlanPrescriber.com*) either directly or through algorithmic natural search listings on Internet search engines and directories. For the three months ended June, 2010 and 2011, applications submitted through us for individual and family health insurance from our direct channel constituted 44% and 45%, respectively, of all individual and family health insurance applications submitted on our website. For the six months ended June, 2010 and 2011, applications submitted through us for

individual and family health insurance from our direct channel constituted 43% and 44%, respectively, of all individual and family health insurance applications submitted on our website.

Table of Contents

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our websites through a network of affiliate partners and financial services and other companies. Growth in our marketing partner channel depends upon our expanding marketing programs with existing partners and adding new partners to our network. For the three months ended June 30, 2010 and 2011, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 28% and 32%, respectively, of all individual and family health insurance applications submitted on our website. For the six months ended June 30, 2010 and 2011, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 28% and 32%, respectively, of all individual and family health insurance applications submitted on our website.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our websites through paid keyword search advertising from search engines such as Google, MSN and Yahoo!, as well as various Internet marketing programs such as banner advertising and email marketing. For the three months ended June 30, 2010 and 2011, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 28% and 23%, respectively, of all individual and family health insurance applications submitted on our website. For the six months ended June 30, 2010 and 2011, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 29% and 24%, respectively, of all individual and family health insurance applications submitted on our website.

Operating Costs and Expenses

Cost of Revenue

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

Cost of revenue also includes direct labor and other direct costs incurred in connection with our government systems activities. Initial direct labor and other direct costs incurred prior to the availability of our technology for use by a government agency were deferred and included in prepaid expenses and other current assets in our consolidated balance sheet and are being amortized to cost of revenue from the date our technology was available for use by the government agency in October 2010 to the end of the initial one-year term of the contract in July 2011. Direct labor and other direct costs incurred subsequent to the availability of our technology for use by the government agency are recognized as cost of revenue as incurred.

Additionally, cost of revenue includes the amortization of consideration we paid to certain brokers in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies. In November 2010, we entered into an agreement with a partner, whereby the partner transferred certain of its existing Medicare insurance members to us as the broker of record on the underlying policies. Total arrangement consideration of $3.3 million is being amortized to cost of revenue as we recognize commission revenue related to the transferred members over a period of up to five years. In May 2011, we entered into a similar agreement with the same partner, whereby the partner transferred certain of its existing Medicare insurance members to us as the broker of record on the underlying policies. Total arrangement consideration of $3.0 million is being amortized to cost of revenue as we recognize commission revenue related to the transferred members over a period of up to five years.

We expect cost of revenue to increase in absolute dollars in 2011 compared to 2010 due to a full year of costs related to our government systems activities, an increase in the amortization of the consideration we paid in connection with the transfer of certain Medicare members to us from a partner, and an expected increase in the amount of revenue-sharing expense related to partners.

Table of Contents

Marketing and Advertising

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

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

Paid keyword search advertising on search engines represents the majority of expenses in our online advertising channel. We incur expenses associated with search engine advertising in the period in which the consumer clicks on the advertisement. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of such search engine advertising. For example, due to the substantial increase in the number of consumers referred to our website from paid keyword search advertising performed during the Medicare annual enrollment period in the fourth quarter of 2010, we experienced a significant increase in our Medicare online marketing expenses during the fourth quarter of 2010 compared to other quarters in 2010. We expect this same seasonal pattern to impact our Medicare online marketing expenses in the fourth quarter of 2011.

We expect our marketing and advertising expenses to decrease in absolute dollars in 2011 compared to 2010. We have reduced our advertising expenses for individual and family health insurance plans in response to the reduction in commission rates we are paid on those plans that began in 2011. The decline in advertising expenses for individual and family health insurance plans is expected to be partially offset by increased marketing and advertising expenses related to our Medicare plan and government system businesses.

Customer Care and Enrollment

Customer care and enrollment expenses primarily consist of compensation and benefits costs for personnel engaged in pre-sales assistance to applicants who call our customer care center and for enrollment personnel who assist applicants during the underwriting process. We intend to hire a number of additional employees in our customer care centers as part of our plan to increase the number of Medicare leads serviced by us as a health insurance agent. We expect customer care and enrollment expenses to increase in absolute dollars in 2011 compared to 2010 as a result of additional personnel and expenditures necessary to develop future Medicare plan sales capabilities, and a full year of costs related to our customer care center in Salt Lake City, Utah that we opened during the second half of 2010.

Technology and Content

Technology and content expenses consist primarily of compensation and benefits costs for personnel associated with developing and enhancing our website technology as well as maintaining our website. A majority of our technology and content group is located at our wholly owned subsidiary in China, where technology development costs are generally lower than in the United States. We expect technology and content expenses to increase in absolute dollars in 2011 compared to 2010 due to our continued focus on technology development, technology licensing implementations, an increase in technology and content employees and the enhancement of our current ecommerce platform for Medicare-related insurance plans.

17

Table of Contents

General and Administrative

General and administrative expenses include compensation and benefits costs for staff working in our executive, finance, corporate development, investor relations, government relations, 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 and information technology fees. We expect our general and administrative expenses to increase in absolute dollars in 2011 compared to 2010 due to the increased costs necessary to support the future growth of our business.

Amortization of Acquired Intangible Assets

Acquired intangible assets with finite useful lives, which include purchased technology, pharmacy and customer relationships, trade names, trademarks and website addresses, are amortized over their estimated useful lives and are reviewed for impairment annually on or about November 30 of each year or when facts or circumstances suggest that the carrying value of these assets may not be recoverable.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics as of June 30, 2010 and 2011 and for the three months ended June 30, 2010 and 2011:

	Three Months Ended June 30, 2010	Three Months Ended June 30, 2011
Key Metrics:		
Operating cash flows (1)	$ 8,164,000	$ 7,816,000
IFP submitted applications (2)	117,200	101,600
IFP approved members (3)	93,400	87,600
Total approved members (4)	122,700	124,400
Commission revenue (5)	$ 31,872,000	$ 30,079,000
Commission revenue per estimated member for the period (6)	$ 42.21	$ 37.47
Total revenue (7)	$ 36,256,000	$ 36,186,000
Total revenue per estimated member for the period (8)	$ 48.02	$ 45.08

	As of June 30, 2010	As of June 30, 2011
IFP estimated membership (9)	660,500	688,100
Total estimated membership (10)	754,900	804,100

	Three Months Ended June 30, 2010	Three Months Ended June 30, 2011
Marketing and advertising expenses (11)	$ 13,883,000	$ 11,668,000
Marketing and advertising expenses as a percentage of total revenue (12)	38%	32%
Other Metrics:		
Source of IFP submitted applications (as a percentage of total IFP applications for the period):		
Direct (13)	44%	45%
Marketing partners (14)	28%	32%
Online advertising (15)	28%	23%

Total	100%	100%

Notes:

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

Table of Contents

(2) IFP applications submitted on eHealth s website during the period. Applications are counted as submitted when the applicant completes the application, provides a method for payment and clicks the submit button on our website and submits the application to us. The applicant generally has additional actions to take before the application will be reviewed by the insurance carrier, such as providing additional information and providing an electronic signature. In addition, an applicant may submit more than one application. We include applications for IFP plans for which we receive commissions as well as other forms of payment. We define our IFP offerings as major medical individual and family health insurance plans, which does not include small business, short-term, stand-alone dental, life, student or Medicare-related health insurance plans.
(3) New IFP members reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.
(4) New members for all plans, including Medicare plans, reported to eHealth as approved during the period. Some members that are approved by a carrier do not accept the approval and therefore do not become paying members.
(5) Commission revenue (from all sources) recognized during the period from the consolidated statements of income.
(6) Calculated as commission revenue recognized during the period (see note (5) above) divided by average estimated membership for the period (calculated as beginning and ending estimated membership for all plans for the period, divided by two).
(7) Total revenue (from all sources) recognized during the period from the consolidated statements of income.
(8) Calculated as total revenue recognized during the period (see note (7) above) divided by average estimated membership for the period (calculated as beginning and ending estimated membership for all plans for the period, divided by two).
(9) Estimated number of members active on IFP insurance policies as of the date indicated.
(10) Estimated number of members active on all insurance policies, including Medicare policies, as of the date indicated.
(11) Marketing and advertising expenses for the period from the consolidated statements of income.
(12) Calculated as marketing and advertising expenses for the period (see note (11) above) divided by total revenue for the period (see note (7) above).
(13) Percentage of IFP submitted applications from applicants who came directly to the eHealth website through algorithmic search engine results or otherwise. See note (2) above for further information as to what constitutes a submitted application.
(14) Percentage of IFP submitted applications from applicants sourced through eHealth s network of marketing partners. See note (2) above for further information as to what constitutes a submitted application.
(15) Percentage of IFP submitted applications from applicants sourced through paid search and other online advertising activities. See note (2) above for further information as to what constitutes a submitted application.

