

eHealth, Inc.
Form 10-Q
August 07, 2015

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, D.C. 20549
FORM 10-Q

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

For the quarterly period ended June 30, 2015

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
(State or other jurisdiction of
incorporation or organization)
440 EAST MIDDLEFIELD ROAD
MOUNTAIN VIEW, CALIFORNIA 94043
(Address of principal executive offices)

56-2357876
(I.R.S Employer
Identification No)

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

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

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

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definitions of "large accelerated filer," "accelerated filer" and "smaller reporting

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company” in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer

Accelerated filer

Non-accelerated filer

Smaller reporting company

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

The number of shares of the registrant's common stock, par value \$0.001 per share, outstanding as of July 31, 2015 was 18,080,207 shares.

Table of Contents

EHEALTH, INC. FORM 10-Q

TABLE OF CONTENTS

	PART I FINANCIAL INFORMATION	PAGE
Item 1.	<u>Financial Statements (unaudited)</u>	<u>1</u>
	<u>Condensed Consolidated Balance Sheets at December 31, 2014 and June 30, 2015</u>	<u>1</u>
	<u>Condensed Consolidated Statements of Comprehensive Income for the three and six months ended June 30, 2014 and 2015</u>	<u>2</u>
	<u>Condensed Consolidated Statements of Cash Flows for the six months ended June 30, 2014 and 2015</u>	<u>3</u>
	<u>Notes to Condensed Consolidated Financial Statements</u>	<u>4</u>
Item 2.	<u>Management's Discussion and Analysis of Financial Condition and Results of Operations</u>	<u>13</u>
Item 3.	<u>Quantitative and Qualitative Disclosures About Market Risk</u>	<u>35</u>
Item 4.	<u>Controls and Procedures</u>	<u>36</u>
	PART II OTHER INFORMATION	
Item 1.	<u>Legal Proceedings</u>	<u>37</u>
Item 1A.	<u>Risk Factors</u>	<u>38</u>
Item 5.	<u>Other Item</u>	<u>67</u>
Item 6.	<u>Exhibits</u>	<u>67</u>
	<u>Signatures</u>	<u>68</u>

Table of Contents

PART I

FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

EHEALTH, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands)

	December 31, 2014 (Note 1)	June 30, 2015 (unaudited)
Assets		
Current assets:		
Cash and cash equivalents	\$51,415	\$51,812
Accounts receivable	8,200	10,169
Deferred income taxes	386	386
Prepaid expenses and other current assets	6,474	6,392
Total current assets	66,475	68,759
Property and equipment, net	9,640	8,510
Other assets	5,679	4,122
Intangible assets, net	10,774	10,140
Goodwill	14,096	14,096
Total assets	\$106,664	\$105,627
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable	\$5,961	\$2,066
Accrued compensation and benefits	8,204	8,365
Accrued marketing expenses	8,707	1,711
Deferred revenue	869	602
Accrued restructuring charges	—	289
Other current liabilities	2,996	4,647
Total current liabilities	26,737	17,680
Non-current liabilities	6,449	6,608
Stockholders' equity:		
Common stock	29	29
Additional paid-in capital	259,007	263,195
Treasury stock, at cost	(199,998)	(199,998)
Retained earnings	14,261	17,929
Accumulated other comprehensive income	179	184
Total stockholders' equity	73,478	81,339
Total liabilities and stockholders' equity	\$106,664	\$105,627

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

Table of Contents

EHEALTH, INC.

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

(In thousands, except per share amounts, unaudited)

	Three Months Ended June 30, 2014	2015	Six Months Ended June 30, 2014	2015
Revenue				
Commission	\$38,526	\$37,396	\$84,103	\$95,215
Other	4,068	2,498	9,431	5,967
Total revenue	42,594	39,894	93,534	101,182
Operating costs and expenses:				
Cost of revenue	892	670	3,005	3,084
Marketing and advertising	9,609	9,285	32,718	34,736
Customer care and enrollment	8,984	7,658	18,697	19,519
Technology and content	9,550	8,591	20,017	19,364
General and administrative	6,857	7,516	15,151	15,489
Restructuring charges	—	58	—	4,541
Amortization of intangible assets	354	288	708	633
Total operating costs and expenses	36,246	34,066	90,296	97,366
Income from operations	6,348	5,828	3,238	3,816
Other expense, net	(29)	(9)	(68)	(23)
Income before provision for income taxes	6,319	5,819	3,170	3,793
Provision for income taxes	3,296	69	1,700	125
Net income	\$3,023	\$5,750	\$1,470	\$3,668
Net income per share:				
Basic	\$0.16	\$0.32	\$0.08	\$0.20
Diluted	\$0.15	\$0.32	\$0.07	\$0.20
Weighted-average number of shares used in per share amounts:				
Basic	18,978	17,967	18,914	17,906
Diluted	19,775	18,035	19,821	17,998
Comprehensive income:				
Net income	\$3,023	\$5,750	\$1,470	\$3,668
Foreign currency translation adjustment	1	4	17	5
Comprehensive income	\$3,024	\$5,754	\$1,487	\$3,673

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,	
	2014	2015
Operating activities		
Net income	\$ 1,470	\$ 3,668
Adjustments to reconcile net income to net cash used in operating activities:		
Deferred income taxes	(2,035) —
Depreciation and amortization	2,061	2,108
Amortization of internally-developed software	209	318
Amortization of book-of-business consideration	1,805	1,991
Amortization of intangible assets	708	633
Stock-based compensation expense	4,295	3,858
Deferred rent	34	28
Changes in operating assets and liabilities:		
Accounts receivable	(2,277	) (1,955
Prepaid expenses and other assets	(1,282	) (243
Accounts payable	(227	) (3,895
Accrued compensation and benefits	(3,051	) 159
Accrued marketing expenses	(6,086	) (6,996
Deferred revenue	(603	) (432
Accrued restructuring charges	—	569
Other liabilities	(123	) 1,736
Net cash provided by (used in) operating activities	(5,102	) 1,547
Investing activities		
Purchases of property and equipment and other assets	(2,340	) (1,432
Purchase of intangible assets	(4,500) —
Net cash used in investing activities	(6,840	) (1,432
Financing activities		
Net proceeds from exercise of common stock options	3,244	1,049
Cash used to net-share settle equity awards	(3,355	) (736
Excess tax benefits from stock-based compensation	3,663	—
Repurchase of common stock	(28,256) —
Principal payments in connection with capital leases	(40	) (40
Net cash provided by (used in) financing activities	(24,744	) 273
Effect of exchange rate changes on cash and cash equivalents	13	9
Net increase (decrease) in cash and cash equivalents	(36,673	) 397
Cash and cash equivalents at beginning of period	107,055	51,415
Cash and cash equivalents at end of period	\$ 70,382	\$ 51,812

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”) is the leading private online source of health insurance for individuals, families and small businesses in the United States. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, and apply for and purchase individual and family, Medicare-related, small business and ancillary health insurance plans. We actively market the availability of Medicare-related insurance plans and offer Medicare plan comparison tools and educational materials for Medicare-related insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. Our ecommerce technology also enables us to deliver consumers’ health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process. We are licensed to market and sell health insurance in all 50 states and the District of Columbia.