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

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

19

Table of Contents

Critical Accounting Policies and Estimates

The discussion and analysis of our consolidated financial condition and results of operations is based upon our consolidated financial statements, which have been prepared in accordance with U.S. generally accepted accounting principles. The preparation of these financial statements requires us to make estimates, judgments and assumptions that affect the reported amount of assets, liabilities, revenues and expenses and related disclosure of contingent assets and liabilities. On an ongoing basis, we evaluate our estimates, including those related to, but not limited to, allowances for commission forfeitures payable to carriers, the assumptions used in determining stock-based compensation, the useful lives of long-lived assets including property and equipment and intangible assets, fair value of acquired intangible assets, goodwill, valuation allowance for deferred income taxes, provision for income taxes and fair value of investments. We base our estimates of the carrying value of certain assets and liabilities on historical experience and on various other assumptions that we believe to be reasonable. In many cases, we could reasonably have used different accounting policies and estimates. In some cases, changes in the accounting estimates are reasonably likely to occur from period to period. Accordingly, actual results may differ materially from these estimates.

We believe the following critical accounting policies, in conjunction with the critical accounting policies presented in our Annual Report on Form 10-K for the year ended December 31, 2010, affect our more significant judgments used in the preparation of our consolidated financial statements.

Revenue Recognition

Adoption of ASU 2009-13. In October 2009, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2009-13 *Revenue Recognition (Topic 605): Multiple-Deliverable Revenue Arrangements* (ASU 2009-13). ASU 2009-13 addresses how to measure and allocate arrangement consideration to one or more units of accounting within certain multiple-deliverable arrangements. ASU 2009-13 modifies the requirements for determining whether a deliverable can be treated as a separate unit of accounting by removing the criterion that objective evidence of fair value must exist for the undelivered elements. ASU 2009-13 was effective for us prospectively for revenue arrangements entered into or materially modified on or after January 1, 2011.

In accordance with ASU 2009-13, effective January 1, 2011, we allocate revenue to all deliverables in an arrangement with multiple deliverables at the inception of the arrangement using the relative selling price method. The relative selling price method allocates any discount in an arrangement proportionally to each deliverable on the basis of each deliverable s relative selling price. The relative selling price established for each deliverable is based on vendor-specific objective evidence of fair value (VSOE) if available, third-party evidence of selling price if VSOE is not available, or best estimate of selling price if neither VSOE nor third-party evidence is available. When used, the best estimate of selling price reflects our best estimates of what the selling prices of certain deliverables would be if they were sold regularly on a stand-alone basis.

Our process for determining best estimate of selling price for deliverables without VSOE or third-party evidence of selling price considers multiple factors that may vary depending upon the unique facts and circumstances related to each deliverable. Key factors considered by us in developing the relative selling prices for our technology licensing fees include prices charged by us for similar offerings and our historical pricing practices. We may also consider additional factors as appropriate, including competition.

A deliverable constitutes a separate unit of accounting when it has stand-alone value and there are no customer-negotiated right of refunds for the delivered elements. If the arrangement includes a customer-negotiated right of refund relative to the delivered item, and the delivery and performance of the undelivered item is considered probable and substantially in our control, the delivered element constitutes a separate unit of accounting. In circumstances when the aforementioned criteria are not met, the deliverable is combined with the undelivered elements, and the allocation of the arrangement consideration and revenue recognition is determined for the combined unit as a single unit. Allocation of the consideration is determined at arrangement inception on the basis of each unit s relative selling price. The new standards do not generally change the units of accounting for our revenue transactions.

After the arrangement consideration has been allocated to each unit of accounting within an arrangement with multiple deliverables based on their relative selling prices, we apply revenue recognition criteria separately to each respective unit of accounting in the arrangement in accordance with applicable accounting guidance. Our multiple-element arrangements primarily consist of ecommerce technology licensing agreements, which typically include delivery of a customized website, maintenance and support services to host the website, and professional services.

Table of Contents

Stock-Based Compensation

We recognize stock-based compensation expense in the accompanying consolidated statements of income based on the fair value of our stock-based awards over their respective vesting periods, which is generally four years. The estimated grant date fair value of our stock-based awards is determined using the Black-Scholes-Merton pricing model and a single option award approach.

Prior to 2011, the weighted-average expected term for stock options granted was calculated using the simplified method, as we did not have sufficient historical option exercise behavior on which to estimate expected terms. The simplified method defines the expected term as the average of the contractual term and the vesting period of the stock option. Beginning in 2011, the weighted-average expected term for stock options granted is calculated based on historical option exercise behavior. The weighted-average expected terms are materially the same using both methodologies, so the change did not have a material impact on our financial position, results of operations or cash flows.

Prior to 2011, we estimated the volatility used as an input to the model based on an analysis of our stock price since our initial public offering in October 2006, as well as an analysis of similar public companies for which we have data. We estimated our expected volatility using the weighted-average of: our implied volatility; our mean reversion volatility; and the mean reversion volatility of similar public companies for which we have data. We have used judgment in selecting these companies, as well as evaluating the available historical and implied volatility data for these companies. Since we have over four years of historical data regarding the volatility of our stock price, beginning in 2011, expected volatility for stock options granted is calculated based on the historical volatility of our stock. The estimated volatility of our stock is materially the same using both methodologies, so the change did not have a material impact on our financial position, results of operations or cash flows.

The dividend yield is determined by dividing the expected per share dividend during the coming year by the grant date stock price. Through June 30, 2011, we had not declared or paid any cash dividends, and we do not expect to pay any in the foreseeable future.

We base the risk-free interest rate on the implied yield currently available on U.S. Treasury zero-coupon issues with a remaining term equal to the expected term of our stock options.

The assumptions used in calculating the fair value of stock-based payment awards represent our best estimates, but these estimates involve inherent uncertainties and the application of management judgment. We will continue to use judgment in evaluating the expected term and volatility related to our own stock-based awards on a prospective basis, and incorporating these factors into the model. Changes in key assumptions will significantly impact the valuation of such instruments.

In the three months ended June 30, 2011, we issued restricted stock units representing 115,080 shares of common stock with both service and performance-based vesting criteria to our executive officers. These performance-based restricted stock units are designed to align the interests of our executive officers with the interests of our stockholders. The performance-based contingency period for these restricted stock units is fiscal 2011 ending December 31, 2011, and the measurement of achievement is based on our 2011 revenue, non-GAAP operating earnings and EBITDA results. These performance-based restricted stock units were granted pursuant to the terms of our 2006 Plan. Shares which are earned and eligible to vest following our 2011 results will vest one-third annually in 2012, 2013 and 2014. The criteria for vesting is as follows: up to one-third of the total number of shares will be considered earned and eligible for vesting based upon achieving each of a pre-determined 2011 revenue goal, 2011 non-GAAP operating earnings goal and 2011 EBITDA goal. For achievement at less than 95% of a goal, no shares will be earned relating to that goal. For achievement at 95% to 95.99% of a goal, 25% of the shares related to that goal (i.e., 1/12th of the total number of shares subject to this restricted stock unit) will be considered earned and eligible for vesting. For achievement at 96% to 96.99% of a goal, 30% of the shares related to that goal will be considered earned and eligible for vesting. For achievement at 97% to 97.99% of a goal, 35% of the shares subject to that goal will be considered earned and eligible for vesting. For achievement at 98% to 98.99% of a goal, 40% of the shares related to that goal will be considered earned and eligible for vesting. For achievement at 99% to 99.99% of a goal, 45% of the shares related to that goal will be considered earned and eligible for vesting. For achievement at 100% or more of a goal, 100% of the shares related to that goal will be considered earned and eligible for vesting. Stock-based compensation expense related to these performance-based restricted stock units will be recognized only if there is a high degree of

Table of Contents

probability (greater than 70% chance) of achieving the vesting criteria. As of June 30, 2011, we evaluated the achievement potential for each of the performance criterions for all of our executive officers and we will continue to monitor the achievement potential during the remainder of 2011 to determine if any accumulated stock-based compensation expense requires adjustment for shares that are not expected to vest. Accumulated stock-based compensation expense related to shares determined not to be earned and not eligible to vest will be reversed.

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

Results of Operations

The following table sets forth our operating results and the related percentage of total revenues for the three and six months ended June 30, 2010 and 2011 (dollars in thousands):

	Three Months Ended June 30,				Six Months Ended June 30,			
	2010		2011		2010		2011	
Revenue:								
Commission	$ 31,872	88%	$ 30,079	83%	$ 63,645	88%	$ 60,839	83%
Other	4,384	12	6,107	17	8,600	12	12,902	17
Total revenue	36,256	100	36,186	100	72,245	100	73,741	100
Operating costs and expenses:								
Cost of revenue	881	2	2,555	7	1,859	3	5,206	7
Marketing and advertising	13,883	38	11,668	32	28,701	40	24,577	33
Customer care and enrollment	3,902	11	4,610	13	7,848	11	10,020	14
Technology and content	4,999	14	5,415	15	9,580	13	10,885	15
General and administrative	6,554	18	6,661	18	12,321	17	13,382	18
Amortization of acquired intangible assets	285	1	427	1	285	0	854	1
Total operating costs and expenses	30,504	84	31,336	87	60,594	84	64,924	88
Income from operations	5,752	16	4,850	13	11,651	16	8,817	12
Interest and other income (expense), net	(12)	(0)	(21)	(0)	16	0	(40)	(0)
Income before provision for income taxes	5,740	16	4,829	13	11,667	16	8,777	12
Provision for income taxes	2,699	7	2,097	6	5,393	7	4,064	6
Net income	$ 3,041	8%	$ 2,732	8%	$ 6,274	9%	$ 4,713	6%

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
Marketing and advertising	$ 201	$ 276	$ 408	$ 522
Customer care and enrollment	88	74	181	181
Technology and content	413	470	856	925
General and administrative	894	1,117	1,804	2,170
Total	$ 1,596	$ 1,937	$ 3,249	$ 3,798

Three and Six Months Ended June 30, 2010 and 2011

Revenue

Table of Contents

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Commission	$ 31,872	$ 30,079	$ (1,793)	(6)%	$ 63,645	$ 60,839	$ (2,806)	(4)%
Percentage of total revenue	88%	83%			88%	83%		
Other	$ 4,384	$ 6,107	$ 1,723	39%	$ 8,600	$ 12,902	$ 4,302	50%
Percentage of total revenue	12%	17%			12%	17%		
Total revenue	$ 36,256	$ 36,186	$ (70)	(0)%	$ 72,245	$ 73,741	$ 1,496	2%

Three Months Ended June 30, 2011 and 2010 Commission revenue decreased $1.8 million, or 6%, in the three months ended June 30, 2011 compared to the three months ended June 30, 2010, due primarily to a reduction in the commission rates we are paid on individual and family health insurance policies as a result of the implementation of the medical loss ratio requirements by insurance carriers. These commission rate changes began to impact our individual and family health insurance plan commission-based revenue in 2011. Partially offsetting the reduction in the commission rates was a 7% increase in our estimated membership to approximately 804,100 members at June 30, 2011 from 754,900 members at June 30, 2010. Other revenue increased $1.7 million, or 39%, in the three months ended June 30, 2011 compared to the three months ended June 30, 2010, due primarily to revenue we received related to our government systems activities and an increase in Medicare-related health insurance product lead referral revenue, partially offset by a decline in sponsorship advertising revenue.

Six Months Ended June 30, 2011 and 2010 Commission revenue decreased $2.8 million, or 4%, in the six months ended June 30, 2011 compared to the six months ended June 30, 2010, due primarily to a reduction in the commission rates we are paid on individual and family health insurance policies as a result of the implementation of the medical loss ratio requirements by insurance carriers beginning in 2011. Partially offsetting the reduction in the commission rates was a 7% increase in our estimated membership. Other revenue increased $4.3 million, or 50%, in the six months ended June 30, 2011 compared to the six months ended June 30, 2010, due primarily to revenue we received related to our government systems activities and an increase in Medicare-related health insurance product lead referral revenue, partially offset by a decline in sponsorship advertising revenue.

Operating Costs and Expenses

Cost of Revenue

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Cost of revenue	$ 881	$ 2,555	$ 1,674	190%	$ 1,859	$ 5,206	$ 3,347	180%
Percentage of total revenue	2%	7%			3%	7%		

Three Months Ended June 30, 2011 and 2010 Cost of revenue increased $1.7 million, or 190%, in the three months ended June 30, 2011 compared to the three months ended June 30, 2010, primarily due to costs we recognized on our government systems activities, which began in the second half of 2010.

Six Months Ended June 30, 2011 and 2010 Cost of revenue increased $3.3 million, or 180%, in the six months ended June 30, 2011 compared to the six months ended June 30, 2010, primarily due to costs we recognized on our government systems activities, which began in the second half of 2010.

Table of Contents

Marketing and Advertising

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Marketing and advertising	$ 13,883	$ 11,668	$ (2,215)	(16)%	$ 28,701	$ 24,577	$ (4,124)	(14)%
Percentage of total revenue	38%	32%			40%	33%		

Three Months Ended June 30, 2011 and 2010 Marketing and advertising expenses decreased $2.2 million, or 16%, in the three months ended June 30, 2011 compared to the three months ended June 30, 2010. This was due primarily to a decrease in online and other advertising expenses of $2.6 million as a result of our strategic decision to reduce our advertising expenses for individual and family health insurance plans in response to the reduction in individual and family health insurance plan commission rates. Partially offsetting the decrease in online and other advertising expenses was an increase of $0.2 million in compensation and benefit costs due primarily to an increase in personnel since June 30, 2010.

Six Months Ended June 30, 2011 and 2010 Marketing and advertising expenses decreased $4.1 million, or 14%, in the six months ended June 30, 2011 compared to the six months ended June 30, 2010. This was due primarily to a decrease in online and other advertising expenses of $5.8 million as a result of our strategic decision to reduce our advertising expenses for individual and family health insurance plans in response to the reduction in individual and family health insurance plan commission rates. Partially offsetting the decrease in online and other advertising expenses was an increase of $0.7 million in fees we pay to marketing partners for referrals that result in the submission of a health insurance application on our website. Additionally, compensation and benefit costs increased $0.6 million due primarily to an increase in personnel since June 30, 2010.

Customer Care and Enrollment

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Customer care and enrollment	$ 3,902	$ 4,610	$ 708	18%	$ 7,848	$ 10,020	$ 2,172	28%
Percentage of total revenue	11%	13%			11%	14%		

Three Months Ended June 30, 2011 and 2010 Customer care and enrollment expenses increased $0.7 million, or 18%, in the three months ended June 30, 2011 compared to the three months ended June 30, 2010, due primarily to incremental compensation, benefits and other personnel costs associated with the customer care center we established in Salt Lake City, Utah in the second half of 2010 to service our Medicare product sales business. As a result, compensation, benefits and other personnel costs increased $0.5 million and other operating costs increased $0.2 million in the three months ended June 30, 2011.

Six Months Ended June 30, 2011 and 2010 Customer care and enrollment expenses increased $2.2 million, or 28%, in the six months ended June 30, 2011 compared to the six months ended June 30, 2010, due primarily to incremental compensation, benefits and other personnel costs associated with the customer care center we established in Salt Lake City, Utah in the second half of 2010 to service our Medicare product sales business. As a result, compensation, benefits and other personnel costs increased $1.6 million and other operating costs increased $0.5 million in the six months ended June 30, 2011.

Table of Contents

Technology and Content

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Technology and content	$ 4,999	$ 5,415	$ 416	8%	$ 9,580	$ 10,885	$ 1,305	14%
Percentage of total revenue	14%	15%			13%	15%		

Three Months Ended June 30, 2011 and 2010 Technology and content expenses increased $0.4 million, or 8%, for the three months ended June 30, 2011 compared to the three months ended June 30, 2010. This increase was due primarily to an increase of $0.4 million in compensation, benefits and other personnel costs associated with an increase in technology and content personnel since June 30, 2010.

Six Months Ended June 30, 2011 and 2010 Technology and content expenses increased $1.3 million, or 14%, for the six months ended June 30, 2011 compared to the six months ended June 30, 2010. This increase was due primarily to an increase of $1.1 million in compensation, benefits and other personnel costs associated with an increase in technology and content personnel since June 30, 2010. Additionally, depreciation expense increased $0.2 million as a result of capital expenditures we made for our data centers since June 30, 2010.

General and Administrative

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
General and administrative	$ 6,554	$ 6,661	$ 107	2%	$ 12,321	$ 13,382	$ 1,061	9%
Percentage of total revenue	18%	18%			17%	18%		

Three Months Ended June 30, 2011 and 2010 General and administrative expenses increased $0.1 million, or 2%, in the three months ended June 30, 2011 compared to the three months ended June 30, 2010, due primarily to a $0.5 million increase in compensation, benefits and other personnel costs due to an increase in general and administrative personnel, primarily as a result of our acquisition of PlanPrescriber in April 2010, and an increase in stock-based compensation expense of $0.2 million related to additional equity grants to employees in our general and administrative departments and to members of our board of directors. Partially offsetting these increases was a decrease of $0.6 million project consultant fees related to the completion of a one-time consulting project in the three months ended June 30, 2010.