Basis of Presentation—The accompanying condensed consolidated balance sheet as of June 30, 2015, the condensed consolidated statements of comprehensive income for the three and six months ended June 30, 2014 and 2015 and the condensed consolidated statements of cash flows for the six months ended June 30, 2014 and 2015, respectively, are unaudited. The condensed consolidated balance sheet data as of December 31, 2014 was derived from the audited consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2014, which was filed with the Securities and Exchange Commission on March 16, 2015. 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, 2014, and include all adjustments necessary for the fair presentation of eHealth’s financial position as of June 30, 2015, its results of operations for the three and six months ended June 30, 2014 and 2015 and its cash flows for the six months ended June 30, 2014 and 2015. All adjustments are of a normal recurring nature. The results for the three and six months ended June 30, 2015 are not necessarily indicative of the results to be expected for any subsequent period or for the fiscal year ending December 31, 2015.

Seasonality—The majority of our individual and family plans are sold in the open enrollment period as defined under the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act. For example, in the second quarter of 2015, the number of individual and family applications submitted on our website decreased compared to periods inside the second open enrollment period that began on November 15, 2014 and ended on February 15, 2015.

The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. Additionally, substantially all Medicare Advantage and Medicare Part D prescription drug policies renew on January 1 of each year, resulting in our recognizing substantially all renewal

Medicare Advantage and Medicare Part D prescription drug plan commission revenue in our first quarter. Accordingly, Medicare plan-related commission revenue is highest in our first quarter, with Medicare plan-related commission revenue being higher in our fourth quarter compared to our second and third quarters.

Since a significant portion of our marketing and advertising expenses consists of expenses incurred as a result of payments owed to our marketing partners in connection with health insurance applications submitted on our ecommerce platform and other forms of marketing, such as direct mail, email marketing, television, radio and retargeting campaigns, those expenses are influenced by seasonal submitted application patterns. As a result of the second open enrollment period for individual and family health insurance that began on November 15, 2014 and ended on February 15, 2015, marketing and advertising expenses increased during the fourth quarter of 2014 and first quarter of 2015, consistent with the increases in individual and family submitted applications, compared to periods outside the open enrollment period. During the second quarter of 2015, marketing and advertising expenses decreased, consistent with the decrease in submitted applications, compared to periods during the open enrollment period. In addition, due to the initial open enrollment period for individual and family health insurance that began in October 2013 and ended on March 31, 2014, marketing and advertising expenses

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

increased significantly in the fourth quarter of 2013 and first quarter of 2014, relative to historical levels, and decreased significantly during the second and third quarters of 2014, consistent with the respective increases and decreases in submitted applications.

In the second quarter of 2015, we recorded net income in part due to significantly lower marketing and advertising expenses associated with the decrease in the number of individual and family health insurance applications submitted outside of the open enrollment period and lower customer care and enrollment expenses associated with fewer sales and enrollment personnel required to handle the lower volume of submitted applications outside of the open enrollment period. In the second quarter of 2015, net income also benefitted from increased revenue resulting from members who submitted applications during the second open enrollment period, which ended on February 15, 2015. In addition, our customer care and enrollment and technology and content expenses decreased in the second quarter of 2015, as a result of an organizational restructuring and cost reduction plan we implemented in the first quarter of 2015, which also contributed to net income during the second quarter of 2015. Conversely, in the first quarter of 2015 and the first and fourth quarters of 2014, we incurred a net loss due in part to our higher marketing and advertising expenses associated with the individual and family health insurance applications submitted during the open enrollment periods for individual and family health insurance and Medicare-related health insurance applications submitted during the Medicare annual enrollment periods without a commensurate level of additional revenue resulting from those applicants during the enrollment periods.

Recent Accounting Pronouncements—In February 2015, the Financial Accounting Standard Board (“FASB”) issued Accounting Standards Update (“ASU”) No. 2015-02 (ASU 2015-02) “Consolidation (Topic 810): Amendments to the Consolidation Analysis.” ASU 2015-02 changes the analysis that a reporting entity must perform to determine whether it should consolidate certain types of legal entities. It is effective for annual reporting periods, and interim periods within those years, beginning after December 15, 2015. Early adoption is permitted, including adoption in an interim period. We are currently in the process of evaluating the impact of the adoption of ASU 2015-02 on our consolidated financial statements.

In April 2015, the FASB issued ASU No. 2015-05, “Intangibles - Goodwill and Other - Internal-Use Software (Subtopic 350-40): Customer’s Accounting for Fees Paid in a Cloud Computing Arrangement.” ASU 2015-05 provides guidance to clarify the customer’s accounting for fees paid in a cloud computing arrangement. It is effective for annual periods, and interim periods within those annual periods, beginning after December 15, 2015. Early adoption is permitted, including adoption in an interim period. We are currently in the process of evaluating the impact of the adoption of ASU 2015-05 on our consolidated financial statements.

In May 2014, the FASB issued ASU No. 2014-09, “Revenue from Contracts with Customers.” ASU 2014-09 supersedes the revenue recognition requirements in “Revenue Recognition (Topic 605)”, and requires an entity to recognize revenue when it transfers promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. On July 9, 2015, the FASB agreed to delay the effective date by one year. In accordance with the agreed upon delay, the new standard is effective for annual reporting periods beginning after December 15, 2017, including interim periods within that reporting period and can be adopted using either a full retrospective or modified retrospective approach. Early adoption is not permitted. We are currently in the process of evaluating the impact of the adoption of ASU 2014-09 on our consolidated financial statements.

Note 2 – Balance Sheet Accounts

Cash and Cash Equivalents—As of December 31, 2014 and June 30, 2015, our cash equivalents consisted of money market accounts that invested in U.S. government-sponsored enterprise bonds and discount notes, U.S. government treasury bills and notes and repurchase agreements collateralized by U.S. government obligations. At December 31, 2014 and June 30, 2015, 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, 2014 and 2015.

As of December 31, 2014 and June 30, 2015, our cash and cash equivalent balances were invested as follows (in thousands):

5

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

	December 31, 2014	June 30, 2015
Cash	\$15,793	\$17,189
Money market funds	35,622	34,623
Total cash and cash equivalents	\$51,415	\$51,812

Our money market funds reflect unadjusted quoted prices in active markets for identical assets and are classified as Level 1 as of December 31, 2014 and June 30, 2015.

Accounts Receivable—As of December 31, 2014 and June 30, 2015, our accounts receivable consisted of the following (in thousands):

	December 31, 2014	June 30, 2015
Medicare renewal commission receivable	\$355	\$8,566
Accounts receivable - from other revenues	2,462	1,304
Other commissions receivable	5,383	299
Total accounts receivable	\$8,200	\$10,169

As a result of a regulation issued by CMS, which changed the definition of a plan year from being 12-months from the effective date of a policy to January 1 through December 31 of each year, all Medicare Advantage and Medicare Part D prescription drug policies will renew on January 1 of each year, resulting in our recording of substantially all Medicare Advantage and Medicare Part D prescription drug plan renewal commission revenue in the first quarter of each year. We fully implemented this new rule in our first quarter ended March 31, 2015. We recognize a full year of renewal commission revenue at the time a policy is renewed, however, renewal commissions for Medicare Advantage products are paid monthly. As a result, the majority of renewal commissions for that product is collected in quarters subsequent to the first quarter.