Six Months Ended June 30, 2011 and 2010 General and administrative expenses increased $1.1 million, or 9%, in the six months ended June 30, 2011 compared to the six months ended June 30, 2010, due primarily to a $1.3 million increase in compensation, benefits and other personnel costs due to an increase in general and administrative personnel, primarily as a result of our acquisition of PlanPrescriber in April 2010, and an increase in stock-based compensation expense of $0.4 million related to additional equity grants to employees in our general and administrative departments and to members of our board of directors. Partially offsetting these increases was a decrease of $0.6 million project consultant fees related to the completion of a one-time consulting project in the six months ended June 30, 2010.

Table of Contents

Interest and Other Income (Expense), Net

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Interest and other income (expense), net	$ (12)	$ (21)	$ (9)	(75)%	$ 16	$ (40)	$ (56)	(450)%
Percentage of total revenue	(0)%	(0)%			0%	(0)%		

Three and Six Months Ended June 30, 2011 and 2010 In the three and six months ended June 30, 2010 and 2011, interest and other income (expense), net, primarily consisted of interest expense on our capital lease obligations, administrative bank fees and investment management fees, partially offset by interest income earned on our invested cash. In the three months ended June 30, 2010 and 2011, and the six months ended June 30, 2011, capital lease obligations, administrative bank fees and investment management fees exceeded interest income earned on our invested cash.

Provision for Income Taxes

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

	Three Months Ended June 30,		Change		Six Months Ended June 30,		Change	
	2010	2011	$	%	2010	2011	$	%
Provision for income taxes	$ 2,699	$ 2,097	$ (602)	(22)%	$ 5,393	$ 4,064	$ (1,329)	(25)%
Percentage of total revenue	7%	6%			7%	6%		

Three and Six Months Ended June 30, 2011 and 2010 During the three and six months ended June 30, 2011, we recorded provisions for income taxes of $2.1 million and $4.1 million, respectively, representing effective tax rates of 43.4% and 46.3%, respectively. Our effective tax rates in the three and six months ended June 30, 2011 were higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and tax shortfalls related to share-based payments. During the three and six months ended June 30, 2010, we recorded provisions for income taxes of $2.7 million and $5.4 million, respectively, representing effective tax rates of 47.0% and 46.2%, respectively. Our effective tax rates in the three and six months ended June 30, 2010 were higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses and, to a lesser extent, tax shortfalls related to share-based payments.

Liquidity and Capital Resources

At June 30, 2011 and December 31, 2010, our cash and cash equivalents totaled $135.9 million and $128.1 million, respectively. Cash equivalents are comprised of financial instruments with an original maturity of 90 days or less from the date of purchase, primarily money market funds. At December 31, 2010 and June 30, 2011, our money market accounts were invested primarily 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.

On July 27, 2010, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to $30 million of our common stock. In January 2011, we completed this stock repurchase program, having repurchased in the aggregate 2,297,705 shares for approximately $30.0 million at an average price of $13.06 per share including commissions. The cost of the repurchased shares was funded from available working capital. Shares repurchased under this program complied with Rule 10b-18 under the Securities Exchange Act of 1934, as amended.

Table of Contents

On June 14, 2011, we announced that our board of directors approved a stock repurchase program authorizing us to purchase up to an additional $30 million of our common stock. Repurchases under this program began in the third quarter of 2011. Purchases under the repurchase program may be made in open market or unsolicited negotiated transactions and are expected to comply with Rule 10b-18 under the Securities Exchange Act of 1934, as amended. The timing of purchases and the exact number of shares to be purchased will depend upon market conditions. The repurchase program does not require us to acquire a specific number of shares, and the repurchase program may be suspended from time to time or discontinued at any time. The cost of the repurchased shares will be funded from available working capital.

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

Stock repurchase activity under our stock repurchase programs as of December 31, 2010 and June 30, 2011 and during the six months ended June 30, 2011 is summarized as follows (in thousands, except share and per share amounts):

	Total Number of Shares Purchased	Average Price Paid per Share (2)	Amount of Repurchase
Cumulative balance at December 31, 2010 (1)	3,904,652	$ 14.39	$ 56,202
Repurchases of common stock	270,903	$ 14.01	3,796
Cumulative balance at June 30, 2011 (1)	4,175,555	$ 14.37	$ 59,998

(1) Cumulative balances at December 31, 2010 and June 30, 2011 include shares repurchased in connection with our stock repurchase program announced on July 27, 2010, as well as a previous stock repurchase plan announced in 2008.
(2) Average price paid per share includes commissions.

In addition to the 4,175,555 shares repurchased under our repurchase programs as of June 30, 2011, we have in treasury 95,466 shares that were surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock units. As of December 31, 2010 and June 30, 2011, we had a total of 3,956,128 shares and 4,271,021 shares, respectively, held in treasury.

The following table presents a summary of our cash flows for the six months ended June 30, 2010 and 2011 (in thousands):

	Six Months Ended June 30,	
	2010	2011
Net cash provided by operating activities	$ 11,257	$ 14,591
Net cash used in investing activities	$ (6,447)	$ (5,008)
Net cash provided by (used in) financing activities	$ 5,123	$ (1,745)

The cash flow statement for the six months ended June 30, 2011 includes a $6.2 million cash flow benefit from deferred income taxes, of which $3.7 million of tax benefit, primarily from the utilization of net operating loss carry forwards, is included in cash flow from operations and approximately $2.6 million of net operating loss carry forwards, from the utilization of excess tax benefits related to share-based payments, is included in cash flows from operating activities.

The cash flow statement for the six months ended June 30, 2010 includes a $10.2 million cash flow benefit from deferred income taxes, of which $4.9 million of tax benefit is included in cash flow from operations and approximately $5.2 million of net operating loss carry forwards, from the utilization of excess tax benefits related to share-based payments, is included in cash flow from financing activities.

Operating Activities

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

Table of Contents

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

Historically, we have experienced a reduction in operating cash flows during the first quarter of the year compared to the other quarters due to the payment of annual performance bonuses to employees in the first quarter of the year. In the first quarter of 2011 our operating cash flow was favorably impacted due to a decrease in accounts receivable as a result of collections of Medicare lead referral receivables recorded during the Medicare annual enrollment period in the fourth quarter of 2010, which occurred from November 15, 2010 to December 31, 2010. In addition, a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform. Since our marketing and advertising costs are expensed as incurred and the revenue from approved applications is recognized as commissions are subsequently reported to us, our operating cash flows could be adversely impacted by a substantial increase in the volume of applications submitted during a quarter or positively impacted by a substantial decline in the volume of applications submitted during a quarter.

Six Months Ended June 30, 2011 Our operating activities generated cash of $14.6 million during the six months ended June 30, 2011 and consisted of net income of $4.7 million, increased by non-cash items of $7.0 million and cash provided for working capital and other activities of $2.9 million. Adjustments for non-cash items primarily consisted of $3.8 million of stock-based compensation expense, $3.7 million of deferred income taxes and $2.1 million of depreciation and amortization, including amortization of acquired intangible assets, partially offset by approximately $2.6 million of excess tax benefits from stock-based compensation. Cash provided for working capital and other activities primarily consisted of a decrease of $6.6 million in accounts receivable and a decrease of $1.5 million in prepaid expenses and other current assets, partially offset by a decrease of $2.1 million in deferred revenue, a decrease of $1.2 million in accounts payable, a decrease of $1.1 million in other current liabilities and a decrease of $0.7 million in accrued compensation and benefits. Accounts receivable decreased primarily due to collections of receivables from our government systems business as well as collection of Medicare lead referral receivables recorded during the Medicare annual enrollment period in the fourth quarter of 2010. Accrued compensation and benefits decreased primarily due to the payment of performance bonuses to employees that were earned during 2010 and accounts payable decreased due to the timing of payments to our vendors.

Six Months Ended June 30, 2010 Our operating activities generated cash of $11.3 million during the six months ended June 30, 2010 and consisted of net income of $6.3 million, increased by non-cash items of $4.3 million and cash provided for working capital and other activities of $0.7 million. Adjustments for non-cash items primarily consisted of $4.9 million of deferred income taxes, $3.2 million of stock-based compensation expense and $1.3 million of depreciation and amortization, including amortization of acquired intangible assets, partially offset by $5.2 million of excess tax benefits from stock-based compensation. Cash provided for working capital and other activities primarily consisted of a decrease of $0.7 million in prepaid expenses and other current assets and an increase of $0.7 million in accrued compensation and benefits, partially offset by a decrease of $1.2 million in other current liabilities.

Investing Activities

Our investing activities have primarily consisted of purchases, sales and maturities of marketable securities and purchases of computer hardware and software to enhance our website and to support our growth.

Six Months Ended June 30, 2011 Net cash used in investing activities of $5.0 million during the six months ended June 30, 2011 included a $3.0 payment related to the transfer of a book of business in the three months ended June 30, 2011 and a $0.8 million final payment related to the transfer of a book of business in the fourth quarter of 2010. For both transfers, we became the broker of record on the underlying policies for certain Medicare insurance members that were transferred to us. Additionally, net cash used by investing activities included capital expenditures of $1.2 million.

Six Months Ended June 30, 2010 Net cash used in investing activities of $6.4 million during the six months ended June 30, 2010 was attributable to cash used for the acquisition of PlanPrescriber of $27.2 million and capital expenditures of $1.3 million, partially offset by maturities of marketable securities of $22.1 million.

Table of Contents

Financing Activities

Six Months Ended June 30, 2011 Net cash used in financing activities of $1.7 million during the six months ended June 30, 2011 was due to $3.8 million used to repurchase 270,903 shares of our common stock and $0.5 million used to net-share settle the tax obligation related to equity awards, partially offset by $2.6 million of excess tax benefits from stock-based compensation.

Six Months Ended June 30, 2010 Net cash provided by financing activities of $5.1 million during the six months ended June 30, 2010 was due to $5.2 million of excess tax benefits from stock-based compensation and $0.5 million of proceeds received from the issuance of common stock pursuant to stock option exercises, partially offset by $0.6 million used to net-share settle the tax obligation related to equity awards.

Future Needs

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

Contractual Obligations and Commitments

The following table presents a summary of our future minimum payments under non-cancellable operating lease agreements and certain contractual service and licensing obligations as of June 30, 2011 (in thousands):

Years Ending December 31,	Operating Lease Obligations	Service and Licensing Obligations	Total Obligations
2011 (6 months)	$ 1,976	$ 369	$ 2,345
2012	3,208	151	3,359
2013	1,037	151	1,188
2014	772	38	810
2015	576		576
Thereafter	1,619		1,619
Total	$ 9,188	$ 709	$ 9,897

Operating Lease Obligations

We lease certain of our office, operating facilities, equipment and furniture and fixtures under various operating leases, the latest of which expires in August 2018. Certain of these leases have free or escalating rent payment provisions. We recognize rent expense on our operating leases on a straight-line basis over the terms of the leases, although actual cash payment obligations under certain of these agreements fluctuate over the terms of the agreements.

On July 8, 2011, we entered into an agreement to extend the lease on our headquarters office in Mountain View, California, for an additional seven years through August 2018. Lease obligations totaling $4.0 million related to this lease are included in the contractual obligations table as of June 30, 2011 above, and can also be found in *Note 8 Subsequent Event* of the *Notes to Condensed Consolidated Financial Statements*.

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.

Table of Contents

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Credit Risk

Our financial instruments that are exposed to concentrations of credit risk principally consist of cash and cash equivalents and accounts receivable. We invest our cash and cash equivalents with major banks and financial institutions and such investments are often in excess of federally insured limits. At December 31, 2010 and June 30, 2011, our money market accounts were invested primarily in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations.

We do not require collateral or other security for our accounts receivable. As of June 30, 2011, two customers represented 43% and 19%, respectively, for a total of 62% of our $5.0 million outstanding accounts receivable. No other customers represented 10% or more of our total accounts receivable. We believe the potential for collection issues with any of our customers is minimal as of June 30, 2011. Accordingly, our allowance for uncollectible amounts at June 30, 2011 was not material.

Significant Customers

Substantially all revenue for all periods presented was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in any of the three- and six-month periods ended June 30, 2010 and 2011 are presented in the table below.

	Percentage of Total Revenue			
	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2011	2010	2011
UnitedHealthcare (1)	14%	15%	15%	14%
WellPoint (2)	14%	12%	14%	12%
Aetna	15%	8%	15%	10%

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

Foreign Currency Exchange Risk

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

Table of Contents

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Our Disclosure Controls and Procedures

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

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

Changes in Internal Control Over Financial Reporting

There were no changes in our internal control over financial reporting that occurred during the three months ended June 30, 2011 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

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

Table of Contents

PART II

OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

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

Table of Contents

ITEM 1A. RISK FACTORS

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

Risks Related to Our Business

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

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

Challenges to the constitutionality of health care reform legislation have been initiated in the federal courts. The challenges center upon the constitutionality of the mandate to purchase health insurance. Decisions on the issue have been inconsistent. These decisions will be appealed and it is impossible to predict the outcome of them.

The implementation of health care reform could increase our competition; reduce or eliminate the need for health insurance agents or demand for the health insurance for individuals, families or small businesses that we sell; decrease the number of health insurance plans that we sell as well as the number of health insurance carriers offering them; cause health insurance carriers to apply more rigorous underwriting standards (until provisions in health care reform legislation limiting underwriting go into effect in 2014) or change the benefits and/or premiums for the plans they sell; or cause health insurance carriers to reduce the amount they pay for our services or change our relationship with them in other ways, any of which could materially harm our business, operating results and financial condition. For instance, the manner in which the federal government and the states implement health insurance exchanges and the process for receiving subsidies and cost-sharing credits could substantially increase our competition and member turnover and substantially reduce the number of individuals, families and small businesses that purchase insurance through us, which would materially harm our business, operating results and financial condition. Various aspects of health care reform could cause health insurance carriers to determine to limit the type of health insurance plans we sell and the geographies in which we sell them, to exit the business of selling insurance plans in a particular jurisdiction, to eliminate certain categories of products or attempt to move members into new plans for which we receive lower commissions, any of which would materially harm our business, operating results and financial condition.

Table of Contents

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

The federal Patient Protection and Affordable Care Act enacted in March 2010 and related amendments in the Health Care and Education Reconciliation Act of 2010 contain provisions requiring health insurance carriers to maintain specified medical loss ratios. The medical loss ratio requirements for both individual and family and small business health insurance are effective for calendar year 2011 and later years and, among other things, require health insurance companies to spend 80% of their premium revenue in each of their state individual and small group businesses on reimbursement for clinical services and activities that improve health care quality. The medical loss ratio requirement for Medicare Advantage plans is 85% and goes into effect in 2014. Carrier reaction to the individual and family medical loss ratio requirements has been to significantly reduce the commissions we receive in connection with the sale of these plans. These reductions will significantly impact our business and operating results beginning in 2011. Health insurance carriers may determine to further reduce our commissions as a result of the medical loss ratio requirements or other aspects of health care reform, which would harm our business, operating results and financial condition. In addition, if health insurance companies fail to meet medical loss ratio requirements, they may contend that we are required to pay back commissions that are related to any amounts the carriers are required to pay policy holders. The medical loss ratio requirements may cause certain health insurance carriers to limit the geographies in which they sell health insurance or exit certain markets altogether, place less reliance on agents to distribute their plans, apply stricter underwriting standards (until provisions in health care reform registration limiting underwriting go into effect in 2014) or limit their health insurance offerings in any number of other ways, each of which would harm our business, operating results and financial condition. The implementation of medical loss ratio requirements has caused and could further cause health insurance carriers to reduce the amount they are willing to spend in connection with our sponsorship and technology licensing businesses, which also could harm our business, operating results and financial condition.

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

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

The health insurance industry in the United States has experienced a substantial amount of consolidation over the past several years, resulting in a decrease in the number of health insurance carriers. In the future, we may be forced to offer insurance policies from a reduced number of insurance carriers or to derive a greater portion of our revenue from a more concentrated number of carriers as our business and the health insurance industry evolve. We derived 14% and 15% of our total revenue in the three months ended June 30, 2010 and 2011 from carriers owned by UnitedHealthcare. We derived 14% and 12% of our total revenue in the three months ended June 30, 2010 and 2011, respectively, from carriers owned by WellPoint. We derived 15% and 8% of our total revenue in the three months ended June 30, 2010 and 2011, respectively, from Aetna. We have many agreements that govern our sale of individual health insurance plans with these health insurance carriers. Many of these agreements may be unilaterally amended or terminated by the carrier on short notice and the amendment or termination could adversely impact the commission payments that we receive from these health insurance carriers. Notwithstanding our separate agreements with various carriers directly or indirectly owned by the same entity, certain carriers have attempted and may continue to attempt to consolidate our relationship with them, which could increase the impact of carrier concentration on us, decrease the commission rates we receive and adversely affect our financial results, particularly in states where we offer health insurance from a relatively smaller number of carriers or where a small number of carriers dominates the market. The termination, amendment or consolidation of our relationship with these and other health insurance carriers could harm our business, operating results and financial condition.

Table of Contents

Our rate of growth will likely decline.

We have recently experienced a significant reduction in the commission rates that health insurance carriers pay us on the individual and family health insurance plans that we sell. We also have in the past and may in the future continue to make significant expenditures related to the development of our business, including expenditures relating to marketing, website technology development, the expansion of our technology licensing business to governmental entities and the development of our business selling Medicare related health insurance plans. Although we have experienced revenue growth in prior periods, we do not project that we will grow our revenue in 2011 compared to 2010, and we also expect our earnings per share to be substantially lower in 2011 than 2010. Our ability to resume revenue and earnings per share growth thereafter will be dependent upon a number of factors, including the success of our Medicare product sales business, our ability to attract individuals, families and small businesses to purchase health insurance through our ecommerce platform, our maintaining our relationships with health insurance carriers and the commission rates we receive for our sale of health insurance plans, our ability to maintain our relationship with existing members within historical levels and our success in entering into relationships with government entities to perform services and license our technology for use in the implementation of health insurance exchanges and other health care reform related endeavors. If we are not successful in these areas, our business, operating results and financial condition will be harmed.