Note 3 – Stockholders' Equity

Stock Plans—The following table summarizes activity under our 2014 Equity Incentive Plan, 2006 Equity Incentive Plan, 1998 Stock Plan and 2005 Stock Plan (collectively, the “Stock Plans”) (in thousands):

	Shares Available for Grant	
Shares available for grant December 31, 2014	4,164	
Restricted stock units granted	(692)
Options granted	(34)
Restricted stock units cancelled (1)	85	
Options cancelled (2)	13	
Shares available for grant June 30, 2015	3,536	

Restricted stock units cancelled does not include 62,000 restricted stock units cancelled under the 2006 Equity (1) Incentive Plan, as our 2006 Equity Incentive Plan has been terminated with respect to our making additional awards under the Plan.

(2) Options cancelled does not include 211,000 stock options cancelled under the 2006 Equity Incentive Plan, as our 2006 Equity Incentive Plan has been terminated with respect to our making additional awards under the Plan.

We maintain our 2006 Equity Incentive Plan, 2005 Stock Plan and 1998 Stock Plan, under which we previously granted options to purchase shares of our common stock and restricted stock units. The 2006 Equity Incentive Plan was terminated with respect to the grant of additional awards on June 12, 2014, upon adoption of our 2014 Equity Incentive Plan. The 2005 Stock Plan and 1998 Stock Plan were terminated with respect to the grant of additional awards upon the effectiveness of the 2006 Equity Incentive Plan. We will continue to issue new shares of common stock upon vesting of restricted stock units and the exercise of stock options previously granted under the 2006 Equity Incentive Plan, 2005 Stock Plan and 1998 Stock Plan.

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

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

	Number of Stock Options	Weighted Average Exercise Price	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (1)
Balance outstanding at December 31, 2014	1,724	\$ 18.50	3.31	\$ 12,884
Granted	34	\$ 11.37		
Exercised	(114)	\$ 9.20		\$ 382
Cancelled	(224)	\$ 21.79		
Balance outstanding at June 30, 2015	1,420	\$ 18.56	3.06	\$ 222
Vested and expected to vest at June 30, 2015	1,397	\$ 18.51	3.03	\$ 217
Exercisable at June 30, 2015	1,108	\$ 17.86	2.63	\$ 179

(1) The aggregate intrinsic value is calculated as the difference between eHealth's closing stock price as of December 31, 2014 and June 30, 2015 and the exercise price of in-the-money options as of those dates.

The total fair value of stock options vested during the three and six months ended June 30, 2014 was \$0.5 million and \$1.2 million, respectively. The total fair value of stock options vested during the three and six months ended June 30, 2015 was \$0.4 million and \$0.9 million, respectively.

The following table summarizes restricted stock unit activity, including performance-based and market-based restricted stock unit activity, under the Stock Plans (in thousands, except per share amounts and weighted average remaining contractual life data):

	Number of Restricted Stock Units (1)	Weighted-Average Grant Date Fair Value	Weighted-Average Remaining Contractual Life (years)	Aggregate Intrinsic Value (2)
Balance outstanding as of December 31, 2014	873	\$ 30.86	2.52	\$ 21,753
Granted	692	\$ 10.59		
Vested	(195)	\$ 24.02		
Cancelled	(147)	\$ 26.53		
Balance outstanding as of June 30, 2015	1,223	\$ 21.00	2.92	\$ 15,522

(1) Includes certain restricted stock units with both service and performance-based or market-based vesting criteria granted to our executive officers.

The aggregate intrinsic value is calculated as eHealth's closing stock price as of December 31, 2014 and June 30, 2015 multiplied by the number of restricted stock units outstanding as of December 31, 2014 and June 30, 2015, respectively.

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

expense related to these awards is recognized on an accelerated basis over the vesting period. The amount of expense recorded for performance-based restricted stock units is based on expected attainment of performance criteria. The total fair value of restricted stock units vested during the three and six months ended June 30, 2014 was \$1.4 million and \$9.8 million, respectively. The total fair value of restricted stock units vested during the three and six months ended June 30, 2015 was \$0.9 million and \$2.1 million, respectively.

Stock Repurchase Programs—We had no stock repurchase activity during the three and six months ended June 30, 2015. In addition to the shares repurchased under our past repurchase programs as of June 30, 2015, we have in treasury 348,475 shares that were previously surrendered by employees to satisfy tax withholdings due in connection with the vesting of certain restricted stock

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

units. As of December 31, 2014 and June 30, 2015, we had a total of 10,945,607 shares and 11,012,363 shares, respectively, held in treasury.

Stock-Based Compensation—The fair value of stock options granted to employees for the three and six months ended June 30, 2014 and 2015 was estimated using the following weighted average assumptions:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2015	2014	2015
Expected term	4.2 years	4.3 years	4.2 years	4.3 years
Expected volatility	45.9	% 63.6	% 45.9	% 63.6
Expected dividend yield	—	% —	% —	% —
Risk-free interest rate	1.42	% 1.15	% 1.42	% 1.15
Weighted-average fair value	\$17.01	\$5.70	\$17.01	\$5.70

In March 2015, we granted market-based stock unit awards to certain members of senior management. Each market-based stock unit award represents a contingent right to receive certain shares of the Company's common stock upon the attainment of certain stock prices over a four-year performance period. Once a stock price threshold is achieved, the portion of the award related to that threshold will vest on the one-year anniversary of the date of achievement, subject to the employee's continued service through each vesting date. Compensation expense related to these awards is recognized on an accelerated basis over the requisite service period. The weighted-average fair value of the market-based stock unit awards was determined using the Monte Carlo simulation model incorporating the following weighted average assumptions:

Expected term	2.59	
Expected volatility	64.7	%
Expected dividend yield	—	%
Risk-free interest rate	1.13	%
Weighted-average fair value	\$6.69	

There were no market-based stock unit awards granted during the three months ended June 30, 2015 and the three and six months ended June 30, 2014.

The following table summarizes stock-based compensation expense recorded during the three and six months ended June 30, 2014 and 2015 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2015	2014	2015
Stock options	\$564	\$371	\$1,206	\$833
Restricted stock units	1,286	1,456	3,089	3,025
Total stock-based compensation expense	\$1,850	\$1,827	\$4,295	\$3,858

The following table summarizes stock-based compensation expense by operating function for the three and six months ended June 30, 2014 and 2015 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2015	2014	2015
Marketing and advertising	\$579	\$446	\$1,236	\$1,037
Customer care and enrollment	71	139	167	256
Technology and content	429	511	991	946

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General and administrative	771	731	1,901	1,506
Restructuring charges	—	—	—	113
Total stock-based compensation expense	\$ 1,850	\$ 1,827	\$ 4,295	\$ 3,858

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

Note 4 – Income Taxes

The following table summarizes our provision for income taxes and our effective tax rates for the three and six months ended June 30, 2014 and 2015 (in thousands, except effective tax rate):

	Three Months Ended June 30,		Six Months Ended June 30,		
	2014	2015	2014	2015	
Income before provision for income taxes	\$6,319	\$5,819	\$3,170	\$3,793	
Provision for income taxes	\$3,296	\$69	\$1,700	\$125	
Effective tax rate	52.2	% 1.2	% 53.6	% 3.3	%

Our effective tax rate in the three and six months ended June 30, 2014 was higher than statutory federal and state tax rates due primarily to non-deductible lobbying expenses. Our effective tax rate in the three and six months ended June 30, 2015 was lower than statutory federal and state tax rates due primarily to the change in valuation allowance, partially offset by certain discrete items.

During the three and six months ended June 30, 2014, excess federal and state tax benefits related to share-based payments resulted in increases of \$0.4 million and \$3.7 million, respectively, in Additional Paid-In Capital in the condensed consolidated balance sheets. These amounts are also classified in the condensed consolidated statements of cash flows as both a reduction to operating cash flows and as a financing cash inflow. During the three and six months ended June 30, 2015, no excess federal and state tax benefits related to share-based payments were recognized.

Note 5 – Net Income Per Share

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

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

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,	
	2014	2015	2014	2015
Basic:				
Numerator:				
Net income allocated to common stock	\$3,023	\$5,750	\$1,470	\$3,668
Denominator:				
Weighted average number of common stock shares outstanding	18,978	17,967	18,914	17,906
Net income per share—basic:	\$0.16	\$0.32	\$0.08	\$0.20
Diluted:				
Numerator:				
Net income allocated to common stock	\$3,023	\$5,750	\$1,470	\$3,668
Denominator:				
Weighted average number of common stock shares outstanding	18,978	17,967	18,914	17,906
Weighted average number of options	623	20	702	22
Weighted average number of restricted stock units	174	48	205	70
Total common stock shares used in diluted per share calculation (1)	19,775	18,035	19,821	17,998
Net income per share—diluted:	\$0.15	\$0.32	\$0.07	\$0.20

(1) Total common stock shares used in diluted per share calculation excludes market-based stock unit awards for which the related contingency had not been met as of June 30, 2015.

For each of the three- and six-month periods ended June 30, 2014 and 2015, we had securities outstanding that could potentially dilute net income per share, but the shares from the assumed exercise of these securities were excluded in the computation of diluted net income per share as their effect would have been anti-dilutive for the periods presented. 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,	
	2014	2015	2014	2015
Common stock options	130	1,450	27	1,507
Restricted stock units	65	492	—	447
Total	195	1,942	27	1,954

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

Note 6 – Geographic Information and Significant Customers

Geographic Information—As of December 31, 2014 and June 30, 2015, 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, 2014	As of June 30, 2015
United States	\$39,752	\$36,446
China	437	422
Total	\$40,189	\$36,868

Significant Customers—Substantially all revenue for the three and six months ended June 30, 2014 and 2015 was generated from customers located in the United States. Carriers representing 10% or more of our total revenue in the three and six months ended June 30, 2014 and 2015 are presented in the table below:

	Three Months Ended June 30,		Six Months Ended June 30,		
	2014	2015	2014	2015	
Humana	21	% 13	% 24	% 26	%
Anthem (1)	11	% 11	% 11	% 9	%
UnitedHealthcare (2)	9	% 11	% 10	% 10	%
Aetna (3)	10	% 8	% 10	% 9	%

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

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

(3)Aetna also includes other carriers owned by Aetna.

Commission revenue attributable to major medical individual and family health insurance plans was approximately 68% and 64% of our commission revenue in the three and six months ended June 30, 2014, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 65% and 49% of our commission revenue in the three and six months ended June 30, 2015, respectively. We define our individual and family plan offerings as major medical individual and family health insurance plans, which do not include small business, Medicare-related health insurance plan offerings and other ancillary products such as short-term, stand-alone dental, life, vision, and accident insurance plan offerings.

As of December 31, 2014, three customers represented 30%, 17% and 14%, respectively, of our \$8.2 million outstanding accounts receivable balance. As of June 30, 2015, one customer represented 58% of our \$10.2 million outstanding accounts receivable balance. No other customers represented 10% or more of our total accounts receivable at December 31, 2014 and June 30, 2015. We believe the potential for collection issues with any of our customers is minimal as of June 30, 2015. Accordingly, our estimate for uncollectible amounts at June 30, 2015 was not material.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

Note 7 – Restructuring Charges

In March 2015, we implemented an organizational restructuring and cost reduction plan designed to rebalance our resources and help reduce our cost structure as a result of lower than expected individual and family health insurance plan membership and revenue. As part of the plan, we eliminated approximately 160 full-time positions in the United States, representing approximately 15% of our workforce primarily in our technology and content and customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. We incurred pre-tax restructuring charges of approximately \$3.9 million for employee termination benefits and related costs as well as \$0.6 million in other pre-tax restructuring charges, primarily consisting of facility exit costs. The majority of the restructuring charges were recorded in the first quarter of 2015, when the activities comprising the plan were approved and substantially completed. In March 2015, as part of our restructuring activities, we also eliminated certain positions in our China operation.

The following table summarizes the total cash and non-cash restructuring charges recorded during the three and six months ended June 30, 2015 (in thousands):

	Three Months Ended June 30,		Six Months Ended June 30,	
	2014	2015	2014	2015
Employee termination costs	\$—	\$57	\$—	\$3,791
Non-cash employee termination costs - stock-based compensation	—	—	—	113
Facility and other termination costs	—	1	—	637
Total restructuring charges	\$—	\$58	\$—	\$4,541

The following table summarizes the cash-based restructuring charges liability activity during the six months ended June 30, 2015 (in thousands):

	Six Months Ended June 30, 2015			
	Beginning balance	Charges	Payments	Ending balance
Employee termination costs	\$—	\$3,791	\$(3,754)	) \$37
Facility and other termination costs	—	637	(105)	) 532
Total restructuring liability	\$—	\$4,428	\$(3,859)	) \$569
Less: non-current restructuring charges associated with facilities				(280)
Restructuring charges liability - current				\$289

Note 8 - Commitments and Contingencies

Legal Proceedings—On January 26 and March 10, 2015, two purported class action lawsuits were filed against us, our chairman and chief executive officer, Gary L. Lauer (“Mr. Lauer”), and our senior vice president and chief financial

officer, Stuart M. Huizinga (“Mr. Huizinga”), in the United States District Court for the Northern District of California. On May 6, 2015, the Court consolidated the two cases. On June 10, 2015, a consolidated complaint was filed. The consolidated complaint alleges that the defendants made false and misleading statements regarding the Company’s financial performance, guidance and operations during an alleged class period of May 1, 2014 to January 14, 2015. The consolidated complaint alleges that we and Messrs. Lauer and Huizinga violated Sections 10(b) and 20(a) of the Securities Exchange Act of 1934 and Rule 10b-5 promulgated thereunder. The consolidated complaint seeks compensatory damages, attorneys’ fees and costs, rescission or a rescissory measure of damages, equitable/injunctive relief and such other relief as the court deems proper. On July 15, 2015, defendants moved to dismiss the consolidated complaint.

Table of Contents

EHEALTH, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(unaudited)

In the ordinary course of our business, we have received and may continue to receive inquiries from state regulators relating to various matters. At December 31, 2014 and June 30, 2015 we had no material liabilities included in our consolidated balance sheet for outstanding legal claims.