Our revenue will be adversely impacted if our membership does not grow or if the growth rate in our membership declines. The commission rates that we receive are typically higher in the first twelve months of a policy. After the first twelve months, they generally decline significantly. Accordingly, to the extent that our addition of net new members slows or we experience a reduction in the number of our members, our revenue would be adversely impacted due to a decline in commissions we receive for members whose policies have been active for more than twelve months in addition to the reduction in revenue growth that would occur solely as a result of a decline in our membership growth rate. The commission rates we receive are impacted by a variety of other factors, including the particular health insurance policies chosen by our members, the carriers offering those policies, our members states of residence, the laws and regulations in those jurisdictions and health care reform. Our commission rate per member could decrease as a result of either reductions in contractual commission rates or unfavorable changes in health insurance carrier override commission programs, each of which may be beyond our control and may occur on short notice. To the extent these and other factors cause our commission rate per member to decline, our rate of revenue growth may decline and our business, operating results and financial condition would be harmed.

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

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

The success of our entry into the market for Medicare plans as a health insurance agent will depend upon our ability to enter into and maintain relationships with health insurance carriers on favorable economic terms to market these plans on our ecommerce platform. If we are not successful in maintaining relationships with health insurance carriers to market their Medicare plans, or if we are unable to enter into a sufficient number of these relationships to offer Medicare-eligible individuals the ability to choose from a number of plans from different health insurance carriers in a particular jurisdiction, we may not be successful in marketing Medicare plans, and our business, operating results and financial condition would be harmed.

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

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

Table of Contents

- United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, or CMS, state department of insurance and health insurance carrier approval of the use of our platforms and other marketing material for the marketing of the Medicare plans we sell;

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

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

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

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

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

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

Our success in generating Medicare plan lead referral revenue is dependent upon the same factors that could impact our ability to generate Medicare plan commission revenue and is also subject to other risks and uncertainties, including our ability to generate Medicare plan leads. In addition, we may also determine to retain a higher number of our Medicare plan leads for our own direct fulfillment as health insurance agent. Should we do so, we may experience a reduction in revenue in the immediate short term, as we recognize lead referral revenue at the time of delivery and sale of the leads to third parties, but we recognize commission revenue from the sale of Medicare plans for which we serve as an agent over the term of the sold policies. We depend upon CMS to permit us to use Medicare plan data collected by CMS for significant aspects of our PlanPrescriber platform, which has generated the majority of our Medicare plan related lead referral revenue. Most of our Medicare plan lead referral revenue comes from a single purchaser of leads and we expect to rely upon a limited number of lead purchasers in the future. We also generate a significant number of Medicare plan leads through a limited number of marketing partner relationships with pharmacy chains. If we do not reduce our dependence upon a limited number of lead purchasers or sources for Medicare plan leads, our business, operating results and financial condition could be harmed as a result of termination of these relationships or the inability of the purchasers to pay us for the number of leads that we generate.

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

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

36

Table of Contents

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

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

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

The marketing and sale of Medicare plans are subject to numerous laws, regulations and guidelines at the federal and state level. The marketing and sale of Medicare Advantage and Medicare Part D 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 plans, change frequently. As a result of these laws, regulations and guidelines, we have, and will have to continue to, alter our websites and sales process to comply with several requirements that are not applicable to our sale of non-Medicare-related health insurance plans. For instance, many aspects of our online platforms and our marketing material and processes, as well as changes to these platforms, materials and processes, including call center scripts, must be approved by CMS and by health insurance carriers in light of CMS requirements. In addition, certain aspects of our Medicare plan marketing partner relationships with pharmacy chains have in the past and will in the future been 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 Medicare plan business model. Due to changes in CMS guidance or enforcement of existing guidance, or as a result of new regulations and guidelines, CMS, state departments of insurance or health insurance carriers may determine 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 plan business could be slowed or we could be prevented from operating aspects of our Medicare plan business altogether, which would harm our business, operating results and financial condition, particularly if it occurred during the Medicare annual enrollment period. It could also result in the write-down of the value of assets acquired in our PlanPrescriber acquisition.

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

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

As a result of the reduction in the commission rates we receive for selling individual and family health insurance plans, we expect to reduce our marketing and advertising and other expenses in this area of our business. This reduction will result in fewer individual and family health insurance plan approved members for which we would receive commission revenue, particularly in the event our competitors do not similarly reduce their marketing and advertising and other expenses. The reduction of our cost of acquisition depends significantly on improving the rate at which visitors to our website submit health insurance applications, particularly with respect to paid search advertising, as our paid search costs are incurred on the referral of a potential member rather than on the submission of a health insurance application. As a result, we may not be successful in reducing our individual and family health insurance cost of acquisition in the event the rate at which visitors to our platform submit individual and family health insurance declines, which would harm our business, operating results and financial condition.

Table of Contents

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

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

Our business model is characterized primarily by revenue based on commissions we receive from insurance carriers whose policies are purchased by our members. Although our services are complete upon the approval of a member s application, we receive commissions and record related revenue, typically on a monthly basis, until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. A significant component of our marketing and advertising expenses consists of expenses incurred in search engine advertising at the time a consumer clicks on an advertisement and payments owed to our marketing partners in connection with applications submitted on our ecommerce platform by potential members referred to us by our marketing partners. As a result of this timing difference between expense and associated revenue recognition, our operating results and cash flows may be adversely affected in periods where we experience a significant increase in new applicants. In addition, if we incur other unanticipated or one-time expenses in a particular quarter or if we lose a significant amount of our member base for any reason, we would likely be unable to offset these expenses by increasing sales within that quarter or to replace lost revenue in the quarter with revenue from new members. As a result, our quarterly results may suffer due to unanticipated expenses, one-time charges or significant member turnover.

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

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

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

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

Table of Contents

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

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

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

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

- changes in consumer shopping behavior due to circumstances outside of our control, such as economic conditions, consumers ability or willingness to pay for health insurance, extension of unemployment benefits or proposed or enacted legislative or regulatory changes impacting our business;
- the quality of and changes to the consumer experience on our ecommerce platform or with our customer care center;
- regulatory requirements, including those that make the experience on our online platforms cumbersome or difficult to navigate;
- the variety and affordability of the health insurance plans that we offer;
- system failures or interruptions in the operation of our ecommerce platform or call center operations;
- changes in the mix of consumers who are referred to us through our direct, marketing partner and online advertising member acquisition channels;
- the health insurance carriers offering the health insurance plans for which consumers have expressed interest, and the degree to which our technology is integrated with those carriers;
- health insurance carrier underwriting practices and guidelines applicable to applications submitted by consumers and the amount of time a carrier takes to make a decision on that application; and
- competitive offerings.

Our conversion rates can be impacted by changes in the mix of consumers referred to us through our member acquisition channels. For example, our conversion rates have historically been lower with respect to consumers referred to us by Internet lead aggregators and relatively higher with respect to consumers coming to us through our direct member acquisition channel. In addition, we may make changes to our ecommerce

platform or undertake other initiatives in an attempt to improve consumer experience or for other reasons. These changes in the past, and may in the future, have the unintended consequence of adversely impacting our conversion rates. A decline in the percentage of consumers who submit health insurance applications on our ecommerce platform and are converted into members could cause an increase in our cost of acquiring members on a per member basis. To the extent the rate at which we convert consumers visiting our ecommerce platform into members suffers, our membership growth rate may decline, which would harm our business, operating results and financial condition.

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

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

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

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

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

Table of Contents

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

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

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

In addition to marketing through Internet search engines, we frequently enter into contractual marketing relationships with other online and offline businesses that promote us to their customers. These marketing partners include financial and online service companies, affiliate programs and online advertisers and content providers. Our subsidiary PlanPrescriber also has relationships with marketing partners, including pharmacy chains that promote the PlanPrescriber platform 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;

Table of Contents

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

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

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

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

Health insurance carriers typically pay us a specified percentage of the premium amount on a health insurance policy that we have sold during the period that a member maintains coverage under the policy. We rely on health insurance carriers to timely and accurately report the amount of commissions earned by us, and we calculate our commission revenue, prepare our financial reports, projections and budgets and direct our marketing and other operating efforts based on the reports we receive from health insurance carriers. It is often difficult for us to independently determine whether or not carriers are accurately reporting commissions due to us. To the extent that health insurance carriers understate or fail to accurately report the amount of commissions due to us in a timely manner or at all, we will not recognize revenue to which we are entitled, which would harm our business, operating results and financial condition.