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

In addition to historical information, this Quarterly Report on Form 10-Q contains forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934. These statements include, among other things, statements regarding our expectations relating to submitted applications and our membership; our expectations relating to revenue (including commission revenue, advertising revenue and other revenue), sources of revenue, cost of revenue, the collectability of our accounts receivable, operating expenses, marketing and advertising expenses, customer care and enrollment employees and expenses, technology and content expenses, general and administrative expenses and profitability; expectations regarding the potential costs and impact of our cost reduction measures and reduction in headcount; our expectations regarding the impact of healthcare reform on our business; our ability to enroll and plans relating to the enrollment of individuals and families into qualified health plans through government health insurance exchanges; our ability to enter into agreements with and meet requirements to offer qualified health plans through state and federal health insurance exchanges; our expectations relating to the commission rates that health insurance carriers will pay; our expectations relating to the seasonality of our business; our expectations relating to the renewal of Medicare-related health insurance plans and the timing of our generation of renewal commission revenue on those plans; the timing of our receipt of commission payments; our expectations relating to seasonal trends in our business relating to the sale of Medicare-related health insurance; estimations of our membership and related assumptions that we make in our membership estimations; our expectations relating to membership attrition and retention rates; the shift between marketing partner and direct marketing channels as sources of submitted individual and family plan applications during 2015; our critical accounting policies and related estimates; our expectation that we will experience an increase in submitted applications during open enrollment periods; our belief that cash generated from operations and our current cash and cash equivalents will be sufficient to fund operations for the next twelve months; our beliefs relating to the potential for collection of our accounts receivable; expected competition from government-run health insurance exchanges and other sources; our ability to adjust headcount to respond to changes in demand due to annual open enrollment periods; our ability to convert subsidy-eligible individuals and families into members; the timing of open enrollment periods including restrictions on changes outside of such periods and our readiness therefore; the timing and source of our Medicare-related revenue; the impact of the healthcare reform laws on the healthcare industry in future periods; the potential impact of lawsuits challenging certain aspects of the Affordable Care Act; the merits of any lawsuits filed against us; future capital requirements; our need for additional regulatory licenses and approvals; as well as other statements regarding our future operations, financial condition, prospects and business strategies. These forward-looking statements are subject to certain risks and uncertainties that could cause our actual results to differ materially from those reflected in the forward-looking statements. Factors that could cause or contribute to such differences include, but are not limited to, those risks associated with the impact of healthcare reform and court decisions relating to healthcare reform; our ability to retain existing members and enroll a large number of individuals and families during the annual healthcare reform open enrollment period; our ability to align our expenses with our revenue; the impact of annual enrollment period for the purchase of individual and family health insurance and its timing on our recognition of revenue; our ability to sell qualified health insurance plans to subsidy-eligible individuals

and to enroll subsidy eligible individuals through government-run health insurance exchanges; competition, including competition from government-run health insurance exchanges; political, legislative and legal challenges to the Affordable Care Act; seasonality of our business and the fluctuation of our operating results; our ability to retain existing members and limit member turnover; changes in consumer behaviors and their selection of individual and family health insurance products, including the selection of products for which we receive lower commissions; product offerings among carriers and the resulting impact on our commission revenue; the impact of healthcare reform on the cost of health insurance; the cost of health insurance in the upcoming open enrollment period; the impact of increased health insurance costs on demand; our ability to timely receive and accurately predict the amount of commission payments from health insurance carriers; variability in timing of commission payments from health insurance carriers; medical loss ratio requirements; delays in our receipt of items required to recognize Medicare revenue; changes in member conversion rates; our ability to accurately estimate membership; the evolving nature of Affordable Care Act implementation; our relationships with health insurance carriers; our success in marketing and selling health insurance plans and our unit cost of acquisition; our ability to hire, train and retain licensed health insurance agents and other employees; the need for health insurance carrier and regulatory approvals in connection with the marketing of Medicare-related insurance products; our ability to successfully market and sell Medicare-related health insurance plans; the operations of our customer care center; costs of acquiring new members; scalability of the Medicare business; lack of membership growth and retention rates; consumers' satisfaction with our service; changes in the competitive landscape; our ability to attract new members and

Table of Contents

to convert online visitors into paying members; changes in products offered on our ecommerce platform; changes in commission rates; maintaining and enhancing our brand identity; our ability to derive desired benefits from investments in our business, including membership growth initiatives; system failures, capacity constraints, data loss or online commerce security risks; dependence on acceptance of the Internet as a marketplace for the purchase and sale of health insurance; our ability to develop an effective process for purchasing of health insurance over the Internet on smartphones, tablets and devices other than desktop or laptop computers; dependence upon Internet search engines; reliance on marketing partners; timing of receipt and accuracy of commission reports; payment practices of health insurance carriers; general economic factors; dependence on our operations in China; success of our sponsorship and advertising business; protection of our intellectual property and defense against intellectual property rights claims; legal liability and regulatory penalties; changes in our management and key employees; maintenance of relationships with business development partners; difficulties, delays, unexpected costs and an inability to achieve anticipated cost savings from our recently implemented organizational restructuring and cost reduction program; potential acquisitions; potential consolidation in the health insurance industry; maintenance of proper and effective internal controls; potential changes to accounting standards and interpretations; impact of provisions for income taxes; changes in laws and regulations, including in connection with health care reform and/or with respect to the marketing and sale of Medicare-related plans; compliance with insurance and other laws and regulations; exposure to security risks; and the performance, reliability and availability of our ecommerce platform and underlying network infrastructure. Other risks include the risks discussed under the heading “Risk Factors” 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 2015, 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 private online source of health insurance for individuals, families and small businesses. Through our website addresses (www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com), consumers can get quotes from leading health insurance carriers, compare plans side-by-side, apply for and purchase individual and family, Medicare-related, ancillary and small business health insurance plans. Our ecommerce technology also enables us to deliver consumers’ health insurance applications electronically to health insurance carriers. As a result, we simplify and streamline the complex and traditionally paper-intensive health insurance sales and purchasing process.

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

We generate revenue primarily from commissions we receive from health insurance carriers whose health insurance policies are purchased through our ecommerce platform. Commission revenue represented 90% of total revenue in the three and six months ended June 30, 2014 and represented 94% of total revenue in the three and six months ended June 30, 2015.

The commission payments we receive on individual and family, ancillary and small business health insurance plans we sell primarily consist of either a flat amount per member per month or a percentage of the premium on the policy, and to a much lesser extent, commission override payments that insurance carriers pay us for achieving sales volume

thresholds or other objectives. The commission payments that we receive for individual and family, ancillary and small business health insurance plans are typically made to us on a monthly basis for as long as the plans remain active with us.

In March 2010, the federal Patient Protection and Affordable Care Act and related amendments in the Health Care and Education Reconciliation Act were signed into law. These health care reform laws contain provisions that have changed and will continue to change the health insurance industry in substantial ways. We have described various aspects of health care reform in Part II, Item 1A. Risk Factors - Risks Related to Our Business. While aspects of health care reform may positively impact our business, the aggregate future impact of the implementation of health care reform on our business and financial results is uncertain. Our ability to continue to act as a health insurance agent for our members who switch to a new health insurance product and for new members will depend upon a number of factors, including health insurance company practices, individual financial circumstances and their eligibility for health care reform subsidies, our members' existing health insurance plans, the price of health insurance and our ability to offer and sell subsidy-eligible health insurance plans efficiently in an online process. Moreover, we are facing new competition in the form of government run health insurance exchanges. Our

Table of Contents

ability to act as a health insurance agent to health care reform subsidy-eligible individuals depends upon government-run health insurance exchanges developing and maintaining an efficient, scalable and online enrollment process, and our ability to successfully enter into and maintain agreements and integrate with those government-run exchanges. In order to enroll individuals in subsidy-eligible plans over the Internet, we also need to meet a number of requirements relating to the display of information on our websites as well as new and comprehensive privacy and security requirements. Our ability to maintain compliance with these and other requirements could present significant challenges for us. In addition, the implementation of an open enrollment period for the purchase of individual health insurance also presents challenges to our ability to enroll a significant number of individuals into health insurance over a limited period of time and inhibits our ability to obtain new health insurance members outside of the open enrollment period. The impact of health care reform on our health insurance carrier partners and their reaction is also unclear. For instance, health insurance carriers have the ability to unilaterally change their relationship with us, including the commission rates we receive for acting as a health insurance agent and may reduce the amount they pay us, alter the manner and geographic areas in which they permit us to sell their products and change our relationship with them in any number of ways. In light of these and other considerations, health care reform has negatively impacted our business and results of operations and could in the aggregate have a material adverse effect on our business and results of operations in the future.

We actively market the availability of Medicare-related health insurance plans through our online Medicare plan platforms www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com. Our Medicare plan platforms and telephonic enrollment capabilities enable consumers to research, compare and purchase Medicare-related health insurance plans, including Medicare Advantage, Medicare Supplement and Medicare Part D prescription drug plans. To the extent that we assist in the sale of Medicare-related insurance plans as a health insurance agent, through either online applications or telephonically, we generate revenue from commissions we receive from health insurance carriers. Commission payments we receive for Medicare Advantage and Medicare Part D prescription drug policies sold by us are typically fixed and are earned over a period of six years, or longer depending on the carrier arrangement, and are paid to us either monthly or annually. Commission payments we receive for Medicare Supplement policies sold by us typically are a percentage of the premium on the policy and paid to us until either the health insurance policy is cancelled or we otherwise do not remain the agent on the policy.

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

In addition to the commission revenue we derive from the sale of health insurance plans, we derive other revenue from our online sponsorship and advertising program and from licensing the use of our ecommerce technology. We offer advertising services for our Medicare plan carriers to purchase advertising on separate websites developed, hosted and maintained by us for a pre-determined amount of time. In addition, our online sponsorship program allows carriers to purchase advertising space in specific markets in a sponsorship area on our website. The technology platform we license enables health insurance carriers and agents to market and distribute health insurance plans online.

Restructuring

On March 10, 2015, we implemented an organizational restructuring and cost reduction plan. As part of the plan, we eliminated approximately 160 full-time positions, representing approximately 15% of our workforce primarily in our technology and content and customer care and enrollment groups, and to a lesser extent, in our marketing and advertising and general and administrative groups. We incurred pre-tax restructuring charges of approximately \$3.9 million for employee termination benefits and related costs as well as \$0.6 million in other pre-tax restructuring charges, primarily consisting of facility exit costs. The majority of the restructuring charges were recorded in the first

quarter of 2015, when the activities comprising the plan were substantially completed. In March 2015, as part of our restructuring activities, we also eliminated certain positions in our China operation.

Sources of Revenue

15

Table of Contents

Commission Revenue

Commission revenue attributable to major medical individual and family health insurance plans was approximately 68% and 64% of our commission revenue in the three and six months ended June 30, 2014, respectively. Commission revenue attributable to major medical individual and family health insurance plans was approximately 65% and 49% of our commission revenue in the three and six months ended June 30, 2015, respectively. The decline in the percentage of commission revenue attributable to major medical individual and family health insurance plans in the three and six months ended June 30, 2015 compared to the three and six months ended June 30, 2014 was due primarily to increases in commission revenue attributable to Medicare-related health insurance plans while individual and family plan commissions declined year over year.

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

Individual and Family Plans. Commission rates for individual and family health insurance plans may vary by carrier, by geography and by the type of plan purchased by a member. Additionally, commission rates commonly vary based upon the amount of time that the policy has been active, with commission rates 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, as we experienced in 2014. Individuals and families purchasing health insurance through us typically pay their premiums on a monthly basis. Insurance carriers typically pay commissions to us on these policies monthly, after they receive the premium payment from the member. We generally continue to receive the commission payment from the relevant insurance carrier until the health insurance policy is cancelled or we otherwise do not remain the agent on the policy. As a result, the majority of our individual and family plan commission revenue is recurring in nature. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2014 for details regarding our recognition of individual and family health insurance plan commission revenue.

The implementation of health care reform has had a significant impact on our individual and family health insurance membership and commission revenue. For example, health care reform established open enrollment periods for the purchase of individual and family insurance. The first open enrollment period ran from October 1, 2013 through March 31, 2014 for coverage effective in 2014, and the second ran from November 15, 2014 through February 15, 2015 for coverage effective in 2015. The next annual open enrollment period for individual and family health insurance is scheduled to run from November 1, 2015 through January 31, 2016 for coverage effective in 2016. Individuals and families generally are not able to purchase individual and family health insurance outside of open enrollment periods, unless they qualify for a special enrollment period as a result of certain qualifying events, such as losing employer-sponsored health insurance, moving to another state or becoming eligible or ineligible for a government subsidy for their health insurance. Open enrollment periods have changed the seasonality of our individual and family health insurance business.

Our individual and family health insurance commission revenue is influenced by a number of factors, including:

- the number of applications for individual and family health insurance we submit to health insurance carriers;
- the number of individuals applying for health insurance on submitted applications;
- the rate at which the individuals and families on those applications turn into paying members;
- the commission rates we receive for the plans that we sell; and

our membership retention.

Submitted Applications. In connection with the initial health care reform open enrollment period, that began on October 1, 2013 and ended on March 31, 2014, we experienced a significant increase, relative to historical levels, in the number of submitted applications for individual and family health insurance during the fourth quarter of 2013 and the first quarter of 2014. Following the conclusion of the initial open enrollment period, our individual and family health insurance submitted applications decreased significantly during the second and third quarters of 2014 relative to historical levels and to the first quarter of 2014. The second open enrollment period began on November 15, 2014 and ended on February 15, 2015. While we experienced a significant increase in the number of submitted applications for individual and family health insurance

Table of Contents

during the fourth quarter of 2014 compared to the second and third quarters of 2014, they were 41% below the number of submitted application during the fourth quarter of 2013. The number of individual and family health insurance submitted applications during the first quarter of 2015 was higher than the number of applications submitted during the fourth quarter of 2014, but 17% below the number of applications submitted during the first quarter of 2014. Outside the second open enrollment period, the number of individual and family health insurance submitted applications during the second quarter of 2015 decreased significantly compared to the first quarter of 2015 but remained relatively flat compared to the second quarter of 2014. Similar to 2014, we expect individual and family submitted applications to remain relatively flat in the third quarter of 2015 compared to the second quarter of 2015. We also expect individual and family submitted applications will increase significantly during the fourth quarter of 2015, relative to the second and third quarters of 2015, as a result of the next open enrollment period.

Members per Submitted Application. We also experienced a decline in the average number of members on our submitted individual and family plan health insurance applications in the first quarters of 2014 and 2015 compared to the second through fourth quarters of 2013 and 2014, respectively, which were outside the open enrollment period under health care reform. While the average returned to historical rates in the second quarter of 2014, it did not return to historical rates in the second quarter of 2015. The lower average during the first quarters of 2014 and 2015, when individual and family plan submitted applications were highest as a result of the open enrollment period, adversely impacted our membership throughout 2014 and 2015 as well as the commission revenue we would have received throughout 2014 and 2015 had the average been consistent with historical levels prior to that period.