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

43

Table of Contents

partners often do not communicate this information to us, and it often takes a significant amount of time for us to learn about small business group cancellations and changes in our membership within the group itself. We often are not made aware of policy cancellations until the time of the group s annual renewal.

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

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

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

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

The market for selling health insurance plans is highly competitive. We compete with entities and individuals that offer and sell health insurance plans utilizing traditional distribution channels as well as the Internet. Our competitors include the tens of thousands of local insurance agents across the United States who sell health insurance plans in their communities. There are a number of agents that operate websites and provide an online shopping experience for consumers interested in purchasing health insurance. Some local agents use lead aggregator services that use the Internet to find consumers interested in purchasing health insurance and are compensated for referring those consumers to the traditional agent. In addition to health insurance brokers and agents, many health insurance carriers directly market and sell their plans to consumers through call centers and their own websites. Although we offer health insurance plans for many of these carriers, they also compete with us by offering their plans directly to consumers. We will also compete with state health insurance exchanges implemented as a result of healthcare reform. In connection with our marketing of Medicare plans, we also compete with the original Medicare program. In addition, CMS offers plan information, comparison tools, call centers and online enrollment for Medicare Advantage and Medicare Part D prescription drug plans.

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

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

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

44

Table of Contents

devote more resources to website and systems development;

negotiate more favorable commission rates and commission override payments; and

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

In addition, CMS has the ability to regulate our marketing and sale of Medicare Advantage and Medicare Part D prescription drug plans. Competitive pressures may result in our experiencing increased marketing costs, decreased traffic to our website and loss of market share, or may otherwise harm our business, operating results and financial condition.

There are many risks associated with our operations in China.

A portion of our operations is conducted in China. Among other things, we use employees in China to maintain and update our ecommerce platform. This and other information is delivered to us through secured communications over the Internet. Our business would be harmed if this connection temporarily failed, and we were prevented from promptly updating our software or implementing other changes to our database and systems. Our operations in China also expose us to different and unfamiliar laws, rules and regulations, including different intellectual property laws, which are not as protective of our intellectual property as the laws in the United States, and different labor and tax laws. United States and Chinese trade laws may impose restrictions on the importation of programming or technology to or from the United States. 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.

In addition, our subsidiary in China has a subsidiary business insurance agency license in the Fujian province in China pursuant to which we are selling health, accident and life insurance in the Fujian province. Our license is up for renewal at the end of 2011. We also have entered into a relationship with a local insurance agency outside the Fujian province in Shanghai, China, pursuant to which we offer the local insurance agency s insurance products in Shanghai on our website in our capacity as a technology service provider. We have similar relationships with insurance companies to offer certain of those companies products throughout China. Additionally, we have entered, and may in the future continue to enter, into relationships with marketing partners to refer additional consumers to our website. We have no prior experience marketing or selling insurance in China or in adapting our business and ecommerce platform to Chinese markets and cultures, legal and regulatory regimes or business customs. For instance, the laws and regulations applicable to our marketing and selling insurance online and assisting others in those efforts in China are unclear, and our operations may be in violation of them. In addition, the laws and regulations may change to prohibit our marketing insurance online. The consequences of violating insurance and other applicable laws and regulations in China are unclear, but they could result in the termination of our license and our ability to host insurance products on our technology platform, payment of fines and damages and could harm our business as a whole. For various reasons, we may not expand in China, and even if we do, there can be no assurance that our ecommerce platform in China would ever generate a significant amount of revenue or otherwise be successful. Our success in establishing an insurance-related business in China is dependent upon many of the factors that influence the success of our business in the United States, including, but not limited to, our receiving regulatory approvals (including the renewal of our license), acceptance of the Internet and our ecommerce platform as a marketplace for the purchase of insurance, our success in marketing our ecommerce platform and in retaining members who purchase insurance through that platform, our ability to enter into and maintain relationships with insurance carriers, commission rates, the affordability of the insurance products offered, insurance carrier business practices, the effectiveness with which we establish a brand identity, performance, reliability and availability of our ecommerce platform, competition, the regulatory environment and the manner in which health care delivery is financed and changes to such environment or manner, our ability to attract qualified personnel and network security.

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

45

Table of Contents

Our sponsorship advertising business may not be successful.

We sell advertising space to health insurance carriers on our website through our sponsorship advertising program. Our sponsorship advertising program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. Health insurance carriers have and may continue to determine to eliminate or reduce spending on our sponsorship advertising program as a result of various aspects of health care reform, including the medical loss ratio requirements that became effective in 2011. As a result, our business, operating results and financial condition could be harmed. To the extent that economic conditions, health care reform or other factors impact the amount health insurance carriers are willing to pay for advertising on our ecommerce platform, our sponsorship advertising program will be adversely impacted. The success of our sponsorship advertising program is dependent upon a number of other factors, including the effectiveness of the sponsorship 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 sponsorship advertising, the cost and other features of the health insurance plan that is the subject of the sponsorship advertising, the impact the sponsorship 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 sponsorship 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 sponsorship advertising. As a result, our business, operating results and financial condition could be harmed.

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

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

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

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

An element of our strategy is to license the use of our technology and provide services to government entities in connection with health care reform and its requirement that states establish health insurance exchanges. While we are involved in a small number of government contracts as a prime contractor or as a subcontractor, we are new to government contracting. Generally, government contracts are offered through a competitive bidding process. A number of entities may compete for the award of any particular government contract or related subcontract, and we may not be able to outbid our competitors. Even if we are awarded a contract, unsuccessful bidders may protest or challenge the contract award, which could result in our losing the contract. Complicated rules apply to doing business with the federal and state governments, including without limitation the Federal Acquisition Regulation (FAR), special FAR agency supplements and state procurement laws and regulations. In addition, socio-economic obligations, including various restrictions relating to those of our employees that may perform under the government contract, may accompany government contracts. These requirements may require us to restructure aspects of our operations to perform under a contract, which may be difficult or impossible. As a government contractor, we are subject to audits, cost reviews and investigations by oversight agencies.

Table of Contents

We may not be successful in our effort to enter into government contracts, and even if we are, we may face difficulty and unanticipated expense in complying with applicable laws, regulations and contractual requirements. If we are not successful in our government contracting efforts, our business, operating results and financial condition could be harmed. In addition, if we fail to comply with the terms of one or more of our government contracts or applicable laws and regulations, we could be suspended or barred from future government projects for a significant period of time, as well as face civil or criminal fines and penalties, which would harm our business, operating results and financial condition.

Government contracts that we have entered into for the use of our services or licensing of our technology have short terms. For instance, while our contract with the federal government to provide certain software and information services relating to the federal government s healthcare reform website is expected to continue for at least the remainder of 2011, CMS has informed us that they intend to transfer our responsibilities to another contractor. Our government contracts may not be renewed for any reason, including as a result of performance of the contract, competing solutions or a change in the governmental entity s preferences. Furthermore, the contracts may be terminated as a result of our performance or as a result of the performance or actions of third parties involved in the contracts, such as a subcontractor or the prime contractor where we are a subcontractor. The termination or nonrenewal of any of our government contracts could harm our business, operating results and financial condition and make it more difficult to successfully bid on future government contracting opportunities.

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

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

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

Companies in the Internet and technology industries own large numbers of patents, copyrights, trademarks and trade secrets and 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.

Table of Contents

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

We provide information on our website, through our customer care centers and in other ways regarding health insurance in general and the health insurance plans we market and sell, including information relating to insurance premiums, coverage, benefits, exclusions, limitations, availability, plan comparisons and insurance company ratings. A significant amount of both automated and manual effort is required to maintain the considerable amount of insurance plan information on our website. Separately, from time to time, we use the information provided on our website and otherwise collected by us to publish reports designed to educate consumers, facilitate public debate, and facilitate reform at the state and federal level relating to the accessibility and affordability of health insurance. If the information we provide on our website, through our customer care center 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, and regulators could attempt to subject us to penalties, revoke our license 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. In the ordinary course of operating our business, we have received complaints that the information we provided was not accurate or was misleading. Although in the past we have resolved these complaints without significant financial cost, we cannot guarantee that we will be able to do so in the future. In addition, these types of claims could be time-consuming and expensive to defend, could divert our management s attention and other resources, and could cause a loss of confidence in our services. As a result, whether or not we are able to successfully resolve these claims, they could harm our business, operating results and financial condition.

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

Our ability to attract and retain qualified personnel is critical to our success.

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

Most of our senior management and key employees have sold shares of our common stock in the open market, and some have sold a significant portion of their vested holdings. These employees may be more likely to leave us given that they have liquidated some or a substantial percentage of their holdings. Our senior management and key employees work for us on an at-will basis and our business could be harmed if we lose their services.

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

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

48

Table of Contents

Seasonality may cause fluctuations in our financial results.