Approval Rates. As a result of the health care reform prohibition on using pre-existing health conditions as a reason to deny health insurance applications, we have experienced higher approval rates on individual and family plan applications submitted during the first quarters of 2014 and 2015 compared to periods before health care reform implementation. However, during the second and third quarters of 2014, we also experienced a decrease in the rate at which these approvals resulted in paying members. This decrease was mainly due to an increase in the rate of non-payment of initial premium by applicants, as well as health insurance carrier-specific issues. In addition, during the second and third quarters of 2014, some carriers postponed payment of commission to us for qualified health insurance plans where the member holding the plan is receiving a subsidy, until the health insurance carrier received both the premium payment from the member and the subsidy payment from the federal government, which further delayed our ability to recognize revenue from the sale of these policies during 2014. During the first quarter of 2015, we experienced an increase in the rate at which these approvals resulted in paying members, compared to the first and second quarters of 2014. In addition, during the first and second quarters of 2015, our individual and family plan commission revenue benefitted from carriers paying us earlier on policies approved during the recently completed open enrollment period compared to a year ago. We believe that the more timely payments of commissions resulted from our carrier partners being better prepared to handle large application volumes during the recently completed open enrollment period compared to the first open enrollment period a year ago, and we also took steps to work with our carrier partners to ensure that their processes resulted in more timely commission payments to us. It is unclear whether this trend will continue throughout the remainder of 2015.

Commission Rates. The average commission dollars per-member-per-month that we receive for new individual and family health insurance plan members varies based upon a number of factors, including the ratio of policies that we sold for which we receive per member-per-month commissions compared to percentage-of-premium commissions, the premiums on the policies we sold, the mix of our members by health insurance carrier and the commission rates we receive from each carrier. The increased volume of individual and family health insurance submitted applications during the open enrollment periods caused us to experience a shift in the concentration of our membership by health insurance carrier and type of plan purchased. For example, some health insurance carriers exited or reduced selling efforts in certain markets during the initial open enrollment period, while others increased their marketing efforts in certain markets. These and other factors resulted in a change in the concentration of our individual and family health insurance members by carrier, which had the impact, after incorporating the positive impact of health insurance

premium inflation, of reducing our average commission rate per member in the second and third quarters of 2014. However, we observed higher commissions on many of the individual and family health insurance plan policies that we sold during the second open enrollment period for which we received payments from health insurance carriers during the first and second quarters of 2015 compared to policies that we sold during the first open enrollment period for which we received payments from health insurance carriers during the first and second quarters of 2014. We believe that at least some of this can be explained by higher average premiums on qualified health plans that we were able to sell in greater volume during the most recent open enrollment period and by overall premium inflation across the market for individual and family health insurance. It is unclear whether this trend will continue throughout the remainder of 2015.

Retention Rates. Our individual and family health insurance commission revenue is also influenced by our individual and family health insurance member retention rates. The member retention rates on our individual and family membership were negatively impacted by health care reform beginning in the fourth quarter of 2013, throughout 2014 and during the first half of

Table of Contents

2015. As a result, the number of new individual and family health insurance members added during the second, third and fourth quarters of 2014 and the first and second quarters of 2015, was not enough to offset the loss of existing members, resulting in an annual decline in individual and family health insurance estimated membership during those periods. We expect this trend to continue in the third and fourth quarters of 2015.

Medicare Plans. Commission rates for Medicare-related health insurance plans may vary by carrier, by geography and by the type of plan purchased by a member. In the first plan year of a Medicare Advantage and Medicare Part D prescription drug plan, after the health insurance carrier approves the application but during the effective year of the policy, we are paid a fixed commission that is prorated for the number of months remaining in the calendar year.

Additionally, if the policy is the first Medicare Advantage or Medicare Part D policy issued to the member, we may receive a higher commission rate that covers a full twelve-month period, regardless of the month the policy was effective. We earn commission revenue for both Medicare Advantage and Medicare Part D prescription drug plans typically for a period of at least six years, depending on the carrier arrangement, provided that the policy remains active with us. For Medicare Supplement plans, our commission rates generally represent a percentage of the premium amount collected by the carrier during the period that a member maintains coverage under a policy. We generally continue to receive the Medicare Supplement 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 Medicare commission revenue is recurring in nature. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2014 for details regarding our recognition of Medicare plan commission revenue.

The majority of Medicare plans are sold in our fourth quarter during the Medicare annual enrollment period, when Medicare-eligible individuals are permitted to change their Medicare Advantage and Medicare Part D prescription drug coverage for the following year. As a result, we have generated a significant amount of Medicare plan-related revenue in the fourth quarter resulting from the sale of new Medicare plans. For example, during 2014, 62% of our Medicare plan-related applications were submitted during the fourth quarter. Historically, we recognized a majority of our renewal Medicare Advantage and Medicare Part D prescription drug plan commission revenue in the first quarter of each year as the majority of policies sold during the annual enrollment period typically renew on January 1 of each year. As a result of a regulation issued by the CMS, which changed the definition of a plan year from being 12-months from the effective date of a policy to January 1 through December 31 of each year, all Medicare Advantage and Medicare Part D prescription drug policies renew on January 1 of each year, regardless of the month the policy went into effect, which resulted in our recording substantially all Medicare Advantage and Medicare Part D prescription drug plan renewal commission revenue in the first quarter of 2015, resulted in negligible renewal commission in the second quarter of 2015 and will result in negligible renewal commission revenue in the second, third or fourth quarters of each year for these products. In addition, CMS also issued a regulation prohibiting carriers from paying commissions during the fourth quarter on Medicare Advantage and Medicare Part D prescription drug policies sold during the fourth quarter with an effective date in the following year until January 1st.

Ancillary Plans. We market and sell ancillary health insurance plans, which primarily consist of short-term, dental, life, vision, and accident insurance plans, on our ecommerce platform. Historically, we have sold ancillary health insurance plans alongside individual and family health insurance plans and also as standalone products. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2014 for details regarding our recognition of ancillary health insurance plan commission revenue.

Other Revenue

Online Sponsorship and Advertising. We offer advertising services for our Medicare plan carriers to purchase advertising on separate websites developed, hosted and maintained by us for a pre-determined amount of time. In these instances, we are typically paid a fixed, up-front fee. In addition, our online sponsorship program allows

carriers to purchase advertising space in specific markets in a sponsorship area on our website. In return, we are typically paid a monthly fee and a performance-based fee based on metrics such as submitted health insurance applications. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2014 for details regarding our recognition of online sponsorship and advertising 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 typically paid implementation fees and performance-based fees that are based on metrics such as submitted health insurance applications. See Critical Accounting Policies and Estimates in Part II, Item 7 of our Annual Report on Form 10-K for the year ended December 31, 2014 for details regarding our recognition of technology licensing revenue.

Table of Contents

Member Acquisition

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

Direct. Our direct member acquisition channel consists of consumers who access our website addresses, including www.eHealth.com, www.eHealthInsurance.com, www.eHealthMedicare.com, www.Medicare.com and www.PlanPrescriber.com, either directly, through paid search listings on Internet search engines and directories, or other forms of marketing, such as direct mail, email marketing, television, radio and retargeting campaigns. For the three and six months ended June 30, 2015, applications submitted through us for individual and family health insurance from our direct channel constituted 53% and 41%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2014, applications submitted through us for individual and family health insurance from our direct channel constituted 61% and 39%, respectively, of all individual and family health insurance applications submitted on our website.