The number of individual and family health insurance applications submitted through our ecommerce platform has generally increased in our first quarter compared to our fourth quarter and in our third quarter compared to our second quarter. Conversely, we have generally experienced a decline or flattening of individual and family submitted applications in our second quarter compared to our first quarter and in our fourth quarter compared to our third quarter. Since a significant portion of our marketing and advertising expenses are driven by the number of health insurance applications submitted on our ecommerce platform, those expenses are influenced by these patterns. The reasons for these seasonal patterns are not entirely clear. As the use of the Internet for the purchase and sale of health insurance becomes more widely accepted and our business matures, other seasonality trends may develop and the existing seasonality and consumer behavior that we experience may change. Any seasonality that we experience may cause fluctuations in our financial results.

Our business of marketing Medicare plans is very seasonal. The vast majority of Medicare plans are sold in the fourth quarter each year during the Medicare annual enrollment period. We also incur a significant portion of our Medicare plan related marketing expenses during the fourth quarter. We may not be paid for a considerable portion of the referral fees owed to us until the first quarter. This seasonality pattern results from the timing of the annual enrollment period when Medicare-eligible individuals can make changes to their Medicare Advantage or Medicare Part D prescription drug coverage for the following year.

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

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

- an acquisition may negatively impact our results of operations because it 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.

Table of Contents

As a part of our initiative to enter into the Medicare plan business, we acquired PlanPrescriber, Inc. in April 2010. PlanPrescriber is a provider of online tools to help seniors navigate Medicare health insurance options. PlanPrescriber has derived its Medicare plan related revenue through the referral of Medicare plan leads to third parties. 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 and the marketing of Medicare plans. 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, and we are in the process of expanding our business operations into the areas of the sale of Medicare plans and government contracting. Ensuring that we have adequate internal financial and accounting controls and procedures in place to help ensure that we can produce accurate financial statements on a timely basis is a costly and time-consuming effort that needs to be re-evaluated frequently and is complicated by the expansion of our business operations. Our management, including our chief executive officer and chief financial officer, does not expect that our internal control over financial reporting will prevent all errors or all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system s objectives will be met. Further, the design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Controls can be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. Over time, controls may become inadequate because changes in conditions or deterioration in the degree of compliance with policies or procedures may occur. Because of the inherent limitations in a cost-effective control system, misstatements due to error or fraud may occur and not be detected.

As a result, we cannot assure that significant deficiencies or material weaknesses in our internal control over financial reporting will not be identified in the future. Any failure to maintain or implement required new or improved controls, or any difficulties we encounter in their implementation, could result in significant deficiencies or material weaknesses, cause us to fail to timely meet our periodic reporting obligations, or result in material misstatements in our financial statements. Any such failure could also adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding disclosure controls and the effectiveness of our internal control over financial reporting required under Section 404 of the Sarbanes-Oxley Act of 2002 and the rules promulgated thereunder. The existence of a material weakness could result in errors in our financial statements that could result in a restatement of financial statements, cause us to fail to timely meet our reporting obligations and cause investors to lose confidence in our reported financial information, leading to a decline in our stock price and potential lawsuits against us.

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

Our provision for income taxes is subject to volatility and could be adversely affected by earnings differing materially from our projections; by changes in the valuation of our deferred tax assets and liabilities; by expiration of or lapses in the research and development tax credit laws; by tax effects of share-based compensation; or by changes in tax laws, regulations, accounting principles, including accounting for uncertain tax positions, or interpretations thereof. For instance, in October 2010, the state of California approved budget legislation which substantially limits the utilization of net operating losses. The new law did not affect the amount of net operating losses and tax credits that we expect to ultimately use to offset future California taxes, but limited the amount we could utilize in 2010 and will be able to utilize in 2011. Since the majority of our state taxes are in California, where our headquarters are located, our cash outlay for federal and state taxes increased for the year ended December 31, 2010 and we expect our cash outlay for federal and state to be impacted similarly for the year ending December 31, 2011.

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

Table of Contents

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

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

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

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

Risks Related to Insurance Regulation

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

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

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

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

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

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

department typically has the power, among other things, to:

grant and revoke licenses to transact insurance business;

Table of Contents

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 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. We also are required to maintain health insurance licenses to sell Medicare products. Even if the allegations in any regulatory or other action against us are proven false, any surrounding negative publicity could harm consumer, marketing partner or health insurance carrier confidence in us, which could significantly damage our brand. Because some consumers, marketing partners and health insurance carriers may not be comfortable with the concept of purchasing health insurance using the Internet, any negative publicity may affect us more than it would others in the health insurance industry and would harm our business, operating results and financial condition. Changes in insurance laws, regulations and guidelines may also be incompatible with various aspects of our business and require that we make significant modifications to our existing technology or practices, which may be costly and time-consuming to implement and could also harm our business, operating results and financial condition.

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

Risks Related to the Internet and Electronic Commerce

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

Our services involve the collection and storage of confidential information of consumers and the transmission of this information to their chosen health insurance carriers. For example, we collect names, addresses, Social Security and credit card numbers, and information regarding the medical history of consumers in connection with their applications for health insurance. As a result, we are subject to various federal, state and international laws and regulations regarding the collection, maintenance, protection, use, transmission, disclosure and disposal of sensitive personal information. We cannot guarantee that our facilities and systems, and those of our third party service providers, will be free of security

breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Compliance

Table of Contents

with privacy and security laws, requirements and regulations may result in cost increases due to new constraints on our business, the development of new processes, the effects of potential non-compliance by third party service providers, and enforcement actions. We may be required to expend significant capital and other resources to protect against security breaches or to alleviate problems caused by security breaches. Despite our implementation of security measures, techniques used to obtain unauthorized access or to sabotage systems change frequently. As a result, we may be unable to anticipate these techniques or to implement adequate preventative measures. Additionally, although our third party service providers are required to implement appropriate security measures, we have limited control over their actions and practices.

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

Government regulation of the Internet could adversely affect our business.

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

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

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

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

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

Risks Related to the Ownership of Our Common Stock

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

Table of Contents

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

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

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

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

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

speculation in the press or investment community;

technological advances or introduction of new products by us or our competitors;

actual or anticipated developments in our competitors businesses or the competitive landscape generally;

litigation involving us, our industry or both;

actual or anticipated regulatory developments in the United States or foreign countries, including health care reform legislation in the United States;

major catastrophic events;

announcements or developments relating to the economy;

our sale of common stock or other securities in the future;

the trading volume of our common stock, as well as sales of large blocks of our stock; or

departures of key personnel.

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

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

A small number of greater than 5% stockholders and their affiliated entities beneficially owned approximately sixty percent of our outstanding common stock as of December 31, 2010. 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.

Table of Contents

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

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

- a classified board of directors with three-year staggered terms, which may delay the ability of stockholders to change the membership of a majority of our board of directors;
- cumulative voting in the election of directors is prohibited, which limits the ability of minority stockholders to elect director candidates;
- the exclusive right of our board of directors to elect a director to fill a vacancy created by the expansion of the board of directors or the resignation, death or removal of a director, which prevents stockholders from being able to fill vacancies on our board of directors;
- the ability of our board of directors to determine to issue shares of preferred stock and to determine the price and other terms of those shares, including preferences and voting rights, without stockholder approval, which could be used to significantly dilute the ownership of a hostile acquiror;
- a prohibition on stockholder action by written consent, which forces stockholder action to be taken at an annual or special meeting of our stockholders;
- the requirement that a special meeting of stockholders may be called only by the chairman of the board of directors, the chief executive officer or the board of directors, which may delay the ability of our stockholders to force consideration of a proposal or to take action, including the removal of directors; and
- advance notice procedures that stockholders must comply with in order to nominate candidates to our board of directors or to propose matters to be acted upon at a stockholders meeting, which may discourage or deter a potential acquiror from conducting a solicitation of proxies to elect the acquiror s own slate of directors or otherwise attempting to obtain control of us.

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

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

None.

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.

Exhibit Number	Description of Exhibit
31.1	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Calculation Linkbase Document
101.LAB	XBRL Taxonomy Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

Filed herewith.
Furnished herewith.

Table of Contents

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized on the 5th day of August 2011.

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

/s/ STUART M. HUIZINGA
Stuart M. Huizinga
Chief Financial Officer
(Principal Financial Officer)

Table of Contents

EXHIBIT INDEX

Exhibit Number	Description of Exhibit
31.1	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to Exchange Act Rule 13a-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1	Certification of Gary L. Lauer, Chief Executive Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Stuart M. Huizinga, Chief Financial Officer of eHealth, Inc., pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Taxonomy Extension Schema Document
101.CAL	XBRL Taxonomy Calculation Linkbase Document
101.LAB	XBRL Taxonomy Label Linkbase Document
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

Filed herewith.
Furnished herewith.