Marketing Partners. Our marketing partner member acquisition channel consists of consumers who access our websites through a network of affiliate partners and financial services and other companies. We compensate a significant number of our marketing partners by paying a fee each time a consumer referral from a partner results in a submitted health insurance application, regardless of whether the consumer's application is approved by the health insurance carrier. Many of our marketing partners have tiered arrangements in which the amount of the fee increases as the volume of submitted applications we receive from the marketing partner increases over a particular period. We recognize these expenditures in the period when a marketing partner's referral results in the submission of a health insurance application. 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 and six months ended June 30, 2015, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 42% and 47%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2014, applications submitted through us for individual and family health insurance plans from our marketing partner member acquisition channel constituted approximately 27% and 42%, respectively, of all individual and family health insurance applications submitted on our website. We rely heavily on marketing partners as a source of submitted applications for Medicare-related health insurance plans. In February 2015 CMS issued guidance indicating that third-party websites and marketing material must be filed for approval with CMS. Some health insurance carriers have interpreted this guidance to mean that websites and other marketing material of our marketing partners must go through the process of CMS filing and approval. We have described various risks relating to the CMS guidance in Part II, Item 1A. Risk Factors - Risks Related to our Business.

Online Advertising. Our online advertising member acquisition channel consists of consumers who access our websites through paid keyword search advertising from search engines such as Google, Bing and Yahoo!, as well as various Internet marketing programs such as display advertising. We incur expenses associated with search advertising in the period in which the consumer clicks on the advertisement. For the three and six months ended June 30, 2015, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 5% and 12%, respectively, of all individual and family health insurance applications submitted on our website. For the three and six months ended June 30, 2014, applications submitted through us for individual and family health insurance plans from our online advertising channel constituted approximately 12% and 19%, respectively, of all individual and family health insurance applications submitted on our website.

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

Operating Costs and Expenses

Table of Contents

Cost of Revenue

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

Additionally, cost of revenue includes the amortization of consideration we paid to certain broker partners in connection with the transfer of their health insurance members to us as the new broker of record on the underlying policies. These transfers include primarily Medicare plan members. Total consideration paid in connection with these transfers that occurred between 2009 and 2012 amounted to \$13.9 million. Consideration for all book-of-business transfers is being amortized to cost of revenue as we recognize commission revenue related to the transferred members.

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.

Since a significant portion of our marketing and advertising expenses consists of expenses incurred as a result of payments owed to our marketing partners in connection with health insurance applications submitted on our ecommerce platform and other forms of marketing, such as direct mail, email marketing, television, radio and retargeting campaigns, those expenses are influenced by seasonal submitted application patterns. During the second quarter of 2015, marketing and advertising expenses decreased, consistent with the decrease in submitted applications, compared to periods during the open enrollment period. As a result of the second open enrollment period for individual and family plans that began on November 15, 2014 and ended on February 15, 2015, marketing and advertising expenses increased during the fourth quarter of 2014 and first quarter of 2015, consistent with the increases in submitted applications, compared to periods outside the open enrollment period. In addition, due to the initial open enrollment period for individual and family plans that began in October 2013 and ended on March 31, 2014, marketing and advertising expenses increased significantly in the fourth quarter of 2013 and first quarter of 2014, relative to historical levels, and decreased significantly during the second and third quarters of 2014, consistent with the respective increases and decreases in submitted applications. Additionally, we expect individual and family-related marketing and advertising expense to decline significantly in the third quarter of 2015, outside of the open enrollment period, relative to the first quarter of 2015. We also expect both Medicare and individual and family health insurance submitted applications and related marketing and advertising expenses will increase significantly during the fourth quarter of 2015, relative to the second and third quarters of 2015, as a result of the next Medicare annual enrollment period and individual and family health insurance open enrollment period.

Because the total volume of submitted applications that we receive from our marketing partners is largely outside of our control, particularly during any short-term period, and because of our tiered marketing partner arrangements, we could incur expenses in excess of, or below, the amounts we had planned in periods of rapid change in the volume of submitted applications from marketing partner referrals. Similar to our marketing partner channel, expenses in our online advertising channel will increase or decrease in relation to any increase or decrease in consumers referred to our website as a result of search engine advertising. Increases in submitted applications resulting from marketing partner referrals or visitors to our website from our online advertising channel has in the past resulted and could in the future result in marketing and advertising expenses significantly higher than our expectations. This has in the past negatively impacted and could in the future negatively impact our profitability during such periods, because the

revenue (if any) derived from submitted applications that are approved by health insurance carriers is not recognized until future periods.

During the second quarter of 2015, with the decrease in submitted individual and family plan applications outside of the open enrollment period, the source of our submitted individual and family plan applications shifted so that a greater number of applications came from our direct member acquisition channel compared to the fourth quarter of 2014 and the first quarter of 2015. During the fourth quarter of 2014 and first quarter of 2015, as a result of the health care reform second open enrollment period, the source of our submitted individual and family plan applications shifted so that a greater number of applications came from our higher cost marketing partner member acquisition channel compared to the second and third quarters of 2014. During the second and third quarters of 2014, with the decreases in submitted individual and family plan applications outside of the health care reform open enrollment period, the source of our submitted individual and family plan applications shifted so that a greater number of applications came from our direct member acquisition channel compared to the fourth quarter of 2013 and first quarter of 2014. During the third quarter of 2015, we expect a greater number of submitted individual and family plan

Table of Contents

applications will come from our direct member acquisition channel, similar to the second quarter of 2015 and the third quarter of 2014. During the fourth quarter of 2015, as a result of the next open enrollment period, we expect the source of our submitted individual and family plan applications to again shift to our higher cost marketing partner channel, similar to prior years.

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 enrollment process. In preparation for the Medicare annual enrollment period, and to a lesser extent the open enrollment period for individual and family plans, during 2014, we began ramping up our customer care center staff during our third quarter to handle the anticipated increased volume of health insurance transactions. Additionally, in the first quarters of 2014 and 2015, we retained some Medicare sales and enrollment personnel to handle the increased volume of individual and family plan applications during the initial and second open enrollment periods for individual and family health insurance that ended on March 31, 2014 and February 15, 2015, respectively. Accordingly, our customer care center staffing costs have been significantly higher in our first and fourth quarters compared to the second and third quarters. These seasonal trends are expected to continue in 2015 as we will likely need to add seasonal customer care and enrollment personnel primarily to assist with the increase in submitted applications expected during the next Medicare annual enrollment period.

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.

General and Administrative

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

Restructuring Charges

Restructuring expense consists mainly of costs associated with our March 2015 organizational restructuring and cost reduction plan, designed to rebalance our resources and help reduce our cost structure as a result of lower than expected individual and family health insurance plan membership and revenue.

These restructuring activities were substantially complete in March 2015; however, we expect to continue to incur costs as we finalize previous estimates and actions in connection with these plans.

Summary of Selected Metrics

The following table shows certain selected quarterly metrics for the three months ended June 30, 2014 and 2015 and as of June 30, 2014 and 2015:

Table of Contents

	Three Months Ended June 30, 2014	Three Months Ended June 30, 2015
Key Metrics:		
Operating cash flows (1)	\$ 308,000	\$ 12,719,000
IFP submitted applications (2)	24,800	23,900
IFP approved members (3)	95,100	36,800
Total approved members (4)	208,000	125,200
Commission revenue (5)	\$ 38,526,000	\$ 37,396,000
Commission revenue per estimated member for the period (6)	\$ 30.40	\$ 32.45
	As of	As of
	June 30, 2014	June 30, 2015
IFP estimated membership (7)	751,000	568,400
Medicare estimated membership (8)	113,200	169,100
Other estimated membership (9)	384,600	404,900
Total estimated membership (10)	1,248,800	1,142,400
	Three Months Ended June 30, 2014	Three Months Ended June 30, 2015
Source of IFP submitted applications (as a percentage of total IFP applications for the period):		